CHAPTER 12 GUIDELINES
L – SKIN AND SUBCUTANEOUS

LØ2-Cutaneous abscess, furuncle and carbuncle

• 4th, 5th, and 6th character identifies whether the area is an abscess, a carbuncle or a furuncle and the area of the body it is located.
• Use additional code to identify organism

Diseases of the Skin and Subcutaneous Tissues

• Includes diseases:
  – Pressure ulcers
  – Non Pressure ulcers
  – Chronic skin ulcers
  – Atypical skin ulcers
  – Cutaneous abscesses
  – Cellulitis

Pressure Ulcer Guidelines

• Pressure ulcers (L89.-)
  – Combination codes that indicate location (laterality) and staging of ulcer. They do not require a second code to describe the stage. The 6th character indicates stage.
  – ICD-10-CM classifies pressure ulcers from stages 1-4, unspecified, and unstageable.
  – Assign as many codes in L89.- category that are needed to identify all the pressure ulcers the patient has.
Pressure Ulcer Guidelines

- If a patient is admitted with a pressure ulcer at one stage, and it progresses to a higher stage, assign the code for the highest stage reported for that site.
- Also a new category of pressure ulcers of contiguous sites are included in the (L89.-) pressure ulcer category.

Pressure Ulcer Guidelines

- Assignment of stages of pressure ulcers can be based on:
  - Documentation from the provider
  - Documentation from the agency clinician.
- NPUAP and WOCN guidance:
  - Reverse staging is not allowed
  - Stage III and Stage IV ulcers never “heal”, but close, and therefore will always be coded based on interventions the agency may be performing (assessment and prevention are interventions!)

Pressure Ulcer Guidelines

- Unstageable pressure ulcers (L89.-0)
  - Ulcer whose stage can not be clinically determined due to:
    - Eschar
    - Skin or muscle graft
    - Deep tissue injury (not due to trauma)
  - Do not confuse this with unspecified stage (L89.-9)
  - When there is no specific documentation on what stage the ulcer is. THIS SHOULD NOT BE USED SINCE YOU CAN DERIVE STAGES FROM THE ASSESSMENT BY AGENCY CLINICIANS!

Pressure Ulcer Example

- Patient admitted with a stage III pressure ulcer to left heel, stage II pressure ulcer to right heel. Stage III wound is gangrenous
  - M1021: I96 Gangrenous cellulitis
  - M1023: L89.623 Pressure ulcer of left heel, stage 3
  - M1023: L89.612 Pressure ulcer of right heel, stage 2

Non-pressure Ulcer Guidelines

- Non Pressure ulcers (L97.-)
  - Based on site and laterality
  - Based on depth of wound, defined by anatomical depth including: skin only, subcutaneous tissue layer (fat layer exposed), muscle tissue layer necrosis, and bone necrosis. May be coded based on clinician documentation

L97 Non-pressure chronic ulcer of the lower limb, not elsewhere classified

- Code first any associated conditions such as:
  - Any associated gangrene
  - Atherosclerosis of the lower extremities
  - Chronic venous hypertension
  - Diabetic ulcers
  - Postphlebitic syndrome
  - