ICD-10-CM Official Guidelines for Coding and Reporting 2017

Narrative changes appear in bold text.

Items underlined have been moved within the guidelines since the FY 2016 version.

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The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

A. Conventions for the ICD-10-CM

The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-10-CM as classification independent of the guidelines.

1. The Alphabetic Index and Tabular List

The ICD-10-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a structured list of codes divided into chapters based on body system or condition. The Alphabetic Index consists of the following parts: Index of Diseases and Injury, the Index of External Causes of Injury, the Table of Neoplasms and the Table of Drugs and Chemicals.

See Section I.C.2. General guidelines

See Section I.C.19. Adverse effects, poisoning, undetermined and toxic effects

2. Format and Structure:

The ICD-10-CM Tabular List contains categories, subcategories and codes. Characters for categories, subcategories and codes may be either a letter or a number. All codes are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subentry. This note appears immediately under a three character code title to further define, or give examples of, the content of the category.

See Section I.B.18. Use of Signs/Symptom/Unspecified Codes

3. Use of codes for reporting purposes

For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required.

4. Placeholder character

The ICD-10-CM utilizes a placeholder character “X.” The “X” is used as a placeholder at certain codes to allow for future expansion. An example of this is at the poisoning, adverse effect and undetermined codes, categories T66-T69.

If a placeholder exists, the X must be used in order for the code to be considered a valid code.

5. 7th Characters

Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 7 characters, a placeholder X must be used to fill in the empty characters.

6. Abbreviations

a. Alphabetic Index abbreviations

NEC “Not elsewhere classifiable”

This abbreviation in the Alphabetic Index represents “other specified.” When a specific code is not available for a condition, the Alphabetic Index directs the coder to the “other specified” code in the Tabular List.

NOS “Not otherwise specified”

This abbreviation is the equivalent of unspecified.

b. Tabular List abbreviations

NEC “Not elsewhere classifiable”

This abbreviation in the Tabular List represents “other specified.” When a specific code is not available for a condition, the Tabular List includes an NEC entry under a code to identify the code as the “other specified” code.

NOS “Not otherwise specified”

This abbreviation is the equivalent of unspecified.

7. Punctuation

(1) Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.

(2) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers. These nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence. For example, in the ICD-10-CM Alphabetic Index under the main term Enteral, “acute” is a nonessential modifier and “chronic” is a subentry. In this case, the nonessential modifier “acute” does not apply to the subentry “chronic.”

(3) Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it applicable to a given category.

8. Use of “and”.

See Section I.A.14. Use of the term “and”

9. Other and Unspecified codes

a. Other codes

Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designates “other” in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an “other” code.

b. “Unspecified” codes

Codes titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the “other specified” code may represent both other and unspecified.

See Section I.B.18. Use of Signs/Symptom/Unspecified Codes

10. Includes Notes

This note appears immediately under a three character code title to further define, or give examples of, the content of the category.

11. Inclusion terms

List of terms is included under some codes. These terms are the conditions for which the code is to be used. The terms may be synonyms of the code title, or, in the case of “other specified” codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.
12. Excludes Notes
The ICD-10-CM has two types of excludes notes. Each type of note has a different definition for use but they are all similar in that they indicate that codes excluded from one another are independent of each other.

a. Excludes1
An Excludes1 note is a pure-excludes note. It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider. For example, code F45.8, Other somatoform disorders, has an Excludes1 note for “sleep related teeth grinding (ICD-4:43),” because “teeth grinding” is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other, and it would be appropriate to report F45.8 and G47.43 together.

b. Excludes2
A type 2 Excludes note represents “Not included here.” An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

13. Etiology/manifestation convention (“code first”, “use additional code” and “in diseases classified elsewhere” notes)
Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation. Whenever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. Instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

In most cases the manifestation codes will have in the code title, “in diseases classified elsewhere.” Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. “In diseases classified elsewhere” codes are never permitted to be used as first listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition. See category F02, Dementia in other diseases classified elsewhere, for an example of this convention.

There are manifestation codes that do not have “in diseases classified elsewhere” in the title. For such codes, there is a “use additional code” note at the etiology code and a “code first” note at the manifestation code, and the rules above for sequencing apply. In addition to the notes in the Tabular List, these conditions also have a specific Alphabetic Index entry structure. In the Alphabetic Index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second.

An example of the etiology/manifestation convention is dementia in Parkinson’s disease. In the Alphabetic Index, code G20 is listed first, followed by code F82.8B or F82.81 in brackets. Code G20 represents the underlying etiology, Parkinson’s disease, and must be sequenced first, whereas codes F82.8B and F82.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance.

“Code first” and “use additional code” notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/manifestation combination.

See Section 1B.7, Multiple coding for a single condition.

14. “And”
The word “and” should be interpreted to mean either “and” or “or” when it appears in a title.

For example, cases of “tuberculosis of bones,” “tuberculosis of joints” and “tuberculosis of bones and joints” are classified to subcategory A18.2, Tuberculosis of bones and joints.

15. “With”
The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related. The word “with” in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

16. “See” and “See Also”
The “see” instruction following a main term in the Alphabetic Index indicates that another term should be referenced. It is necessary to go to the main term referenced with the “see” note to locate the correct code. A “see also” instruction following a main term in the Alphabetic Index instructs that there is another main term that may also be referenced that may provide additional Alphabetic Index entries that may be useful. It is not necessary to follow the “see also” note when the original main term provides the necessary code.

17. “Code also” note
A “code also” note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction.

18. Default codes
A code listed next to a main term in the ICD-10-CM Alphabetic Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term, or is the unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.

19. Code assignment and Clinical Criteria
The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

B. General Coding Guidelines
1. Locating a code in the ICD-10-CM
To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Alphabetic Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.

It is essential to use both the Alphabetic Index and Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash ( - ) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

2. Level of Detail in Coding
Diagnosis codes are to be used and reported at their highest number of characters available.
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ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth characters, which provide greater detail.

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

3. Code or codes from AN8.8 through T88.8, Z88-299.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

4. Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R88-89-R99) contains many, but not all, codes for symptoms.

See Section I.D.18 Use of Signs/Symptom/Unspecified Codes

5. Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

7. Multiple coding for a single condition

In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. Additional coding notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as for etiology/manifestation pairs, “use additional code” indicates that a secondary code should be added.

For example, for bacterial infections that are not included in chapter 1, a secondary code from category B96, Streptococcus, Staphylococcus, and Enterococcus, as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, may be required to identify the bacterial organism causing the infection. A “use additional code” note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.

“Code first” notes are also under certain codes that are not specifically manifested codes but may be due to an underlying case. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.

“Code, if applicable, any causal condition first” notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for sequelae, complication codes and etiologic codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

8. Acute and Chronic Conditions

If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

9. Combination Code

A combination code is a single code used to classify:

Two diagnoses, or

A diagnosis with an associated secondary process (manifestation)

A diagnosis with an associated complication

Combination codes are identified by referring to subentries in the Alphabetic Index and by reading the inclusion and exclusion notes in the Tabular List.

Assign only the combination code when that code fully identifies the diagnostic conditions involved or when the Alphabetic Index so directs.

Multiple coding should not be used when the classification provides a combination code that clearly identifies all of the elements documented in the diagnosis. When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as a secondary code.

10. Sequela (Late Effects)

A sequela is a residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela can be used. The residual may be apparent early, such as an cerebral infection, or it may occur months or years later, such as that due to a previous injury. Examples of sequela include: scar formation resulting from a burn, deviated septum due to a nasal fracture, and infertility due to tubal occlusion from old tuberculosis.

Coding of sequelae generally requires two codes sequenced in the following order: the condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

An exception to the above guidelines are those instances where the code for the sequela is followed by a manifestation code identified in the Tabular List and title, or the sequela code has been expanded at the fourth, fifth or sixth character level to include the manifestation(s). The code for the acute phase of an illness or injury that led to the sequela is never used with a code for the late effect.

See Section I.C.9 Sequelae of cerebrovascular disease

See Section I.C.15. Sequelae of complication of pregnancy, childbirth and the puerperium

See Section I.C.19. Application of 7th characters for Chapter 19

11. Impending or Threatened Condition

Code any condition described at the time of discharge as “impending” or “threatened” as follows:

If it did occur, code as confirmed diagnosis.

If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entry for “impending” and for “Threatened” if the subterms are listed, assign the given code.

If the subentries are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

12. Reporting Same Diagnosis Code More than Once

Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

13. Laterality

Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

When a patient has a bilateral condition and each side is treated during separate encounters, assign the “bilateral” code (as the condition still exists on both sides), including for the encounter to treat the first side. For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters). The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.
14. Documentation for BMI, Depth of Non-pressure ulcers, Pressure Ulcer Stages, Coma Scale, and NIH Stroke Scale

For the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (e.g., physician or other qualified healthcare practitioner) legally accountable for establishing the patient’s diagnosis, since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI; a nurse often documents the pressure ulcer stage, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, or pressure ulcer) must be documented by the patient’s provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient’s attending provider should be queried for clarification.

The BMI, coma scale, and NIHSS codes should only be reported as secondary diagnoses.

15. Syndromes

Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign the codes for the documented manifestations of the syndrome. Additional codes for manifestations that are not an integral part of the disease process may also be assigned when the condition does not have a unique code.

16. Documentation of Complications of Care

Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure, unless otherwise instructed by the classification. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication the provider for clarification, if the complication is not clearly documented.

17. Borderline Diagnosis

If the provider documents a “borderline” diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific code for a borderline condition. If a borderline condition has a specific index entry in ICD-10-CM, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient). Whenever the documentation is unclear regarding a borderline condition, codes are encouraged to query for clarification.

18. Use of Sign/Symptom/Unspecified Codes

Sign/symptom and “unspecified” codes have acceptable, even necessary uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

C. Chapter-Specific Coding Guidelines

In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings. Please refer to Section II for guidelines on the selection of principal diagnosis.

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

a. Human Immunodeficiency Virus (HIV) Infections

1) Code only confirmed cases

Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.

In this context, “confirmation” does not require documentation of position or culture for the patient’s diagnostic report. The statement that the patient is HIV positive, or has an HIV-related illness is sufficient.

2) Selection and sequencing of HIV codes

(a) Patient admitted for HIV-related condition

If a patient is admitted for an HIV-related condition, the principal diagnosis should be B20, Human immunodeficiency virus (HIV) disease followed by additional diagnosis codes for all reported HIV-related conditions.

(b) Patient with HIV disease admitted for unrelated condition

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be B20 followed by additional diagnosis codes for all reported HIV-related conditions.

(c) Whether the patient is newly diagnosed

Whether the patient is newly diagnosed or has had previous admissions/encounters for HIV conditions is irrelevant to the sequencing decision.

(d) Asymptomatic human immunodeficiency virus

Z21, Asymptomatic human immunodeficiency virus (HIV) infection status, is to be applied when the patient without any documentation of symptoms is listed as being “HIV positive,” “HIV+,” “HIV+ test positive,” or similar terminology. Do not use this code if the term “AIDS” is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status, use B20 in these cases.

(e) Patients with inconclusive HIV serology

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned code R75, Inconclusive laboratory evidence of human immunodeficiency virus [HIV].

(f) Previously diagnosed HIV-related illness

Patients with any known prior diagnosis of an HIV-related illness should be coded B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21, Asymptomatic human immunodeficiency virus (HIV) infection status.

(g) HIV Infection in Pregnancy, Childbirth and the Puerperium

During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of D09.7, Human immunodeficiency virus (HIV) disease complicating pregnancy, childbirth and the puerperium, followed by B20 and the code(s) for the HIV-related (diagnosis). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during...
b. Infectious agents as the cause of diseases classified to other chapters
Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism. A code from category B95, Staphylococcus, Streplococci, and Enterococci as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.

c. Infections resistant to antibiotics
Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign a code from category Z71.7, Human immunodeficiency virus [HIV] counseling, may be used if counseling is provided during the encounter for the test.

If the results are positive, see previous guidelines and assign codes as appropriate.

