Learning the Lingo of ICD-10
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By now, learners should be familiar with the format and structure of ICD-10. As we continue to prepare, this webinar focuses on the terms and coding guidelines that differ from what current coders are familiar with. Understanding what is required for specific reporting purposes will ease the transition to ICD-10.

- Identify certain new terms, definitions, and structure issues of ICD-10 that are both unique and sometimes puzzling.
- Identify inconsistencies in ICD-10
- Use the information provided in this webinar to help you plan to review, analyze, and interpret your current documentation needs.
- Identify specific areas of concern of documentation for ICD-10.
Learning the Lingo: Why?

• Will make the transition easier
• Terms that used to be important may not be any longer e.g. controlled
• Help make faster decisions
• Understand where documentation is confusing or lacking and learn where to improve
• Understand where improving matters
• Inconsistencies in resources, will need to make many decisions even with use of an encoder
  – How was this entered?
Learning the Lingo: Everyday Decisions

Mental health

F02 Dementia in other diseases classified elsewhere

**Code first** the underlying physiological condition, such as:
- Alzheimer's (G30.-)
- cerebral lipidosis (E75.4)
- Creutzfeldt-Jakob disease (A81.0-)
- dementia with Lewy bodies (G31.83)
- epilepsy and recurrent seizures (G40.-)

**Excludes1**: dementia with Parkinsonism (G31.83)
Learning the Lingo: Everyday Decisions

Diverticulosis vs. Diverticulitis
Contiguous and Overlapping
Use of the dash -
In the neoplasm table the instructions state that the presence of a dash means that an additional character is needed to identify the laterality of the tumor.

- Every code on the table that had a dash didn't necessarily require a character specific to laterality, some required additional characters for other reasons. Also some other errors were noted where a dash was present but the code was complete as is. An example of this is C79.2-.
In the 2013 index under abuse childhood and adult are at the same indention level but childhood comes before adult instead of after adult as our alphabetization rules would tell us.

- personal (of) —see also History, family (of)
  - - abuse
  - - - childhood Z62.819
  - - - physical Z62.810
  - - - psychological Z62.811
  - - - sexual Z62.810
  - - adult Z91.419
  - - physical and sexual Z91.410
  - - psychological Z91.411
  - - alcohol dependence F10.21
Documentation Issues?
Guideline Comments

- The word "documentation" is mentioned over 70 times in the ICD-10-CM guidelines document.
- Querying is referred to over 20 times in the guidelines document.
- The instructions and conventions of the classification take precedence over guidelines.
- Specific statements:

  The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.
Guidelines Usage: Case Example, Neoplasm

- Consider the fact that there are few differences between ICD-9-CM and ICD-10-CM coding guidelines.
- A coder whether experienced or not will need to be very familiar with the guidelines.
- The guidelines are helpful but do not describe everything in a way that everyone can understand.
Guidelines Usage: Case Example, Neoplasm

• Management of dehydration due to the malignancy
• Guideline States: When the admission/encounter is for management of dehydration due to the malignancy and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.
Guidelines Usage: Case Example, Neoplasm

• Issues:
  – Relatively inexperienced coder, little actual experience
  – Scenario presented is patient admitted with dehydration nausea and vomiting, later determined to be due to pancreatic cancer. Treated for dehydration and discharged for further outpatient testing.
  – Coder thinks dehydration should be the principal diagnosis
  – New coder doesn't have the experience to know that the guideline for principal diagnosis—reason for admission after study—should be applied rather than this guideline
Guidelines Usage: Case Example, Neoplasm and Anemia

• ICD-9-CM
  – When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, Anemia in neoplastic disease) is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy.

• ICD-10-CM
  – 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 or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease).
Guidelines Usage: Case Example, Neoplasm and Anemia

• Issue:
  – Experienced coder thinks anemia should be sequenced first because they have knowledge of ICD-9-CM
  – No discussion of changing this for the future.
Guideline Terminology

• Laterality
  – 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.

• Syndromes
  – Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign 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.
Guideline Terminology

• Encounter
  – Used for all settings, including hospital admissions.

• Provider
  – Used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis.
Specific Guideline Documentation Requirements: BMI and Skin Ulcers

• For the Body Mass Index (BMI), depth of non-pressure chronic ulcers and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis).