1) Coding of Sepsis and Severe Sepsis
In the absence of an identified organism, the infection code does not identify drug resistance. It is necessary to use an additional code if the type of infection or organism is not specified, assign code A41.9, Sepsis, unspecified organism. A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

(i) Negative or inconclusive blood cultures and sepsis
Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition; however, the provider should be queried.

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

(iii) Sepsis with organ dysfunction
If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction (MOD), follow the instructions for coding severe sepsis.

(a) Acute organ dysfunction that is not clearly associated with the sepsis
If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign a code from subcategory R65.2, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

(b) Severe sepsis
The coding of severe sepsis requires a minimum of 2 codes: first, the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. If the causal organism is not documented, assign code A41.9, Sepsis, unspecified organism, for the infection. Additional code(s) for the associated acute organ dysfunction are also required.

Due to the complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes.

2) Septic shock
(a) Septic shock generally refers to circulatory failure associated with severe sepsis, and therefore, it represents a type of acute organ dysfunction.

For cases of septic shock, the code for the systemic infection should be sequenced first, followed by code R65.21, Severe sepsis with septic shock or code T81.12, Postprocedural septic shock. Any additional codes for the other acute organ dysfunctions should also be assigned. As noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

3) Sequencing of severe sepsis
If severe sepsis is present on admission, and meets the definition of principal diagnosis, the underlying systemic infection should be assigned as principal diagnosis followed by the appropriate code from subcategory R65.2 as required by the sequencing rules in the Tabular List. A code from subcategory R65.2 can never be assigned as a principal diagnosis.

When severe sepsis develops during an encounter (it was not present on admission), the underlying systemic infection and the appropriate code from subcategory R65.2 should be assigned as secondary diagnoses.

Severe sepsis may be present on admission, but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether severe sepsis was present on admission, the provider should be queried.

4) Sepsis and severe sepsis with a localized infection
If the reason for admission is both sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(s) for the underlying systemic infection should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis. If the patient has severe sepsis, a code from subcategory R65.2 should also be assigned as a secondary diagnosis. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/severe sepsis doesn't develop until after admission, the localized infection should be assigned first, followed by the appropriate sepsis/severe sepsis codes.

5) Sepsis due to a postprocedural infection
(a) Documentation of causal relationship
As with all postprocedural complications, code assignment is based on the provider's documentation of the relationship between the infection and the procedure.

(b) Sepsis due to a postprocedural infection
For such cases, the postprocedural infection code, such as T88.0, Infection following infusional, transfusion, and therapeutic injection, T81.4, Infection following a therapeutic intervention, or O86.0, Infection of obstetric surgical wound, should be coded first, followed by the code for the specific infection. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.
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1) Selection and sequencing of MRSA codes

In cases where a postprocedural infection has occurred and has resulted in severe sepsis, the code for the precipitating complication such as code T81.4, Infection following a procedure, or O86.8, Infection of obstetrical surgical wound should be coded first followed by code R96.2, Severe sepsis without septic shock. A code for the systemic infection should also be assigned.

If a postprocedural infection has resulted in postprocedural septic shock, the code for the precipitating complication such as code T81.4, Infection following a procedure, or O86.8, Infection of obstetrical surgical wound should be coded first followed by code T81.12, Postprocedural septic shock. A code for the systemic infection should also be assigned.

8) Newborn sepsis

If the infection meets the definition of principal diagnosis, it should be sequenced first, followed by the code for the resulting infection. If severe sepsis is present, a code from subcategory R65.2 should also be assigned with any associated organ dysfunction(s). It is not necessary to assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin, for these cases. When both the associated non-infectious condition and the infection meet the definition of principal diagnosis, either may be assigned as principal diagnosis.

Only one code from category R65, Symptoms and signs specifically associated with systemic inflammation and infection, should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in severe sepsis, assign the appropriate code from subcategory R65.2, Severe sepsis. Do not additionally assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin.

See Section C.18, SIRS due to non-infectious process

f. Zika virus infections

1) Code only confirmed cases

Code only a confirmed diagnosis of Zika virus (A92.5, Zika virus disease) as documented by the provider. This is an exception to the hospital inpatient guideline Section H. H. In this context, “confirmation” does not require documentation of the type of test performed; the physician’s diagnostic statement that the condition is confirmed is sufficient. This code should be assigned regardless of the stated mode of transmission.

If the provider documents “suspected” or “probable” Zika, do not assign code A92.5. Assign a code(s) explaining the reason for encounter (such as fever, rash, or joint pain) or Z22.828, Contact with and (suspected) exposure to other viral communicable diseases.

2. Chapter 2: Neoplasms (C00-D49)

General guidelines

Chapter 2 of the ICD-10-CM contains the codes for most benign and all malignant neoplasms. Certain benign neoplasms, such as prostatic adenomas, may be found in the specific body system chapters. To properly code a neoplasm it is necessary to determine from the record if the neoplasm is benign, in situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

Primary malignant neoplasms overlapping site boundaries

A primary malignant neoplasm that overlaps two or more contiguous (next to each other) sites should be classified to the subcategory/code 8 (overlapping lesion), unless the combination is specifically indexed elsewhere. For multiple neoplasms of the same site that are not contiguous such as tumors in different quadrants of the same breast, codes for each site should be assigned.
Malignant neoplasm of ectopic tissue

Malignant neoplasms of ectopic tissue are to be coded to the site of origin mentioned, e.g., ectopic pancreatic malignant neoplasms involving the stomach are coded to pancreas, unspecified (C25.9).

The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates “adenoma,” refer to the term in the Alphabetic Index to review the entries under this term and the instructional note to “see also neoplasms, by site, benign.” The table provides the proper code based on the type of adenoma and the site. It is important to select the proper column in the table that corresponds to the type of neoplasm. The Tabular List should then be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist.

See Section I.C.21. Factors influencing health status and contact with health services, Status, for information regarding Z15.8, codes for genetic susceptibility to cancer.

1. Treatment directed at the malignancy

If the treatment is directed at the malignancy, designate the malignancy as the principal diagnosis.

The only exception to this guideline is if a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy. The appropriate Z11 code is assigned as the first-listed or principal diagnosis, and the diagnosis or problem for which the service is being performed is sequenced as a secondary diagnosis.

2. Treatment of secondary site

When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

3. Coding and sequencing of complications

Coding and sequencing of complications associated with the malignancies or with the therapy thereof are subject to the following guidelines:

a. Anemia associated with malignancy

When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal diagnosis, followed by the appropriate neoplasm code and code D63.0, Anemia in neoplastic disease.

b. Anemia associated with chemotherapy, immunotherapy and radiation therapy

When the admission/encounter is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy and the only treatment is for the anemia, the anemia code is sequenced first followed by the appropriate codes for the neoplasm and the adverse effect (T45.1X5, Adverse effect of antineoplastic and immunosuppressive drugs).

When the admission/encounter is for management of an anemia associated with an adverse effect of radiotherapy, the anemia code should be sequenced first, followed by the appropriate neoplasm code and code V84.2, 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.

c. Management of dehydration due to the malignancy

When the admission/encounter is for management of dehydration due to the malignancy and only the dehydration is being treated (e.g., hydrea rehydrant), the dehydration is sequenced first, followed by the code(s) for the malignancy.

4. Treatment of a complication resulting from a surgical procedure

When the admission/encounter is for treatment of a complication resulting from a surgical procedure, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

d. Primary malignancy previously excised

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy, a code from category Z51.0, Primary history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed with the 85 code used as a secondary code.

e. Admissions/Encounters involving chemotherapy, immunotherapy and radiation therapy

1) Episode of care involves surgical removal of neoplasm

When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, follow by code Z15.8, codes for genetic susceptibility to cancer.

2) Patient admission/encounter solely for administration of chemotherapy, immunotherapy and radiation therapy

If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or radiation therapy assign code Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If the patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence.

The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

3) Patient admitted for radiation therapy, chemotherapy or immunotherapy and develops complications

When a patient is admitted for the purpose of radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrollable nausea and vomiting or dehydration, the principal or first-listed diagnosis is Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.

f. Admission/encounter to determine extent of malignancy

When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.

g. Symptoms, signs, and abnormal findings listed in Chapter 18 associated with neoplasms

Symptoms, signs, and ill-defined conditions listed in Chapter 18 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

See section I.C.21. Factors influencing health status and contact with health services, Status, for information on coding admission/encounter for the complications.

h. Admission/encounter for pain control/management

See Section I.C.6. for information on coding admission/encounter for the complications.

i. Malignancy in two or more noncontiguous sites

A patient may have more than one malignant tumor in the same organ. These tumors may represent different primaries or metastatic disease, depending on the site. Should the documentation be
10.  

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1.  

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3.  

Disseminated malignant neoplasm, unspecified

4.  

Code C88B, Disseminated malignant neoplasm, unspecified, is for use only in those cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified. It should not be used in place of assigning codes for the primary site and all known secondary sites.

5.  

Malignant neoplasm without specification of site

6.  

Code C88B, Malignant (primary) neoplasm, unspecified, equates to Cancer, unspecified. This code should only be used when no determination can be made as to the primary site of a malignancy. This code should rarely be used in the inpatient setting.

7.  

Sequencing of neoplasm codes

8.  

1) Encounter for treatment of primary malignancy

9.  

If the reason for the encounter is for treatment of a primary malignancy, assign the malignancy as the principal-first-listed diagnosis. The primary site is to be sequenced first, followed by any metastatic sites.

10.  

2) Encounter for treatment of secondary malignancy

11.  

When an encounter is for a primary malignancy with metastasis and treatment is directed toward the metastatic (secondary) site(s) only, the metastatic site(s) is designated as the principal-first-listed diagnosis. The primary malignancy is coded as an additional code.

12.  

3) Malignant neoplasm in a pregnant patient

13.  

When a pregnant woman has a malignant neoplasm, a code from subcategory O9A.1, Malignant neoplasm complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate code from Chapter 2 to indicate the type of neoplasm.

14.  

4) Encounter for complication associated with a neoplasm

15.  

When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm.

16.  

The exception to this guideline is anemia. When the admission(encounter) is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal-first-listed diagnosis followed by code D63.8, Anemia in neoplastic disease.

17.  

5) Complication from surgical procedure for treatment of a neoplasm

18.  

When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of the neoplasm, designate the complication as the principal-first-listed diagnosis. See guideline regarding the coding of a current malignancy versus personal history to determine if the code for the neoplasm should also be assigned.

19.  

6) Pathologic fracture due to a neoplasm

20.  

When an encounter is for a pathologic fracture due to a neoplasm, and the focus of treatment is the fracture, a code from subcategory M84.5, Pathological fracture in neoplastic disease, should be sequenced first, followed by the code for the neoplasm.

21.  

If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5 for the pathological fracture.

22.  

m. Current malignancy versus personal history of malignancy

23.  

When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

24.  

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment of the malignancy directed to that site, and there is no evidence of any existing primary malignancy, a code from category B85, Personal history of malignancy, should be used to indicate the former site of the malignancy.

See Section I.C.21. Factors influencing health status and contact with health services, History (of)

25.  

n. Leukemia, Multiple Myeloma, and Malignant Plasma Cell Neoplasms in remission versus personal history

26.  

The categories for leukemia, and category C90, Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission. There are also codes B85.6, Personal history of leukemia, and B85.79, Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues. If the documentation is unclear as to whether the leukemia has achieved remission, the provider should be queried.

See Section I.C.21. Factors influencing health status and contact with health services, History (of)

27.  

o. Aftercare following surgery for neoplasm

28.  

See Section I.C.21. Factors influencing health status and contact with health services, Aftercare

29.  

p. Follow-up care for completed treatment of a malignancy

30.  

See Section I.C.21. Factors influencing health status and contact with health services, Follow-up

31.  

q. Prophylactic organ removal for prevention of malignancy

32.  

See Section I.C.21. Factors influencing health status and contact with health services, Prophylactic organ removal

33.  

r. Malignant neoplasm associated with transplanted organ

34.  

A malignant neoplasm of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code from category T86.-, Complications of transplanted organs and tissue, followed by code C88B, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy.

35.  

3. Chapter 3: Disease of the blood and blood-forming organs and certain disorders involving the immune mechanism (D00-D89)

Reserved for future guideline expansion

36.  

4. Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E90)

a. Diabetes mellitus

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for the particular encounter. Assign as many codes from categories E08 – E13 as needed to identify all of the associated conditions that the patient has.

1) Type of diabetes

The age of the patient is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason type 1 diabetes mellitus is also referred to as juvenile diabetics.

2) Type of diabetes mellitus not documented

If the type of diabetes mellitus is not documented in the medical record the default is E11., Type 2 diabetes mellitus.

3) Diabetes mellitus and the use of insulin and oral hypoglycemics

If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11., Type 2 diabetes mellitus, should be assigned. Code Z79.4, Long term (current) use of insulin, or Z79.84, Long term (current) use of oral hypoglycemic drugs, should also be assigned to indicate that the patient uses insulin or hypoglycemic drugs. Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

4) Diabetes mellitus in pregnancy and gestational diabetes

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1) In Remission

Selection of codes for “in remission” for categories F10-F19, Mental and behavioral disorders due to psychoactive substance use (categories F10-F19 with -21) requires the provider’s clinical judgment. The appropriate codes for “in remission” are assigned only on the basis of provider documentation (as defined in the Official Guidelines for Coding and Reporting).

2) Psychoactive Substance Use, Abuse and Dependence

When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

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

3) Psychoactive Substance Use

As with all other diagnoses, the codes for psychoactive substance use (F10-9, F11-9, F12-9, F13-9, F14-9, F15-9, F16-9) should only be assigned based on provider documentation and when they meet the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). The codes are to be used only when the psychoactive substance use is associated with a mental or behavioral disorder, and such a relationship is documented by the provider.

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

Categories G98, G99, and G90-99 are included in the Tabular List for information and sequence only. These categories are not intended for coding a principal diagnosis.

a) General coding information

Codes in category G90, Pain, and G99, Not elsewhere classified, may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain.

b) Pain - Category G99

1) General coding information

Codes in category G99, Pain, not elsewhere classified, may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain.
2) Pain due to devices, implants and grafts

(a) Postoperative pain not associated with specific surgery should not be coded.

(b) When a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the principal or first-listed diagnosis.

Additional Diagnoses coding of postoperative pain, as well as the provider's documentation should be used to guide the appropriate code(s) found in Chapter 19, Injury, poisoning and certain other consequences of external causes.

5) Neoplasm Related Pain

(a) Code G99.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.

(b) This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter was documented as pain control/pain management. The underlying neoplasm should be reported as an additional diagnosis. When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code G99.3 may be assigned as an additional diagnosis. It is not necessary to assign an additional code for the site of the pain.

6) Chronic pain syndrome

Central pain syndrome (G99.8) and chronic pain syndrome (G99.4) are different than the term “chronic pain” and therefore codes should only be used when the provider has specifically documented this condition.


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

a. Glaucoma

1) Assigning Glaucoma Codes

Assign as many codes from category H40, Glaucoma, as needed to identify the type of glaucoma, the affected eye, and the glaucoma stage.

2) Bilateral glaucoma with same type and stage

When a patient has bilateral glaucoma and both eyes are documented as having the same type and stage, and there is a code for bilateral glaucoma, report only the code for the type of glaucoma, bilateral, with the seventh character for the stage.

When a patient has bilateral glaucoma and both eyes are documented as being the same type and stage, and the classification does not provide a code for bilateral glaucoma (i.e. subcategories H40.10, H40.11 and H40.20), report only one code for the type of glaucoma with the appropriate seventh character for the stage.

3) Bilateral glaucoma stage with different types or stages

When a patient has bilateral glaucoma and each eye is documented as having different types or stages, and the classification does not distinguish laterality, assign the appropriate code for each eye.

When a patient has bilateral glaucoma and each eye is documented as having different types or stages, and the classification does not distinguish laterality (i.e. subcategories H40.10, H40.11 and H40.20) report only one code for the type of glaucoma with the appropriate seventh character for the stage.

4) Patient admitted with glaucoma and stage evolves during the admission

If a patient is admitted with glaucoma and the stage progresses during the admission, assign the code for highest stage documented.

5) Indeterminate stage glaucoma

Assignment of the seventh character “4” for “Indeterminate stage” should be based on the clinical documentation. The
8. Chapter 8: Diseases of the Ear and Mastoid Process (H60-H95)

Reserved for future guideline expansion.

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

a. Hypertension

The classification presumes a causal relationship between hypertension and heart disease, and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For hypertension and conditions not specifically linked by relational terms such as “with,” “associated with” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.

1) Hypertension with Heart Disease

Hypertension with heart conditions classified to I00- or I51.4-I51.9, are assigned to a code from category I11, Hypertensive heart disease. Use an additional code from category I68, Heart failure, to identify the type of heart failure in those patients with heart failure.

The same heart conditions (I50.-, I51.4-I51.9) with hypertension are coded separately if the provider has specifically documented a different cause. Sequence according to the circumstances of the admission/encounter.

2) Hypertensive Chronic Kidney Disease

Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present. CKD should not be coded as hypertensive if the physician has specifically documented a different cause.

The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.


If a patient has both hypertension and acute renal failure, an additional code for the acute renal failure is required.

3) Hypertensive Heart and Chronic Kidney Disease

Assign codes from combination category I13. Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement. If heart failure is present, assign an additional code from category I68 to identify the type of heart failure.

The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.


The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. The includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease, then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12.

For patients with both acute renal failure and chronic kidney disease, an additional code for acute renal failure is required.

4) Hypertensive Cerebrovascular Disease

For hypertensive cerebrovascular disease, first assign the appropriate code from categories I60-I69, followed by the appropriate hypertension code.

b. Atherosclerotic Coronary Artery Disease and Angina

ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are I25.1, 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.

When using one of these combination codes it is not necessary to use an additional code for angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis.

If a patient with coronary artery disease is admitted due to an acute myocardial infarction (AMI), the AMI should be sequenced before the coronary artery disease.


c. Intraoperative and Postprocedural Cerebrovascular Accident

Medical record documentation should clearly specify the cause and effect relationship between the medical intervention and the cerebrovascular accident in order to assign a code for intraoperative or postprocedural cerebrovascular accident.

Proper code assignment depends on whether it was an infection or hemorrhage and whether it occurred intraoperatively or postoperatively. If it was a cerebrovascular hemorrhage, code assignment depends on the type of procedure performed.

d. Sequelae of Cerebrovascular Disease

1) Category I69, Sequelae of Cerebrovascular Disease

Category I69 is used to indicate conditions classifiable to categories I68-I67 as the causes of sequelae (neurologic deficits), themselves classified elsewhere. These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to categories I68-I67. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I68-I67.

Codes from category I69, Sequelae of cerebrovascular disease, that specify hemiplegia, hemiparesis and monoplegia identify...
whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

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

2) Codes from category I69 with codes from I68-67
Could not be used for a new care record with codes from I68-67, if the patient has a current cerebrovascular disease and deficits from an old cerebrovascular disease.

3) Codes from category I69 and Personal history of transient ischemic attack (TIA) and cerebral infarction (28A-73)
Codes from category I69 should not be assigned if the patient does not have neurologic deficits. See Section I.C.21.4. History (of) use of personal history codes

a. Acute myocardial infarction (AMI)

1) ST elevation myocardial infarction (STEMI) and non ST elevation myocardial infarction (NSTEMI): The ICD-10-CM codes for acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Suffix codes Q21.1 and Q21.2 and code Q21.3 are used for ST elevation myocardial infarction (STEMI). Code Q21.4, Non-ST elevation (NSTEMI) myocardial infarction, is used for non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs. If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

For encounters occurring while the myocardial infarction is equal to, or less than, four weeks old, including transfers to another acute care setting, and the myocardial infarction meets the definition for "other diagnoses" (see Section II, Reporting Additional Diagnoses), codes from category Q21 may continue to be reported. For encounters after the 4 week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned, rather than a code from category Q21. For old or healed myocardial infarctions not requiring further care, code Q21.5, Old myocardial infarction, may be assigned.

2) Acute myocardial infarction, unspecified
Code Q21.3, ST elevation (STEMI) myocardial infarction of unspecified site, is the default for unspecified acute myocardial infarction. If only STEMI or transmural MI without the site is documented, assign code Q21.3.

3) MI documented as nontransmural or subendocardial but site provided
If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial MI. See Section I.C.21.3 for information on coding status post administration of tPA in a different facility within the last 24 hours.

4) Subsequent acute myocardial infarction: A code from category Q22. Subsequent ST elevation (STEMI) and non ST elevation (NSTEMI) myocardial infarction, is to be used when a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial AMI. A code from category Q22 must be used in conjunction with a code from category Q21. The sequencing of the 122 and 121 codes depends on the circumstances of the encounter.

10. Chapter 10: Diseases of the Respiratory System (460-519)
a. Chronic Obstructive Pulmonary Disease (COPD) and Asthma

1) Asthma exacerbation of chronic obstructive bronchitis and asthma
The codes in categories J44 and J45 distinguish between uncomplicated cases and those with an acute exacerbation. An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

b. Acute Respiratory Failure

1) Acute respiratory failure as principal diagnosis
A code from subcategory J94.8. Acute respiratory failure, or subcategory J94.2. Acute and chronic respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter-specific coding guidelines (such as obstetrics, poisoning, HIE, newborn) that provide sequencing direction take precedence.

2) Acute respiratory failure as secondary diagnosis
Respiratory failure may be listed as a secondary diagnosis if it occurs after admission, or if it is present on admission, but does not meet the definition of principal diagnosis.

3) Sequencing of acute respiratory failure and another acute condition
When a patient is admitted with respiratory failure and another acute condition, such as myocardial infarction, cerebrovascular accident, aspiration pneumonia, the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis (Section II, C.) may be applied in these situations.

If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.

Acute Respiratory Failure

1) Acute respiratory failure as principal diagnosis
A code from subcategory J94.8. Acute respiratory failure, or subcategory J94.2. Acute and chronic respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter-specific coding guidelines (such as obstetrics, poisoning, HIE, newborn) that provide sequencing direction take precedence.

2) Acute respiratory failure as secondary diagnosis
Respiratory failure may be listed as a secondary diagnosis if it occurs after admission, or if it is present on admission, but does not meet the definition of principal diagnosis.

3) Sequencing of acute respiratory failure and another acute condition
When a patient is admitted with respiratory failure and another acute condition, such as myocardial infarction, cerebrovascular accident, aspiration pneumonia, the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis (Section II, C.) may be applied in these situations.

If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.

c. Infection due to certain identified influenza viruses
Code only confirmed cases of influenza due to certain identified influenza viruses (category J09), and due to other identified influenza virus (category J10). This is an exception to the hospital inpatient guideline Section I.H.5 (Certain Diagnosis).

In this context, “confirmation” does not require documentation of positive laboratory testing specific for avian or other novel influenza A or other identified influenza virus. However, coding should be based on the provider’s diagnostic statement that the patient has avian influenza, or other novel influenza A, for category J09, or has another particular identified strain of influenza, such as H1N1 or H3N2, but not identified as novel or variant, for category J10.

If the provider records “suspect” or “possible” or “probable” avian influenza, or novel influenza, or other identified influenza, then the appropriate influenza code from category J01, Influenza due to unidentified influenza virus, should be assigned. A code from category J09, Influenza due to certain identified influenza viruses, should not be assigned nor should a code from category J10, Influenza due to other identified influenza virus.

d. Ventilator associated Pneumonia

1) Documentation of Ventilator associated Pneumonia
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. Code J95.851, Ventilator associated pneumonia, should be assigned only when the provider has documented ventilator associated pneumonia (VAP). An additional code to identify the organism (e.g., Pseudomonas aeruginosa, code B96.5) should also be assigned. Do not assign an additional code from categories J05.2-J08 to identify the type of pneumonia.