• However, the associated diagnosis (such as overweight, obesity, 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.
Specific Guideline Documentation Requirements: 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 entry (e.g., borderline diabetes).

• 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, coders are encouraged to query for clarification.
Specific Guideline Documentation Requirements:
Sequelae of Cerebrovascular Disease

- 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.
Specific Guideline Documentation Requirements: Influenza

• Code only confirmed cases of influenza due to certain identified influenza viruses (category J09), and due to other identified influenza virus (category J10).

• 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.
Specific Guideline Documentation Requirements: Influenza

• If the provider records “suspected” or “possible” or “probable” avian influenza, or novel influenza, or other identified influenza, then the appropriate influenza code from category J11, 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.
Specific Guideline Documentation Requirements: 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.
- 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.
- Query the provider for clarification, if the complication is not clearly documented.
Specific Guideline Documentation Requirements: Human Immunodeficiency Virus (HIV) Infections

- Code only confirmed cases of HIV infection/illness.
- In this context, “confirmation” does not require documentation of positive serology or culture for HIV; the provider’s diagnostic statement that the patient is HIV positive, or has an HIV-related illness is sufficient.
- 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,” “known 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.
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.
Specific Guideline Documentation Requirements: Sepsis

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.*
Specific Guideline Documentation Requirements: Sepsis

Sepsis due to a postprocedural infection, as with all postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the infection and the procedure.

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.
Specific Guideline Documentation Requirements: MRSA

• When there is **documentation of a current infection** (e.g., wound infection, stitch abscess, urinary tract infection) **due to MRSA**, and that infection does not have a combination code that includes the causal organism, **assign the appropriate code to identify the condition along with code B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere for the MRSA infection.**
Specific Guideline Documentation Requirements: Malignancy

• 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 unclear, the provider should be queried* as to the status of each tumor so that the correct codes can be assigned.

• If the *documentation* is unclear, as to whether the leukemia has achieved remission, *the provider should be queried.*
• 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, should also be assigned to indicate that the patient uses insulin.
Specific Guideline Documentation Requirements: Mental and Behavioral Disorders

- Mental and behavioral disorders due to psychoactive substance use
  - 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).

- 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*. 
Specific Guideline Documentation Requirements: Pain Disorders

• Pain Disorders
  – Code F45.42, Pain disorders with related psychological factors, should be used with a code from category G89, Pain, not elsewhere classified, if there is documentation of a psychological component for a patient with acute or chronic pain.

• Postoperative Pain
  – The provider’s documentation should be used to guide the coding of postoperative pain, as well as Section III. Reporting Additional Diagnoses and Section IV. Diagnostic Coding and Reporting in the Outpatient Setting.

• Chronic pain
  – Chronic pain is classified to subcategory G89.2. There is no time frame defining when pain becomes chronic pain. The provider’s documentation should be used to guide use of these codes.
Specific Guideline Documentation Requirements: Indeterminate Stage Glaucoma

Assignment of the seventh character “4” for “indeterminate stage” should be based on the clinical documentation. The seventh character “4” is used for glaucomas whose stage cannot be clinically determined.

This seventh character should not be confused with the seventh character “0”, unspecified, which should be assigned when there is no documentation regarding the stage of the glaucoma.
Specific Guideline Documentation Requirements: 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 I25.11, Atherosclerotic heart disease of native coronary artery with angina pectoris and I25.7, Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris.

- 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.
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.
Specific Guideline Documentation Requirements: Respiratory

- 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.
Specific Guideline Documentation Requirements: VAP

• 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 J12-J18 to identify the type of pneumonia.
Specific Guideline Documentation Requirements: VAP

- Documentation of Ventilator Associated 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 unclear as to whether the patient has a pneumonia that is a complication attributable to the mechanical ventilator, query the provider.
Specific Guideline Documentation Requirements: Unstageable Pressure Ulcers

- Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on *the clinical documentation*.
- When there is *no documentation* regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.--9).
- Assignment of the pressure ulcer stage code *should be guided by clinical documentation* of the stage or *documentation* of the terms found in the Alphabetic Index. For clinical terms describing the stage that are not found in the Alphabetic Index, and there is no *documentation* of the stage, the provider should be queried.
Specific Guideline Documentation Requirements: Unstageable Pressure Ulcers

• Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign the appropriate code for unspecified stage.