Code J95.851 should not be assigned for cases where the patient has pneumonia and is on a mechanical ventilator and the provider has not specifically stated that the pneumonia is ventilator-associated pneumonia. If the documentation is
13. Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M80-M99)

a. Site and laterality

Most of the codes within Chapter 13 have site and laterality designations. The site represents the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a “multiple sites” code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

1) Bone versus joint

For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M77, Osteoporosis, M81). Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.

b. Acute traumatic versus chronic or recurrent musculoskeletal conditions

Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions. Bone, joint or muscle conditions that are the result of a healed injury are usually found in chapter 13. Recurrent bone, joint or muscle conditions are also usually found in chapter 13. Any current, acute injury should be coded to the appropriate injury code from chapter 19. Chronic or recurrent conditions should generally be coded with a code from chapter 13. It is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.

c. Coding of Pathologic Fractures

7th character A is for use as long as the patient is receiving active treatment for the fracture. While the patient may be seen by a new or different provider over the course of treatment for a pathological fracture, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is the same for the first time.

7th character D is to be used for encounters after the patient has completed active treatment. The other 7th characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for routine care of fractures during the healing and recovery phase as well as treatment of problems associated with the healing, such as malunions, nonunions, and sequelae.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

See Section I.C.19 Coding of traumatic fractures.

d. Osteoporosis

Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. Therefore, site is not a component of the codes under category M80. Osteoporosis without current pathological fracture. The site codes under category M80, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis.

1) Osteoporosis without pathological fracture

Category M81. Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. For patients with a history of osteoporosis fractures, status code Z87.310, Personal history of healed osteoporosis fracture, should follow the code from M81.

2) Osteoporosis with current pathological fracture

Category M80. Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter. The codes under M80 identify the site of the fracture. A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, that fall or trauma would not usually break a normal, healthy bone.
14. Chapter 15: Diseases of the Genitourinary System (N00-N99)
   a. Chronic kidney disease
      1) Stages of chronic kidney disease (CKD)
         The ICD-10-CM classifies CKD based on severity. The severity of CKD is designated by stages: Stage 1, code N18.2, equates to mild CKD; Stage 2, code N18.3, equates to moderate CKD; and Stage 4, code N18.4, equates to severe CKD. Code N18.6, End stage renal disease (ESRD), is assigned when the provider has documented end stage renal disease (ESRD).
         If both a stage of CKD and ESRD are documented, assign code N18.6 only.
      2) Chronic kidney disease and kidney transplant status
         Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function. Therefore, the presence of CKD alone does not constitute a transplant complication. Assign the appropriate N18 code for the patient’s stage of CKD and code Z49.4, Kidney transplant status, if a transplant complication such as failure or rejection or other transplant complication is documented, see section IC.19.g for information on coding complications of a kidney transplant. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.
      3) Chronic kidney disease with other conditions
         Patients with CKD may also suffer from other serious conditions, most commonly diabetes mellitus and hypertension. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the Tabular List. See IC.9, Hypertensive chronic kidney disease. See IC.19, Chronic kidney disease and kidney transplant complications.

15. Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O9A)
   a. General Rules for Obstetric Cases
      1) Codes from chapter 15 and sequencing priority
         Obstetric cases require codes from chapter 15, codes in the range O00-O49, Pregnancy, Childbirth, and the Puerperium. Chapter 15 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 15 codes to further specify conditions. Should the provider document that the pregnancy is incidental to the encounter, then code Z33.1, Prenatal care, incidental, should be used in place of any chapter 15 codes. It is the provider’s responsibility to state that the condition being treated is not affecting the pregnancy.
      2) Chapter 15 codes used only on the maternal record
         Chapter 15 codes are to be used only on the maternal record, never on the record of the newborn.
      3) Final character for trimester
         The majority of codes in Chapter 15 have a final character indicating the trimester of pregnancy. The timeframes for the trimesters are indicated at the beginning of the chapter. If trimester is not a component of a code, it is because the condition always occurs in a specific trimester, or the concept of trimester of pregnancy is not applicable. Certain codes have characters for only certain trimesters because the condition does not occur in all trimesters, but it may occur in more than just one. Assignment of the final character for trimester should be based on the provider’s documentation of the trimester (or number of weeks) for the current admission/encounter. This applies to the assignment of trimester for pre-existing conditions as well as those that develop during or are due to pregnancy. The provider’s documentation of the number of weeks may be used to assign the appropriate code identifying the trimester.
         Whenever delivery occurs during the current admission, and there is an ‘in childbirth’ code for the obstetric complication being coded, the “in childbirth” code should be assigned.
h. Long term use of insulin and oral hypoglycemics

i. Gestational (pregnancy induced) diabetes

Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts the woman at greater risk of developing diabetes after the pregnancy. Codes for gestational diabetes are in subcategory O24.4. Gestational diabetes mellitus. No other code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, should be used with a code from O24.4.

The codes under subcategory O24 include diet controlled, insulin controlled, and controlled by oral hypoglycemic drugs. If a patient with gestational diabetes is treated with both diet and insulin, only the code for insulin-controlled diabetes mellitus is required. Code Z79.4, Long-term (current) use of insulin, or code Z79.84, Long-term (current) use of oral hypoglycemic drugs, should not be assigned with codes from subcategory O24.4.

An abnormal glucose tolerance in pregnancy is assigned a code from subcategory O99.81, Abnormal glucose complicating pregnancy, childbirth, and the puerperium.

j. Sepsis and septic shock complicating abortion, pregnancy, childbirth, and the puerperium

When assigning a chapter 15 code for sepsis complicating abortion, pregnancy, childbirth, and the puerperium, a code for the specific type of infection should be assigned as an additional diagnosis. If severe sepsis is present, a code from subcategory R65.2, Severe sepsis, and code(s) for associated organ dysfunction(s) should also be assigned as additional diagnoses.

k. Puerperal sepsis

Code O85, Puerperal sepsis, should be assigned with a secondary code to identify the causative organism (e.g., for a bacterial infection, assign a code from category B95-B96, Bacterial infections in conditions classified elsewhere). A code from category A48, Streptococcal sepsis, or A41, Other sepsis, should not be used for puerperal sepsis. If applicable, use additional codes to identify severe sepsis (R65.2) and any associated acute organ dysfunction.

l. Alcohol and tobacco use during pregnancy, childbirth, and the puerperium

1) Alcohol use during pregnancy, childbirth and the puerperium

Codes under subcategory O99.31, Alcohol use complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a mother uses alcohol during the pregnancy or postpartum. A secondary code from category F17, Nicotine dependence, should also be assigned to identify manifestations of the alcohol use.

2) Tobacco use during pregnancy, childbirth and the puerperium

Codes under subcategory O99.33, Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a mother uses any type of tobacco product during the pregnancy or postpartum. A secondary code from category F17, Nicotine dependence, should also be assigned to identify the type of nicotine dependence.
18 – Coding Guidelines

q. Termination of Pregnancy and Spontaneous abortions

1) Abortion with Liveborn Fetus
   When an attempted termination of pregnancy results in a liveborn fetus, assign code Z33.2, Encounter for elective termination of pregnancy and a code from category O27, Outcome of Delivery.

2) Retained Products of Conception following an abortion
   Subsequent encounters for retained products of conception following a spontaneous abortion or elective termination of pregnancy are assigned the appropriate code from category O05, Spontaneous abortion, or codes O07.4, Failed attempted termination of pregnancy without complication and Z33.2, Encounter for elective termination of pregnancy. This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion.

3) Complications leading to abortion
   Codes from Chapter 15 may be used as additional codes to identify any documented complications of the pregnancy in conjunction with codes in categories O05 and O07.

r. Abuse in a pregnant patient
   For suspected or confirmed cases of abuse of a pregnant patient, a code(s) from subcategories O9A.3, Physical abuse complicating pregnancy, childbirth, and the puerperium, O9A.4, Sexual abuse complicating pregnancy, childbirth, and the puerperium, and O9A.5, Psychological abuse complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate codes (if applicable) to identify any associated current injury due to physical abuse, sexual abuse, and the perpetrator of abuse.

   See Section I.C.19. Adult and child abuse, neglect and other maltreatment.

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

a. General Perinatal Rules

1) Use of Chapter 16 Codes
   Codes in this chapter are never used for the maternal record. Codes from Chapter 15, the Obstetric chapter, are never permitted on the newborn record. Chapter 16 codes may be used throughout the life of the patient if the condition is still present.

2) Principal Diagnosis for Birth Record
   When coding the delivery episode in a newborn record, assign a code from category Z38, Birth process or community acquired and the documentation does not indicate which is the case.

   A code from category Z38 should not be used at the receiving hospital. If a newborn is transferred to another institution, a code from category Z38 should not be used at the receiving hospital.

   Codes from Chapter 16 should be sequenced first.

3) Use of Codes from other Chapters with Codes from Chapter 16
   Codes from other chapters may be used with codes from Chapter 16 if the codes from the other chapters provide more specific detail. Codes for signs and symptoms may be assigned when a definitive diagnosis has not been established. If the reason for the encounter is a perinatal condition, the code from chapter 16 should be sequenced first.

4) Use of Chapter 16 Codes after the Perinatal Period
   Should a condition originate in the perinatal period, and continue throughout the life of the patient, the perinatal code should continue to be used regardless of the patient’s age.

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

e) Code all clinically significant conditions
All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:
- clinical evaluation,
or
- therapeutic intervention,
or
- diagnostic procedures,
or
- extended length of hospital stay,
or
- increased nursing care and/or monitoring,
or
- has implications for future health care needs.

Note: The perinatal guidelines listed above are the same as the general coding guidelines for “additional diagnoses,” except for the final point regarding implications for future health care needs. Codes should be assigned for conditions that have been specified by the provider as having implications for future health care needs.

b. Observation and Evaluation of Newborns for Suspected Conditions Not Found

1) Assign a code from category Z85. Observation and evaluation of newborns and infants for suspected conditions ruled out, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present. Do not use a code from category Z85 when the patient has identified signs or symptoms of a suspected problem; in such cases code the sign or symptom.

2) A code from category Z85 may also be assigned as a principal or first-listed code for readmissions or encounters when the code from category Z85 no longer applies. Codes from category Z85 are for use only for healthy newborns and infants for which no condition after study is found to be present.

3) Z05 on a birth record
A code from category Z05 is to be used as a secondary code after the code from category Z38, Liveborn infants according to place of birth and type of delivery.

c. Coding Additional Perinatal Diagnoses

1) Assigning codes for conditions that require treatment
Assign codes for conditions that require treatment or further investigation, prolonging the length of stay, or require resource utilization.

2) Codes for conditions specified as having implications for future health care needs
Assign codes for conditions that have been specified by the provider as having implications for future health care services. 

Note: This guideline should not be used for adult patients.

d. Prematurity and Fetal Growth Retardation

Provides criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented.

Assignment of codes in categories P85, Disorders of newborn related to slow fetal growth and fetal malnutrition, and P97, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified, should be based on the recorded birth weight and estimated gestational age. Codes from category P95 should not be assigned with codes from category P97.

When both birth weight and gestational age are available, two codes from category P97 should be assigned, with the code for birth weight sequenced before the code for gestational age.

e. Low birth weight and immaturity status

Codes from category P87, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified, are for use for a child or adult who was premature or had a low birth weight as a newborn and this is affecting the patient’s current health status.
See Section C.21. Factors influencing health status and contact with health services, Status.

e. Bacterial Sepsis of Newborn
Category P36, Bacterial sepsis of newborn, includes congenital sepsis. If a perinate is documented as having sepsis without documentation of congenital or community acquired, the default is congenital and a code from category P36 should be assigned. If the P36 code includes the causal organism, an additional code from category B96, Streptococcus, Staphylococcus, and Enterococci as the cause of disease classified elsewhere, or B98, Other bacterial agents as the cause of diseases classified elsewhere, should not be assigned. If the P36 code does not include the causal organism, assign an additional code from category B96. If applicable, use additional codes to identify severe sepsis (96.2) and any associated acute organ dysfunction.

Stillbirth
Code P95, Stillbirth, is only for use in institutions that maintain separate records for stillbirths. No other code should be used with P95. Code P95 should not be used on the mother’s record.

Chapter 17: Congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)

Assign an appropriate code(s) from categories Q00-Q99. Congenital malformations, deformations, and chromosomal abnormalities when a malformation/deformation or chromosomal abnormality is documented. A malformation/deformation or chromosomal abnormality may be the principal/first-listed diagnosis on a record or a secondary diagnosis.

When a malformation/deformation or chromosomal abnormality does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.

When the code assignment specifically identifies the malformation/deformation or chromosomal abnormality, manifestations that are an inherent component of the anomaly should not be coded separately. Additional codes should be assigned for manifestations that are not an inherent component.

Codes from Chapter 17 may be used throughout the life of the patient. If a congenital malformation has already been documented, a personal history code should be used to identify the history of the malformation or deformity. Although present at birth, malformation/deformation or chromosomal abnormality may not be identified until later in life. Whenever the condition is diagnosed by the physician, it is appropriate to assign a code from category Q00-Q99. For the birth admission, the appropriate code from category Z38, Liveborn infants, according to place of birth and type of delivery, should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, Q00-Q99.

Chapter 18: Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)

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

a. Use of symptom codes

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

b. Use of a symptom code with a definitive diagnosis code

Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes. The definitive diagnosis code should be sequenced before the symptom code. Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

c. Combination codes that include symptoms

ICD-10-CM contains a number of combination codes that identify both the definitive diagnosis and common symptoms of that diagnosis. When using one of these combination codes, an additional code should not be assigned for the symptom.
d. Repeated falls
Code R29.6. Repeated falls, is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated. Code Z91.81, History of falling, is for use when a patient has fallen in the past and it is at risk for future falls. When appropriate, both codes R29.6 and Z91.81 may be assigned together.

a. Coma scale
The coma scale codes (R40.2-) can be used in conjunction with traumatic brain injury codes, acute cerebrovascular disease or sequelae of cerebrovascular disease codes. These codes are primarily used in the emergency department or other healthcare facility. They may be used in any setting where this information is collected. The coma scale may also be used to assess the status of the central nervous system for non-trauma conditions, such as monitoring patients in the intensive care unit regardless of medical condition. The coma scale codes should be documented after the diagnosis code(s) for the injury. These codes, one from each subcategory, are needed to complete the scale. The 7th character indicates when the score was recorded. The 7th character should match for all these codes.

At a minimum, report the initial score documented on presentation at your facility. This may be a score from the emergency medicine technician (EMT) or in the emergency department. If desired, a facility may choose to capture multiple coma scale scores.

Assign code R40.24, Glasgow coma scale, total score, when only the total score is documented in the medical record and not the individual score(s).

b. Functional quadriplegia
Functional quadriplegia (code R53.2) is the lack of ability to use one or both limbs to or ambulate due to extreme debility. It is not associated with neurologic deficit or injury, and code R53.2 should not be used for cases of neurologic quadriplegia. It should only be assigned if functional quadriplegia is specifically documented in the medical record.

c. SIRS due to Non-Infectious Process
The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious disease processes, such as trauma, malignant neoplasm, or pancreateatitis. When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as an injury, should be assigned, followed by code R65.16, Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction, or code R65.11, Systemic inflammatory response syndrome (SIRS) of non-infectious origin with acute organ dysfunction. If an associated organ dysfunction is documented, the appropriate code(s) for the specific type of organ dysfunction(s) should be assigned in addition to code R65.11. If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is associated with SIRS or due to another condition (e.g., directly due to the trauma), the provider should be queried.

d. Death NOS
Code R99. It defined and unknown cause of mortality, is only for use in the very limited circumstance when a patient who has already died is brought into an emergency department or other healthcare facility and is pronounced dead upon arrival. It does not represent the discharge disposition of death.

e. NHSS Stroke Scale
The NH stroke scale (NHSS) codes (R29.7-) can be used in conjunction with acute stroke codes (R33) to identify the patient’s neurological status and the severity of the stroke. The stroke scale codes should be documented after the acute stroke diagnosis code(s).

At a minimum, report the initial score documented. If desired, a facility may choose to capture multiple stroke scale scores.

See Section I.B.14, for information concerning the medical record documentation that may be used for assignment of the NHSS codes.
d. Coding of Burns and Corrosions

The ICD-10-CM makes a distinction between burns and corrosions. The burn codes are for thermal burns, except sunburns, that come from a heat source, such as a fire or hot appliance. The burn codes are also for burns resulting from electricity and radiation. Corrosions are burns due to chemicals. The guidelines are the same for burns resulting from electricity and radiation. Corrosions are burns due to chemicals. The guidelines are the same for burns resulting from electricity and radiation.

Current burns (T28-T28), assigned on the basis of depth, extent, and agent (X code). Burns are classified by first degree (erythema), second degree (blistering), and third degree (full thickness involvement). Burns of the eye and internal organs (T26-T28) are classified by site, but not by degree.

1) Sequencing of burn and related condition codes

Sequence first the code that reflects the highest degree of burn when more than one burn is present.

a. When the reason for the admission or encounter is for treatment of external multiple burns, sequence first the code that reflects the burn of the highest degree.

b. When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis or first-listed diagnosis.

c. When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal or first-listed diagnosis.

2) Burns of the same local site

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

3) Non-healing burns

Non-healing burns are coded as acute burns.

4) Infected Burn

For any documented infected burn site, use an additional code for the infection.

5) Assign separate codes for each burn site

When coding burns, assign separate codes for each burn site. Category T33. Burns are not necessary to identify low degree burns but are necessary to identify high degree burns.

6) Burns and Corrosions Classified According to Extent of Body Surface Involved

Assign codes from category T31. Burns classified according to extent of body surface involved, or T32. Corrosions classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. It is advisable to use category T31 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category T31 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface.

Categories T31 and T32 are based on the classic “rule of nines” in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Providers may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults, and patients who have large buttocks, thighs, or abdomens that may involve burns.

7) Encounters for treatment of sequelae of burns

Encounters for the treatment of the late effects of burns or corrosion (i.e., scars or joint contractures) should be coded with a burn or corrosion code with the 7th character “S” for sequela.

8) Sequela with a late effect code and current burn

When appropriate, both a code for a current burn or corrosion with 7th character “S” or “D” and a burn or corrosion code with 7th character “S” may be assigned on the same record (when both a current burn and sequela of an old burn exist). Burns and corrosions do not heal at the same rate and a current healing wound may still exist with sequela of a healed burn or corrosion.

See Section I.R.10 Sequela (Late Effects)

9) Use of an external cause code with burns and corrosions

An external cause code should be used with burns and corrosions to identify the source and intent of the burn, as well as the place where it occurred.

e. Adverse Effects, Poisoning, Underdosing and Toxic Effects

Codes in categories T36-T65 are combination codes that include the substance that was taken as well as the intent. No additional external cause code is required for poisonings, toxic effects, adverse effects and underdosing codes.

1) Do not code directly from the Table of Drugs

Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List.

2) Use as many codes as necessary to describe

Use as many codes as necessary to describe completely all drugs, medicinal or biological substances.
5) The occurrence of drug toxicity is classified in ICD-10-CM as:

(a) Adverse Effect
- When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T58). The code for the drug should have a 5th or 6th character “5” (for example, T36.BX5) (Examples of the nature of an adverse effect are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure).

(b) Poisoning
- When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36-T50. The poisoning codes have an associated intent as their 5th or 6th character (accidental, intentional self-harm, assault and undetermined). If the intent of the poisoning is unknown or unspecified, code the intent as accidental intent. The undetermined intent is only for use if the documentation in the record specifies that the intent cannot be determined. Use additional code(s) for all manifestations of poisonings.

(c) Underdosing
- When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36-T50. The poisoning codes have an associated intent as their 5th or 6th character (accidental, intentional self-harm, assault and undetermined). If the intent of the poisoning is unknown or unspecified, code the intent as accidental intent. The undetermined intent is only for use if the documentation in the record specifies that the intent cannot be determined. Use additional code(s) for all manifestations of poisonings.

If there is also a diagnosis of abuse or dependence of the substance, the abuse code is assigned as an additional code.

Examples of poisoning include:
- If error was made in drug prescription
- Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person.
- If overdose of a drug intentionally taken
- If an overdose of a drug was intentionally taken and administered and resulted in drug toxicity, it would be coded as an overdose.
- If nonprescribed drug taken with correctly prescribed and properly administered drug
- If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.
- Interaction of drug(s) and alcohol
- When a reaction results from the interaction of a drug(s) and alcohol, this would be classified as poisoning.

See Section I.C.4 if poisoning is the result of insulin pump malfunction.

(c) Underdosing

Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer’s instruction. For underdosing, assign the code from categories T36-T58 (fifth or sixth character “6”).

Codes for underdosing should never be assigned as principal or first-listed codes. If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be coded. Noncompliance (Z91.12, Z91.13) or complication of care (Y63.6-Y63.9) codes are to be used with an underdosing code to indicate intent, if known.

(d) Toxic Effects

When a harmful substance is ingested or comes in contact with a person, this is classified as a toxic effect. The toxic effect codes are in categories T51-T65.

Toxic effect codes have an associated intent: accidental, intentional self-harm, assault and undetermined.

7. Adult and child abuse, neglect and other maltreatment

Sequence first the appropriate code from categories T74.- (Adult and child abuse, neglect and other maltreatment, confirmed) or T76.- (Adult and child abuse, neglect and other maltreatment, suspected) 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 it is coded as confirmed (T74.-). It is coded as suspected if it is documented as suspected (T76.-).

For cases of confirmed abuse or neglect an external cause code from the assault section (X50-Y99) should be added to identify the cause of any physical injuries. A perpetrator code (Y07) should be added when the perpetrator of the abuse is known. For suspected cases of abuse or neglect, do not report external cause or perpetrator code.

If a suspected case of abuse, neglect or mistreatment is ruled out during an encounter code Z04.71, Encounter for examination and observation following alleged physical adult abuse, ruled out; or code Z04.72, Encounter for examination and observation following alleged child physical abuse, ruled out; should be used, not a code from T76.

If a suspected case of alleged rape or sexual abuse is ruled out during an encounter code Z04.73, Encounter for examination and observation following alleged adult rape or code Z04.62, Encounter for examination and observation following alleged child rape, should be used, not a code from T76.


9. Complications of care

1) General guidelines for complications of care

(a) Documentation of complications of care

See Section I.B.16. for information on documentation of complications of care.

2) Pain due to medical devices

Pain associated with devices, implants or grafts left in a surgical site (for example, painful hip prosthesis) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. Specific codes for pain due to medical devices are found in the T code section of the ICD-10-CM. Use additional code(s) from category G89 to identify acute or chronic pain due to presence of the device, implant or graft (G89.18 or G89.28).

3) Transplant complications

(a) Transplant complications other than kidney

Codes under category T86, Complications of transplanted organs and tissues, are for use for both complications and rejection of transplanted organs. A transplant complication code is only assigned if the complication affects the function of the transplanted organ. Two codes are required to fully describe a transplant complication: the appropriate code from category T86 and a secondary code that identifies the complication.

Pre-existing conditions or conditions that develop after the transplant are not coded as complications unless they affect the function of the transplanted organs.


See I.C.2. for malignant neoplasm associated with transplanted organ.
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(b) Kidney transplant complications

Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function. Code T86.1 should not be assigned for post kidney transplant patients who have chronic kidney (CKD) unless a transplant complication such as transplant failure or rejection is documented. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

Conditions that affect the function of the transplanted kidney, other than CKD, should be assigned a code from subchapter T86.1, Complications of transplanted organ, Kidney, and a secondary code that identifies the complication.