• If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider
Specific Guideline Documentation Requirements: Trauma and Transplant

• 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. *If it is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.*

• If the *documentation is unclear* as to whether the patient has a complication of the transplant, query the provider.
Specific Guideline Documentation Requirements: Pregnancy

• 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.

• Unspecified trimester
  – Each category that includes codes for trimester has a code for “unspecified trimester.” The “unspecified trimester” code should rarely be used, such as when the documentation in the record is insufficient to determine the trimester and it is not possible to obtain clarification.
Specific Guideline Documentation Requirements: Pregnancy

• 7th character for Fetus Identification
  – Where applicable, a 7th character is to be assigned for certain categories (O31, O32, O33.3 - O33.6, O35, O36, O40, O41, O60.1, O60.2, O64, and O69) to identify the fetus for which the complication code applies. Assign 7th character “0”:

• For single gestations
  – When the documentation in the record is insufficient to determine the fetus affected and it is not possible to obtain clarification.
  – When it is not possible to clinically determine which fetus is affected.
Specific Guideline Documentation Requirements: Pregnancy

• 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 it is, the default is due to the birth process and the code from Chapter 16 should be used. If the condition is community-acquired, a code from Chapter 16 should not be assigned.

• Bacterial sepsis
  – 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.
Specific Guideline Documentation Requirements: 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.-).

• Use of undetermined intent
  – External cause codes for events of undetermined intent are only for use *if the documentation* in the record specifies that the intent cannot be determined.
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.
Present on Admission

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.
• Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.

• 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.

• The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.
A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used. The 'sequelae' include conditions specified as such; they also include residuals of diseases classifiable to the above categories if there is evidence that the disease itself is no longer present. Codes from these categories are not to be used for chronic infections. Code chronic current infections to active infectious disease as appropriate.

Subacute care is the level of care between acute and chronic.
More Terms

• Underdosing refers to a drug dose that is less than required or is insufficient.
• 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.
• Contiguous/overlapping
Term Usage: Code First/Use Additional Code notes (etiology/manifestation paired codes)

- 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 followed by the manifestation. Wherever such a combination exists there is a 'use additional code' note at the etiology code, and a 'code first' note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.
- “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.
Term Usage: 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. “Use additional code” 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 the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.
• 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.
• A code also note instructs that 2 codes may be required to fully describe a condition but the sequencing of the two codes is discretionary, depending on the severity of the conditions and the reason for the encounter.
Terms of ICD-10-CM: More Not Less, ICD-9 vs ICD-10

253.2 Panhypopituitarism
- Cachexia, pituitary
- Necrosis of pituitary (postpartum)
- Pituitary insufficiency NOS
- Sheehan's syndrome
- Simmonds' disease
E23.0  Hypopituitarism
Fertile eunuch syndrome
Hypogonadotropic hypogonadism
Idiopathic growth hormone deficiency
Isolated deficiency of gonadotropin
Isolated deficiency of growth hormone
Isolated deficiency of pituitary hormone
Kallmann's syndrome
Lorain-Levi short stature
Necrosis of pituitary gland (postpartum)
Panhypopituitarism
Pituitary cachexia
Pituitary insufficiency NOS
Pituitary short stature
Sheehan's syndrome
Simmonds' disease
Terms: Mental Disorders Due To Known Physiological Conditions (F01-F09)

This block comprises a range of mental disorders grouped together on the basis of their having in common a demonstrable etiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction.

F01.51 Vascular dementia with behavioral disturbance
  - Vascular dementia with aggressive behavior
  - Vascular dementia with combative behavior
  - Vascular dementia with violent behavior
F10.15 Alcohol abuse with alcohol-induced psychotic disorder

- F10.150 Alcohol abuse with alcohol-induced psychotic disorder with delusions
- F10.151 Alcohol use with alcohol-induced psychotic disorder with hallucinations
- F10.159 Alcohol abuse with alcohol-induced psychotic disorder, unspecified
Terms: Mental Disorders Due To Known Physiological Conditions (F01-F09)