For patients with CKD following a kidney transplant, but who do not have a complication such as failure or rejection, see section C.14. Chronic kidney disease and kidney transplant status.

4) Complication codes that include the external cause

As with certain other T codes, some of the complications of care codes have the external cause included in the code. The code includes the nature of the complication as well as the type of procedure that caused the complication. No external cause code indicating the type of procedure is necessary for these codes.

5) Complications of care codes within the body system chapters

Intraoperative and postprocedural complication codes are found within the body system chapters with codes specific to the organs and structures of that body system. These codes should be sequenced first, followed by a code(s) for the specific complication, if applicable.

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

The external causes of morbidity should never be sequenced as the first-listed or principal diagnosis. External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how, when, where, and the activity of the patient at the time of the event, and the person’s status (e.g., civilian, military).

There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

a. General External Cause Coding Guidelines

1) Used with any code in the range of A80–T88.9, 280–299

An external cause code may be used with any code in the range of A80–T88.9, 280–299, classification that is a health condition due to an external cause. Although they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

2) External cause code used for length of treatment

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequelae) for each encounter for which the injury or condition is being treated.

Most categories in chapter 20 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values: A, initial encounter, D, subsequent encounter and S, sequel. While the patient may be seen by a new or different provider over the course of treatment for an injury or condition, assignment of the 7th character for external cause should match the 7th character of the code assigned for the associated injury or condition for the encounter.

3) Use the full range of external cause codes

Use the full range of external cause codes to completely describe the cause, the intent, the place of occurrence, and if applicable, the activity of the patient at the time of the event, and the patient’s status, for all injuries, and other health conditions due to an external cause.

4) Assign as many external cause codes as necessary

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.

5) The selection of the appropriate external cause code

The selection of the appropriate external cause code is guided by the Alphabetic Index of External Causes and by Inclusion and Exclusion notes in the Tabular List.

6) External cause code can never be a principal diagnosis

An external cause code can never be a principal (first-listed) diagnosis.

7) Combination external cause codes

Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

8) No external cause code needed in certain circumstances

No external cause code from Chapter 20 is needed if the external cause and intent are included in a code from another chapter (e.g. T30.8X1). Poisoning by penicillin, accidental (unintentional).

b. Place of Occurrence Guideline

Codes from category Y92, Place of occurrence of the external cause, are secondary codes or use after other external cause codes to identify the location of the patient at the time of injury or other condition.

Generally, a place of occurrence code is assigned only once, at the initial encounter for treatment. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned. No 7th characters are used for Y92.

Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

c. Activity Code

Assign a code from category Y93, Activity code, to describe the activity of the patient at the time the injury or other health condition occurred.

An activity code is used only once, at the initial encounter for treatment. Only one code from Y93 should be recorded on a medical record.

The activity codes are not applicable to poisonings, adverse effects, misadventures or sequela.

Do not assign Y93.9, Unspecified activity, if the activity is not stated.

A code from category Y93 is appropriate for use with external cause and intent codes if identifying the activity provides additional information about the event.

d. Place of Occurrence, Activity, and Status Codes Used with other External Cause Code

When applicable, place of occurrence, activity, and external cause status codes are sequenced after the main external cause code(s). Regardless of the number of external cause codes assigned, generally there should be only one place of occurrence code, one activity code, and one external cause status code assigned to an encounter. However, in the rare instance that a new injury occurs
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Coding Guidelines

During hospitalization, an additional place of occurrence code may be assigned.

a.

If the Reporting Format Limits the Number of External Cause Codes

If the reporting format limits the number of external cause codes that can be used in reporting clinical data, report the code for the cause/intent most related to the principal diagnosis. If the format permits, use additional external cause codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity, or external status.

f.

Multiple External Cause Coding Guidelines

More than one external cause code is required to fully describe the external cause of an illness or injury. The assignment of external cause codes should be sequenced in the following priority:

1) Sequela external cause codes
2) Cause of injury identified by the Federal Government (FBI) as terrorism
3) Cause of injury identified by the Federal Government (FBI) as terrorism, the first-listed external cause code should be a code from category Y38, Terrorism. The definition of terrorism employed by the FBI is found at the inclusion note at the beginning of category Y38. Use additional code for place of occurrence (Y92.-). More than one Y38 code may be assigned if the injury is the result of more than one mechanism of terrorism.
4) Cause of an injury is suspected to be the result of terrorism
5) Code Y38.9, Terrorism, secondary effects

Assign code Y38.9, Terrorism, secondary effects, for conditions occurring subsequent to the terrorist event. This code should not be assigned for conditions that are due to the initial terrorist act.

b.

Unknown or Undetermined Intent Guideline

If the intent (accident, self-harm, assault) of the cause of an injury or other condition is unknown or unspecified, code the intent as unknown or undetermined. Intent cannot be determined.

2) Use of unknown or undetermined intent

External cause codes for transport accidents take priority over all other external cause codes except child and adult abuse and terrorism.

External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse and terrorism.

Activity and external cause status codes are assigned following all causal (intent) external cause codes.

The first-listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

g.

Child and Adult Abuse Guidelines

Adult and child abuse, neglect and maltreatment are classified as assault. Any of the assault codes may be used to indicate the cause/intent of the most serious diagnosis due to an assault, accident, or self-harm. The perpetrator is known, a code from Y81. Perpetrator of maltreatment and neglect, should accompany any other assault code.

If the perpetrator is unknown, a code from Y77. Perpetrator of maltreatment and neglect, should accompany any other assault code.

h.

Sequela (Late Effects) of External Cause Guidelines

Sequela external cause codes

Sequela are reported using the external cause code with the 7th character “S” for sequela. These codes should be used with any report of a late effect or sequela resulting from a previous injury.

See Section I.B.10 Sequela (Late Effects)

Sequela external cause code with a related current injury

A sequela external cause code should never be used with a late effect code.

Sequela external cause code for subsequent visits

Use a late effect external cause code for subsequent visits when a late effect of the initial injury is being treated. Do not use a late effect external cause code for subsequent visits for follow-up care (e.g., to assess healing, to receive rehabilitative therapy) of the injury when no late effect of the injury has been documented.

j.

Terrorism Guidelines

1) Cause of injury identified by the Federal Government (FBI) as terrorism

When the cause of an injury is identified by the Federal Government (FBI) as terrorism, the first-listed external cause code should be a code from category Y38, Terrorism. The definition of terrorism employed by the FBI is found at the inclusion note at the beginning of category Y38. Use additional code for place of occurrence (Y92.-). More than one Y38 code may be assigned if the injury is the result of more than one mechanism of terrorism.

2) Cause of an injury is suspected to be the result of terrorism

When the cause of an injury is suspected to be the result of terrorism a code from category Y38 should not be assigned. Suspected cases should be classified as assault.

3) Code Y38.9, Terrorism, secondary effects

Assign code Y38.9, Terrorism, secondary effects, for conditions occurring subsequent to the terrorist event. This code should not be assigned for conditions that are due to the initial terrorist act.

It is acceptable to assign code Y38.9 with another code from Y38 if there is an injury due to the initial terrorist event and an injury that is a subsequent result of the terrorist event.

k.

External cause status

A code from category Y99, External cause status, should be assigned whenever any other external cause code is assigned for an encounter, including an Activity code, except for the events noted below. Assign a code from category Y99, External cause status, to indicate the work status of the person at the time the event occurred. The status code indicates whether the event occurred during military activity, whether a non-military person was at work, whether an individual including a student or volunteer was involved in a non-work activity at the time of the causal event.

A code from Y99, External cause status, should be assigned, when applicable, with other external cause codes, such as transport accidents and falls. The external cause status codes are not applicable to poisonings, adverse effects, medical misadventures or late effects.

Do not assign a code from category Y99 if no other external cause codes (cause, activity) are applicable for the encounter. An external cause status code is used only once, at the initial encounter for treatment. Only one code from Y99 should be recorded on a medical record.

Do not assign code Y99.9, Unspecified external cause status, if the status is not stated.

21. Chapter 21: Factors influencing health status and contact with health services (Z00-Z99)

Note: The chapter specific guidelines provide additional information about the use of Z codes for specified encounters.

a. Use of Z codes in any healthcare setting

Z codes are for use in any healthcare setting. Z codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain Z codes may only be used as first-listed or principal diagnosis.

b. Z Codes indicate a reason for an encounter

Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe any procedure performed.

c. Categories of Z Codes

1) Contact/Exposure

Category Z21 indicates contact with, and suspected exposure to, communicable diseases. These codes are for patients who do not show any sign or symptoms of a disease but are suspected to have been exposed to it by close personal contact with an
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infected individual or are in an area where a disease is epidemic. Category Z11, Other contact with and (suspected) exposures hazardous to health, indicates contact with and suspected exposures hazardous to health. Contact/exposure codes may be used as a first listed code to explain an encounter for testing, or more commonly, as a secondary code to identify a potential risk.

2) Infections and vaccinations

Code Z23 is for encounters for inclusions and vaccinations. It indicates that a patient is being seen to receive a prophylactic inoculation against a disease. Procedure codes are required to identify the actual administration of the injection and the type(s) of immunizations given. Code Z23 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

3) Status

Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prothetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code Z94.1, Heart transplant status, should not be used with a code from subcategory T86.2, Complications of heart transplant. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

For encounters for wearing from a mechanical ventilator, assign a code from subcategory J96.1, Chronic respiratory failure, followed by code Z99.11, Dependence on respirator (ventilator) status.

The status 2 codes/categories are:

Z14 Genetic carrier

Genetic carrier status indicates that a person carries a gene, associated with a particular disease, which may be passed to offspring who may develop the disease. The person does not have the disease and is not at risk of developing the disease.

Z15 Genetic susceptibility to disease

Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease. Codes from category Z15 should not be used as principal or first-listed codes. If the patient has the condition to which he/she is susceptible, and that condition is the reason for the encounter, the code for the current condition should be sequenced first. If the patient is being seen for follow-up after completed treatment for this condition, and the condition no longer exists, a follow-up code should be sequenced first, followed by the appropriate personal history and genetic susceptibility codes. If the purpose of the encounter is genetic counseling, associated with genetic counseling, code Z21.5, Encounter for genetic counseling, should be assigned as the first-listed code, followed by a code from category Z15.

Additional codes should be assigned for any applicable family or personal history.

Z16 Resistance to antimicrobial drugs

This code indicates that a patient has a condition that is resistant to antimicrobial drug treatment. Sequence the infection code first.

Z17 Estrogen receptor status

Z18 Retained foreign body fragments

Z19 Hormone sensitivity malignancy status

Z21 Asymptomatic HIV infection status

This code indicates that a patient has tested positive for HIV but has manifested no signs or symptoms of the disease.

Z22 Carrier of infectious disease

Carrier status indicates that a person harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection.

Z23.3 Underministration status

Z33.1 Pregnant state, incidental

This code is a secondary code only for use when the pregnancy is in no way complicating the reason for visit. Otherwise, a code from the obstetric chapter is required.

Z66 Do not resuscitate

This code may be used when it is documented by the provider that a patient is on do not resuscitate status at any time during the stay.

Z67 Blood type

Z68 Body mass index (BMI)

As with all other secondary diagnosis codes, the BMI codes should only be assigned when they meet the definition of a reportable diagnosis (see Section II, Reporting Additional Diagnoses).

Z74.81 Bed confinement status

Z76.82 Awaiting organ transplant status

Z78 Other specified health status

Code Z78.1, Physical restraint status, may be used when it is documented by the provider that a patient has been put in restraints during the current encounter. Please note that this code should not be reported when it is documented by the provider that a patient is temporarily restrained during a procedure.

Z79 Long-term (current) drug therapy

Codes from this category indicate a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have additions to drugs. This subcategory is not for use of medications for detoxification or maintenance programs to prevent withdrawal symptoms in patients with drug dependence (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug dependence instead.

Assign a code from Z79 if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer). Do not assign a code from category Z79 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acne, bronchitis).

Z88 Allergy status to drugs, medicaments and biological substances

Except Z88.9, Allergy status to unspecified drugs, medicaments and biological substances status

Z89 Acquired absence of limb

Z90 Acquired absence of organs, not elsewhere classified

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4) History (of)

There are two types of history Z codes, personal and family. Personal history codes explain a patient’s past medical history, whereas family history codes explain the patient’s family’s medical history.

Personal history codes are assigned when a patient has a specific chronic condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.

Family history codes are assigned when a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record and not to the transferring facility record.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Assign code Z93.82, Status post administration of tPA (rPA) in a different facility within the last 24 hours prior to admission to a current facility.

This guideline applies even if the patient is still receiving the tPA at the time they are received into the current facility.

The appropriate code for the condition for which the tPA was administered (such as cerebrovascular disease or myocardial infarction) should be assigned first.

Assign code Z98.85, Transplanted organ removal status, for the transplant organ should be assigned for that encounter.

Assignment of the transplant organ should be assigned for that encounter.

Note: Categories Z89-Z90 and Z93-Z99 are for use only in very limited circumstances when a person is being observed for a suspected condition that is ruled out. The observation code is used with the corresponding external cause code.

The observation codes are to be used as principal diagnosis because the patient has some sign or symptom that is not a result of an injury or illness or any signs or symptoms related to the suspected condition are present. In such cases the diagnosis/symptom code is used with the corresponding external cause code.

The observation codes are not for use if an injury or illness or any signs or symptoms related to the suspected condition are present. In such cases the diagnosis/symptom code is used with the corresponding external cause code.

The observation codes are to be used as principal diagnosis only. The only exception to this is when the principal diagnosis is required to be a code from category Z38, Liveborn infants according to place of birth and type of delivery. Then a code from category Z85, Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out, is sequenced after the Z38 code. Additional codes may be used in addition to the observation code, but only if they are unrelated to the suspected condition being observed.

Codes from subcategory Z85.7, Encounter for suspected maternal and fetal conditions ruled out, may either be used as a
7) Aftercare

Aftercare visit codes cover situations when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare Z code should not be used if treatment is directed at a current, acute disease. The diagnosis code is to be used in those cases. Exceptions to this rule are codes Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy. These codes are to be first-listed, followed by the diagnosis code when a patient’s encounter is solely to receive radiation therapy, chemotherapy, or immunotherapy for a condition other than malignant neoplasm. If the reason for the encounter is more than one type of antineoplastic therapy, code Z51.8 and a code from subcategory Z51.1 may be assigned together, in which case one of these codes should be reported as a secondary diagnosis.

The aftercare Z codes should also not be used for aftercare for injuries. For aftercare of an injury, assign the appropriate injury code with the appropriate 7th character (for subsequent encounter) instead.

The aftercare codes are generally first-listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

Aftercare codes should be used in conjunction with other aftercare codes or diagnosis codes to provide better detail on the specifics of the encounter. An aftercare code may be used when a patient receives multiple types of antineoplastic therapy during the same encounter, code Z51.8, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy, may be used together on a record. The sequencing of multiple aftercare codes depends on the circumstances of the encounter.

Certain aftercare Z code categories need a secondary diagnosis code to describe the resolving condition or sequelae. For others, the condition is included in the code title.

Additional Z code aftercare categories include fitting and adjustment, and attention to artificial openings.

Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare. For example, code Z95.1, Presence of aortocoronary bypass graft, may be used with code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system, to indicate the surgery for which the aftercare is being performed.

Certain status codes should not be used when the aftercare code indicates the type of status, such as using Z91.8, Encounter for attention to tracheostomy, with Z48.812, Tracheostomy status.

The aftercare Z code categories:

Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury
Z43 Encounter for attention to artificial openings
Z44 Encounter for fitting and adjustment of external prosthetic device
Z45 Encounter for adjustment and management of implanted device
Z46 Encounter for fitting and adjustment of other devices
Z47 Orthopedic aftercare
Z48 Encounter for other postprocedural aftercare
Z49 Encounter for care involving renal dialysis
Z51 Encounter for other aftercare and medical care

8) Follow-up

The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They are used in conjunction with a diagnosis code that identifies care of a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.

A follow-up code may be used to explain multiple visits. Should a condition be found to have recurred on the follow-up visit, then the diagnosis code for the condition should be assigned in place of the follow-up code.

The follow-up Z code categories:

Z88 Encounter for follow-up examination after completed treatment for malignant neoplasm
Z89 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
Z99 Encounter for maternal postpartum care and examination

9) Donor

Codes in category Z52, Donors of organs and tissues, are used for living individuals who are donating blood or other body tissues. These codes are only for individuals donating for others, not for self-donations. They are not used to identify cadaveric donations.

10) Counseling

Counseling Z codes are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems. They are not used in conjunction with a diagnosis code when the counseling component of care is considered integral to standard treatment.

The counseling Z code categories:
12) Newborns and Infants

Z30.0 Encounter for contraceptive management
Z31.6 Encounter for general counseling and advice on procreation
Z32.2 Encounter for childbirth instruction
Z32.3 Encounter for childcare instruction
Z69 Encounter for mental health services for victim and perpetrator of abuse
Z70 Counseling related to sexual attitude, behavior and orientation
Z71 Persons encountering health services for other counseling and medical advice, not elsewhere classified

Z codes for family planning (contraceptive) or procreative management and counseling should be included on an obstetric record either during the pregnancy or the postpartum stage, if applicable.

Z codes/categories for obstetrical and reproductive services:
Z30 Encounter for contraceptive management
Z31 Encounter for procreative management
Z32.2 Encounter for childbirth instruction
Z32.3 Encounter for childcare instruction
Z33 Pregnant state
Z34 Encounter for antenatal screening of mother
Z35 Encounter for supervision of normal pregnancy
Z36 Encounter for antenatal screening of father
Z37 Outcome of delivery
Z39 Encounter for maternal postpartum care and examination

Codes in category Z3A, Weeks of gestation, may be assigned to provide additional information about the pregnancy. Category Z3A codes should not be assigned for pregnancies with abortive outcomes (categories O80-O88), elective termination of pregnancy (code Z31.32), nor for postpartum conditions, as category Z3A is not applicable to these conditions. The date of the admission should be used to determine weeks of gestation for inpatient admissions that encompass more than one gestational week.

The outcome of delivery, category Z37, should be included on all maternal delivery records. It is always a secondary code.

Z codes for family planning (contraceptive) or procreative management and counseling should be included on an obstetric record either during the pregnancy or the postpartum stage, if applicable.

Z codes/categories for obstetrical and reproductive services:
Z30 Encounter for contraceptive management
Z31 Encounter for procreative management
Z32.2 Encounter for childbirth instruction
Z32.3 Encounter for childcare instruction
Z33 Pregnant state
Z34 Encounter for antenatal screening of mother
Z35 Encounter for supervision of normal pregnancy
Z36 Encounter for antenatal screening of father
Z37 Outcome of delivery
Z39 Encounter for maternal postpartum care and examination
Z76.81 Expectant mother prebirth pediatrician visit

Codes in category Z3A, Weeks of gestation, may be assigned to provide additional information about the pregnancy. Category Z3A codes should not be assigned for pregnancies with abortive outcomes (categories O80-O88), elective termination of pregnancy (code Z31.32), nor for postpartum conditions, as category Z3A is not applicable to these conditions. The date of the admission should be used to determine weeks of gestation for inpatient admissions that encompass more than one gestational week.

The outcome of delivery, category Z37, should be included on all maternal delivery records. It is always a secondary code.

Z codes for family planning (contraceptive) or procreative management and counseling should be included on an obstetric record either during the pregnancy or the postpartum stage, if applicable.

Z codes/categories for obstetrical and reproductive services:
Z30 Encounter for contraceptive management
Z31 Encounter for procreative management
Z32.2 Encounter for childbirth instruction
Z32.3 Encounter for childcare instruction
Z33 Pregnant state
Z34 Encounter for antenatal screening of mother
Z35 Encounter for supervision of normal pregnancy
Z36 Encounter for antenatal screening of father
Z37 Outcome of delivery
Z39 Encounter for maternal postpartum care and examination
Z76.81 Expectant mother prebirth pediatrician visit

13) Routine and administrative examinations

The Z codes allow for the description of encounters for routine examinations, such as, a general check-up, or, examinations for administrative purposes, such as, a pre-employment physical.

The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases the diagnosis code is used. During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code. Pre-existing and chronic conditions and history codes may also be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition.

Some of the codes for routine health examinations distinguish between “with” and “without” abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded. For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for “without abnormal findings.” When assigning a code for “with abnormal findings,” additional code(s) should be assigned to identify the specific abnormal finding(s).

Pre-operative examination and pre-procedural laboratory examination codes are for use only in those situations when a patient is being checked for a procedure or surgery and no treatment is given.

The Z codes/categories for routine and administrative examinations:
Z00 Encounter for general examination without complaint, suspected or reported diagnosis
Z01 Encounter for special examination without complaint, suspected or reported diagnosis
Z02 Encounter for administrative examination
Z02.9 Encounter for administrative examination
Z08 Encounter for general examination with abnormal findings, suspected or reported diagnosis
Z09 Encounter for special examination with abnormal findings, suspected or reported diagnosis
Z12 Encounters for procedures for other than treatment purposes, unspecified
Z41 Encounter for procedures for purposes other than treatment purposes

14) Miscellaneous Z codes

The miscellaneous Z codes capture a number of other health care encounters that do not fall into one of the other categories. Certain of these codes identify the reason for the encounter; others are for use as additional codes that provide useful information on circumstances that may affect a patient’s care and treatment.

Prophylactic Organ Removal

For encounters specifically for prophylactic removal of an organ (such as prophylactic removal of breasts due to a genetic susceptibility to cancer or a family history of cancer), the principal or first-listed code should be a code from category Z48, Encounter for prophylactic surgery. Followed by the appropriate code(s) to identify the associated risk factor (such as genetic susceptibility or family history).

If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metatstatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory Z48.8, Encounter for prophylactic surgery for risk factors related to malignant neoplasms. A Z48.9 code should not be assigned if the patient is having organ removal for treatment of a malignancy, such as the removal of the testes for the treatment of prostate cancer.

Miscellaneous Z codes/categories:
Z28 Immunoablation not carried out
Z29 Immunoablation not carried out
Z30 Encounter for chemotherapy
Z31 Encounter for chemotherapy
Z32 Encounter for chemotherapy
Z33 Encounter for chemotherapy
Z34 Encounter for chemotherapy
Z35 Encounter for chemotherapy
Z36 Encounter for chemotherapy
Z37 Encounter for chemotherapy
Z38 Encounter for chemotherapy
Z39 Encounter for chemotherapy
Z40 Encounter for prophylactic surgery
Z41 Encounter for prophylactic surgery
Z42 Encounter for prophylactic surgery
Z43 Encounter for prophylactic surgery
Z44 Encounter for prophylactic surgery
Z45 Encounter for prophylactic surgery
Z46 Encounter for prophylactic surgery
Z47 Encounter for prophylactic surgery
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Z93 Encounter for prophylactic surgery
Z94 Encounter for prophylactic surgery
Z95 Encounter for prophylactic surgery
Z96 Encounter for prophylactic surgery
Z97 Encounter for prophylactic surgery
Z98 Encounter for prophylactic surgery
Z99 Encounter for prophylactic surgery
Z00 Encounter for general examination without complaint, suspected or reported diagnosis
Z01 Encounter for special examination without complaint, suspected or reported diagnosis
Z02 Encounter for administrative examination
Z02.9 Encounter for administrative examination
Z12- Encounter for pregnancy test

Miscellaneous Z codes:
Z28 Implantation not carried out
Z29 Implantation not carried out
Z30 Encounter for chemotherapy
Z31 Encounter for chemotherapy
Z32 Encounter for chemotherapy
Z33 Encounter for chemotherapy
Z34 Encounter for chemotherapy
Z35 Encounter for chemotherapy
Z36 Encounter for chemotherapy
Z37 Outcome of delivery
Z39 Encounter for maternal postpartum care and examination
Z76.81 Expectant mother prebirth pediatrician visit

12) Newborns and Infants

See Section C.16, Newborn (Perinatal) Guidelines, for further instruction on the use of these codes.