- Other terms used with alcohol, opioid, others:
  - Dependence
  - Abuse
  - Use
  - Perceptual Disturbance
  - Delirium
  - Intoxication
  - Psychotic Disorder
  - Sedative, Hypnotic Or Anxiolytic
  - Inhalant Use
  - Psychoactive Substance Abuse
  - Recurrent
### Terms: Mental Disorders Due To Known Physiological Conditions (F01-F09)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F31.6</td>
<td>Bipolar disorder, current episode mixed</td>
</tr>
<tr>
<td>F31.60</td>
<td>Bipolar disorder, current episode mixed, unspecified</td>
</tr>
<tr>
<td>F31.61</td>
<td>Bipolar disorder, current episode mixed, mild</td>
</tr>
<tr>
<td>F31.62</td>
<td>Bipolar disorder, current episode mixed, moderate</td>
</tr>
<tr>
<td>F31.63</td>
<td>Bipolar disorder, current episode mixed, severe, without psychotic features</td>
</tr>
<tr>
<td>F31.64</td>
<td>Bipolar disorder, current episode mixed, severe, with psychotic features</td>
</tr>
<tr>
<td></td>
<td>Bipolar disorder, current episode mixed with mood-congruent psychotic symptoms</td>
</tr>
<tr>
<td></td>
<td>Bipolar disorder, current episode mixed with mood-incongruent psychotic symptoms</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>F70</td>
<td>Mild intellectual disabilities</td>
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<tr>
<td>F71</td>
<td>Moderate intellectual disabilities</td>
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<td>F72</td>
<td>Severe intellectual disabilities</td>
</tr>
<tr>
<td>F73</td>
<td>Profound intellectual disabilities</td>
</tr>
<tr>
<td>F78</td>
<td>Other intellectual disabilities</td>
</tr>
</tbody>
</table>
| F79  | Unspecified intellectual disabilities | | Mental deficiency NOS  
Mental subnormality NOS |
Term Usage: Epilepsy

G40.00  Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable

Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset without intractability

G40.001  Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, with status epilepticus

G40.009  Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, without status epilepticus

Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset NOS
I21.2  **ST elevation (STEMI) myocardial infarction of other sites**

I21.21 **ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery**

I21.29 **ST elevation (STEMI) myocardial infarction involving other sites**

- Acute transmural myocardial infarction of other sites
- Apical-lateral transmural (Q wave) infarction (acute)
- Basal-lateral transmural (Q wave) infarction (acute)
- High lateral transmural (Q wave) infarction (acute)
- Lateral (wall) NOS transmural (Q wave) infarction (acute)
- Posterior (true) transmural (Q wave) infarction (acute)
- Posterobasal transmural (Q wave) infarction (acute)
- Posterolateral transmural (Q wave) infarction (acute)
- Posteroseptal transmural (Q wave) infarction (acute)
- Septal transmural (Q wave) infarction (acute) NOS
Cerebral infarction due to thrombosis of precerebral arteries

I63.0 Cerebral infarction due to thrombosis of precerebral arteries
   I63.00 Cerebral infarction due to thrombosis of unspecified precerebral artery
   I63.01 Cerebral infarction due to thrombosis of vertebral artery
       I63.011 Cerebral infarction due to thrombosis of right vertebral artery
       I63.012 Cerebral infarction due to thrombosis of left vertebral artery
       I63.019 Cerebral infarction due to thrombosis of unspecified vertebral artery
   I63.02 Cerebral infarction due to thrombosis of basilar artery
   I63.03 Cerebral infarction due to thrombosis of carotid artery
       I63.031 Cerebral infarction due to thrombosis of right carotid artery
       I63.032 Cerebral infarction due to thrombosis of left carotid artery
       I63.039 Cerebral infarction due to thrombosis of unspecified carotid artery
   I63.09 Cerebral infarction due to thrombosis of other precerebral artery
I63.1 Cerebral infarction due to embolism of precerebral arteries

I63.10 Cerebral infarction due to embolism of unspecified precerebral artery
I63.11 Cerebral infarction due to embolism of vertebral artery
       I63.111 Cerebral infarction due to embolism of right vertebral artery
       I63.112 Cerebral infarction due to embolism of left vertebral artery
Term Usage: Respiratory Failure

J96.1 Chronic respiratory failure
   J96.10 Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
   J96.11 Chronic respiratory failure with hypoxia
   J96.12 Chronic respiratory failure with hypercapnia