Newborn Z codes/categories:
Z76.1 Encounter for health supervision and care of founding
Z78.1 Encounter for routine child health examination
Z38 Liveborn infants according to place of birth and type of delivery
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15) Nonspecific Z codes

Certain Z codes are so non-specific, or potentially redundant with other codes in the classification, that there can be little justification for their use in the inpatient setting. Their use in the outpatient setting should be limited to those instances when there is no further documentation to permit more precise coding. Otherwise, any sign or symptom or any other reason for visit that is captured in another code should be used.

Non-specific Z codes/categories:

- Z82.9 Encounter for administrative examinations, unspecified
- Z84.9 Encounter for examination and observation for unspecified reason
- Z13.9 Encounter for screening, unspecified
- Z41.9 Encounter for procedure for purposes other than remediating health state, unspecified
- Z52.9 Donor of unspecified organ or tissue
- Z86.9 Personal history of other mental and behavioral disorders
- Z88.9 Allergy status to unspecified drugs, medicaments and biological substances
- Z89.2- Personal history of contraception

16) Z Codes That May Only Be Principal/First-Listed Diagnosis

The following Z codes/categories may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined:

- Z00 Encounter for general examination without complaint, suspected or reported diagnosis
- Z01 Encounter for medical observation for suspected or reported diagnosis
- Z02 Encounter for administrative examination
- Z03 Encounter for medical observation for suspected and conditions ruled out
- Z04 Encounter for examination and observation for other reasons
- Z08.6 Encounter for other special examination without complaint, suspected or reported diagnosis
- Z11.8 Encounter for assisted reproductive fertility procedure cycle
- Z11.83 Encounter for elective termination of pregnancy
- Z11.81 Encounter for male factor infertility in female patient
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances
- Z67 Problems related to lifestyle

Note: These codes should be assigned only when the documentation specifies that the patient has an associated problem

17) Problems related to life management difficulty

18) Problems related to care provider dependency

19) Except: Z74.01, Bed confinement status

20) Zhealthy person accompanying sick person

21) Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury

22) Z76.1 Encounter for health supervision and care of brandling

23) Z76.2 Encounter for health supervision and care of other healthy infant and child

24) Z99.12 Encounter for respirator (ventilator) dependence during power failure

Section II. Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”

The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No. 147), pp. 31038-40. Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals, home health agencies, rehab facilities, nursing homes, etc.). The UHDDS definitions also apply to hospice services (all levels of care).

In determining principal diagnosis, coding conventions in the ICD-10-CM, the Tabular List and the Alphabetical Index take precedence over these official coding guidelines.

See Section I.A., Conventions for the ICD-10-CM.

The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

A. Codes for symptoms, signs, and ill-defined conditions

Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established.
B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.

When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characterized in a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis.

In those instances when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

D. Two or more comparative or contrasting conditions.

In rare instances when two or more contrasting or comparative diagnoses are documented as either/or (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

E. A symptom(s) followed by contrasting/comparative diagnoses.

When the admission is for the treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

F. Original treatment plan not carried out.

Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

G. Complications of surgery and other medical care.

When the admission is for the treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

H. Uncertain Diagnosis.

If the diagnosis documented at the time of discharge is qualified as “probable,” “suspected,” “likely,” “questionable,” “possible,” or “still to be ruled out,” other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup and/or therapy, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

I. Admission from Observation Unit.

1. Admission Following Medical Observation.

When a patient is admitted to an observation unit to monitor a condition or to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should apply the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis as “the condition established after study to be chiefly responsible for that admission.”

2. Admission Following Post-Operative Observation.

When a patient is admitted to an observation unit to monitor a condition or to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should apply the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis as “the condition established after study to be chiefly responsible for that admission.”

J. Admission from Outpatient Surgery.

When a patient is admitted to the hospital as an outpatient and is subsequently admitted to the hospital as an inpatient, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:

- If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.
- If no complication, or other condition, is documented as the reason for the inpatient admission, choose as the reason for the inpatient admission the diagnosis as the principal diagnosis.
- If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

K. Admissions/Encounters for Rehabilitation.

When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the patient was being performed. For example, for an admission/encounter for rehabilitation for multiple fractures sustained during a hospital stay, sequence initial codes for fractures, and then code T85.1, Rehabilitation for fractures sustained during a hospital stay.

See Section I.C.2 <1.7 Factors influencing health status and contact with health services, aftercare.

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER ADDITIONAL DIAGNOSES.

For reporting purposes the definition for “other diagnosis” is interpreted as additional conditions that affect patient care in terms of requiring clinical evaluation; or therapeutic treatment; or additional diagnostic workup and/or therapy provided, and the Tabular List, or another coding guidelines does not provide sequencing direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider.

A. Previous Conditions.

If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if requested by hospital policy. However, history codes (categories Z80-Z87) may be used as secondary codes in the case of a medical condition that is not currently present, but is still relevant to the patient’s condition.

B. Abnormal Findings.

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the...
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2. Observation Stay
When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis. When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

B. Codes from A88.0 through T88.9, Z00-299
The appropriate code(s) from A88.0 through T88.9, Z00-299 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

C. Accurate Reporting of ICD-10-CM Diagnosis Codes
For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient’s condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

D. Codes that Describe Symptoms and Signs
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings: Not Elsewhere Classified (codes R16-R99) contain many, but not all codes for symptoms.

E. Encounters for Circumstances Other than a Disease or Injury
ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (280-299) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems. See Section I.C.1. Factors influencing health status and contact with health services.

F. Level of Detail in Coding
1. ICD-10-CM codes with 3, 4, 5, 6 or 7 characters
ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity.

2. Use of Full Number of Characters Required for a Code
A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

G. ICD-10-CM Code for the Diagnosis, Condition, Problem, or Other Reason for Encounter/Visit
List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

H. Uncertain Diagnosis
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.

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

1. Chronic Diseases
Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
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Appendix I. Present on Admission Reporting Guidelines

Introduction

These guidelines are to be used as a supplement to the ICD-10-CM Official Guidelines for Coding and Reporting to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim forms (UB-04 and 837 Institutional).

These guidelines are not intended to replace any guidelines in the main body of the ICD-10-CM Official Guidelines for Coding and Reporting. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of coding codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-10-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-10-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term “provider” means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis.

These guidelines are not a substitute for the provider’s clinical judgment as to the determination of whether a condition was/was not present on admission. The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.

Please see the CDC website for the detailed list of ICD-10-CM codes that do not require the use of a POA indicator (ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2017/). The conditions on this exempt list represent categories and/or codes for circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission.

General Reporting Requirements

All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information. Present on admission is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission. POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes.

Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider. If a condition would not be coded and reported based on ICD-10-CM definitions and current official coding guidelines, then the POA indicator would not be reported.

Reporting Options

Y - Yes
N - No
U - Unknown
W - Clinically undetermined
Unreported/Not used – (Exempt from POA reporting)
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Reporting Definitions

Y = present at the time of inpatient admission
N = not present at the time of inpatient admission
U = documentation is insufficient to determine if condition is present on admission or not
W = provider is unable to clinically determine whether condition was present on admission or not

Timeframe for POA Identification and Documentation

There is no required timeframe as to when a provider (per the definition of “provider” used in these guidelines) must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission. In some cases it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission. Determination of whether the condition was present on admission or not will be based on the applicable POA guideline as identified in this document, or on the provider’s best clinical judgment.

If at the time of code assignment the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification.

Assigning the POA Indicator

Condition is on the “Exempt from Reporting” list
Leave the “present on admission” field blank if the condition is on the list of ICD-10-CM codes for which this field is not applicable. This is the only circumstance in which the field may be left blank.

POA Explicitly Documented

Assign Y for any condition the provider explicitly documents as being present on admission.
Assign N for any condition the provider explicitly documents as not present at the time of admission.

Conditions diagnosed prior to inpatient admission

Assign “Y” for conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)
Conditions diagnosed during the admission but clearly present before admission

Assign “Y” for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred.
Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that is present at the time of admission.
Condition develops during outpatient encounter prior to inpatient admission

Assign Y for any condition that develops during an outpatient encounter prior to a written order for inpatient admission.

Documentation does not indicate whether condition was present on admission

Assign “U” when the medical record documentation is unclear as to whether the condition was present on admission. “U” should not be routinely assigned and used only in very limited circumstances. Coders are encouraged to query the providers when the documentation is unclear.
Documentation states that it cannot be determined whether the condition was or was not present on admission

Assign “W” when the medical record documentation indicates that it cannot be clinically determined whether or not the condition was present on admission.

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Chronic condition with acute exacerbation during the admission

If a single code identifies both the chronic condition and the acute exacerbation, use POA guidelines pertaining to codes that contain multiple clinical concepts.
If a single code only identifies the chronic condition and not the acute exacerbation (e.g., acute exacerbation of chronic leukemia), assign “Y”.
Conditions documented as possible, probable, suspected, or rule out at the time of discharge

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on signs, symptoms or clinical findings suspected at the time of inpatient admission, assign “Y”.
If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on signs, symptoms or clinical findings that were not present on admission, assign “N”.

Codes That Contain Multiple Clinical Concepts

Assign “Y” if at least one of the clinical concepts included in the code were present on admission (e.g., COPD with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission).
Assign “Y” for chronic conditions, even though the condition may not be diagnosed until after admission.
Assign “Y” for chronic conditions, even though the condition may not be diagnosed until after admission.
Assign “Y” for conditions that were diagnosed prior to admission
Conditions diagnosed prior to inpatient admission

Assign “Y” for conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)
Assign “N” for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred.
Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that is present at the time of admission.
Condition develops during outpatient encounter prior to inpatient admission

Assign Y for any condition that develops during an outpatient encounter prior to a written order for inpatient admission.

Documentation does not indicate whether condition was present on admission

Assign “U” when the medical record documentation is unclear as to whether the condition was present on admission. “U” should not be routinely assigned and used only in very limited circumstances. Coders are encouraged to query the providers when the documentation is unclear.
Documentation states that it cannot be determined whether the condition was or was not present on admission

Assign “W” when the medical record documentation indicates that it cannot be clinically determined whether or not the condition was present on admission.

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Obstetrical conditions

Whether or not the patient delivers during the current hospitalization does not affect assignment of the POA indicator. The determining factor for POA assignment is whether the pregnancy complication or the obstetrical condition described by the code was present at the time of admission or not.
If the pregnancy complication or obstetrical condition was present on admission (e.g., patient admitted in preterm labor), assign "Y".

If the pregnancy complication or obstetrical condition was not present on admission (e.g., 2nd degree laceration during delivery, postpartum hemorrhage that occurred during current hospitalization, fetal distress develops after admission), assign "N".

If the obstetrical code includes more than one diagnosis and any of the diagnoses identified by the code were not present on admission assign "N". (e.g., Category O11, Pre-existing hypertension with pre-eclampsia)

External cause of injury codes
Assign "Y" for any external cause code representing an external cause of morbidity that occurred prior to inpatient admission (e.g., patient fell out of bed at home, patient fell out of bed in emergency room prior to admission)
Assign "N" for any external cause code representing an external cause of morbidity that occurred during inpatient hospitalization (e.g., patient fell out of hospital bed during hospital stay, patient experienced an adverse reaction to a medication administered after inpatient admission)

Congenital conditions and anomalies
Assign "Y" for congenital conditions and anomalies except for categories Q00-Q99, Congenital anomalies, which are on the exempt list.

Congenital conditions are always considered present on admission.

Newborns are not considered to be admitted until after birth. Therefore, any condition present at birth or that developed in utero is considered present at admission and should be assigned "Y". This includes conditions that occur during delivery (e.g., injury during delivery, meconium aspiration, exposure to streptococcus B in the vaginal canal).