J96.2 Acute and chronic respiratory failure
   Acute on chronic respiratory failure
   J96.20 Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
   J96.21 Acute and chronic respiratory failure with hypoxia
   J96.22 Acute and chronic respiratory failure with hypercapnia

J96.9 Respiratory failure, unspecified
   J96.90 Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia
   J96.91 Respiratory failure, unspecified with hypoxia
   J96.92 Respiratory failure, unspecified with hypercapnia
Trimesters are counted from the first day of the last menstrual period. They are defined as follows:

- **1st trimester** - less than 14 weeks 0 days
- **2nd trimester** - 14 weeks 0 days to less than 28 weeks 0 days
- **3rd trimester** - 28 weeks 0 days until delivery

Use additional code from category Z3A, Weeks of gestation, to identify the specific week of the pregnancy.
Term Usage: Pregnancy Characters

One of the following 7th characters is to be assigned to each code under category O31. 7th character 0 is for single gestations and multiple gestations where the fetus is unspecified. 7th characters 1 through 9 are for cases of multiple gestations to identify the fetus for which the code applies. The appropriate code from category O30, Multiple gestation, must also be assigned when assigning a code from category O31 that has a 7th character of 1 through 9.

- O31, Complications specific to multiple gestation
- O32, Maternal care for malpresentation of fetus
- NOT O33.0-O33.2-, O33.7-, O33.8-, O33.9-
- O33.3-, O33.4-, O33.5-, O33.6-
- NOT O34, Maternal care for abnormality of pelvic organs
- O35, O36

Where applicable, a 7th character is to be assigned for certain categories (O31, O32, O33.3 - O33.6, O35, O36, O40, O41, O60.1, O60.2, O64, and O69) to identify the fetus for which the complication code applies.
Z36  Encounter for antenatal screening of mother

Excludes1: abnormal findings on antenatal screening of mother (O28.-)
  diagnostic examination - code to sign or symptom
  encounter for suspected maternal and fetal conditions ruled out (Z03.7-)
  suspected fetal condition affecting management of pregnancy - code to condition in Chapter 15

Excludes2: genetic counseling and testing (Z31.43-, Z31.5)
  routine prenatal care (Z34)

Z3A  Weeks of gestation

Note: Codes from category Z3A are for use, only on the maternal record, to indicate the weeks of gestation of the pregnancy.

Code first  complications of pregnancy, childbirth and the puerperium (O00-O9A)

Z3A.0  Weeks of gestation of pregnancy, unspecified or less than 10 weeks

  Z3A.00  Weeks of gestation of pregnancy not specified
  Z3A.01  Less than 8 weeks gestation of pregnancy
Encounter for delivery (O80-O82)

O80  Encouter for full-term uncomplicated delivery
    Delivery requiring minimal or no assistance, with or without episiotomy, without fetal manipulation [e.g., rotation version] or instrumentation [forceps] of a spontaneous, cephalic, vaginal, full-term, single, live-born infant. This code is for use as a single diagnosis code and is not to be used with any other code from chapter 15. This code must be accompanied by a delivery code from the appropriate procedure classification.
    Use additional code to indicate outcome of delivery (Z37.0)

O82  Encounter for cesarean delivery without indication
    This code must be accompanied by a delivery code from the appropriate procedure classification.
    Use additional code to indicate outcome of delivery (Z37.0)
R40.2 Coma

**Code first** any associated:
  coma in fracture of skull (S02.-)
  coma in intracranial injury (S06.-)

The appropriate 7th character is to be added to each code from subcategory R40.21-, R40.22-, R40.23-:
  0 - unspecified time
  1 - in the field [EMT or ambulance]
  2 - at arrival to emergency department
  3 - at hospital admission
  4 - 24 hours or more after hospital admission

**Note:** A code from each subcategory is required to complete the coma scale

R40.20 Unspecified coma
  Coma NOS
  Unconsciousness NOS

R40.21 Coma scale, eyes open
  R40.211 Coma scale, eyes open, never
  R40.212 Coma scale, eyes open, to pain
R40.23 Coma scale, best motor response
  R40.231 Coma scale, best motor response, none
  R40.232 Coma scale, best motor response, extension
  R40.233 Coma scale, best motor response, abnormal
  R40.234 Coma scale, best motor response, flexion withdrawal
  R40.235 Coma scale, best motor response, localizes pain
  R40.236 Coma scale, best motor response, obeys commands

R40.24 Glasgow coma scale, total score
Use codes R40.21- through R40.23- only when the individual score(s) are documented
  R40.241 Glasgow coma scale score 13-15
  R40.242 Glasgow coma scale score 9-12
  R40.243 Glasgow coma scale score 3-8
  R40.244 Other coma, without documented Glasgow coma scale score, or with partial score reported
Term Usage: Injury

S81.81 Laceration without foreign body, unspecified lower leg

S81.82 Laceration with foreign body of lower leg
  S81.821 Laceration with foreign body, right lower leg
  S81.822 Laceration with foreign body, left lower leg
  S81.829 Laceration with foreign body, unspecified lower leg

S81.83 Puncture wound without foreign body of lower leg
  S81.831 Puncture wound without foreign body, right lower leg
  S81.832 Puncture wound without foreign body, left lower leg
  S81.839 Puncture wound without foreign body, unspecified lower leg

S81.84 Puncture wound with foreign body of lower leg
  S81.841 Puncture wound with foreign body, right lower leg
  S81.842 Puncture wound with foreign body, left lower leg
  S81.849 Puncture wound with foreign body, unspecified lower leg

S81.85 Open bite of lower leg
  Bite of lower leg NOS
  Excludes1: superficial bite of lower leg (S80.86-, S80.87-)
  S81.851 Open bite, right lower leg
  S81.852 Open bite, left lower leg
S82 Fracture of lower leg, including ankle

**Note:** A fracture not indicated as displaced or nondisplaced should be coded to displaced
A fracture not indicated as open or closed should be coded to closed
The open fracture designations are based on the Gustilo open fracture classification

**Includes:** fracture of malleolus

**Excludes1:** traumatic amputation of lower leg (S88.-)

**Excludes2:** fracture of foot, except ankle (S92.-)
  - periprosthetic fracture of prosthetic implant of knee (T84.042, T84.043)

The appropriate 7th character is to be added to all codes from category S82
- A - initial encounter for closed fracture
- B - initial encounter for open fracture type I or II
- initial encounter for open fracture NOS
- C - initial encounter for open fracture type IIIA, IIIB, or IIIC
- D - subsequent encounter for closed fracture with routine healing
- E - subsequent encounter for open fracture type I or II with routine healing
- F - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
- G - subsequent encounter for closed fracture with delayed healing
- H - subsequent encounter for open fracture type I or II with delayed healing
- J - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
- K - subsequent encounter for closed fracture with nonunion
- M - subsequent encounter for open fracture type I or II with nonunion
- N - subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
- P - subsequent encounter for closed fracture with malunion
- O - subsequent encounter for open fracture type I or II with malunion
Type I fractures are generally small, like cracks, and the bone pieces remain fitted together. Type II fractures are slightly displaced and involve a larger piece of bone. Type III fractures have multiple broken pieces of bone, which cannot be fitted back together for healing.

<table>
<thead>
<tr>
<th>Gustilo Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Open fracture, clean wound, wound &lt;1 cm in length</td>
</tr>
<tr>
<td>II</td>
<td>Open fracture, wound &gt; 1 cm in length without extensive soft-tissue damage, flaps, avulsions</td>
</tr>
<tr>
<td>III</td>
<td>Open fracture with extensive soft-tissue laceration, damage, or loss or an open segmental fracture. This type also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 h prior to treatment</td>
</tr>
<tr>
<td>IIIA</td>
<td>Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage</td>
</tr>
<tr>
<td>IIIB</td>
<td>Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e., free or rotational flap)</td>
</tr>
<tr>
<td>IIIC</td>
<td>Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury</td>
</tr>
</tbody>
</table>
Learning the Lingo: ICD-10-PCS

• Different methodology based on specific root operation terms
• Which ones are going to be used most?
  – Excision and Resection NOT Alteration and Creation
  – Character meanings
    • Devices
      – Intraluminal
      – Autologous
• Documentation by providers? When they say this, they mean that....
Summary

• What’s important to you?
• Create an items to watch list
• Documentation is key
• Learn the lingo, create a glossary
• Take care in selection
• What you teach and learn now may not be the same later, doesn't mean you stop teaching, just be aware
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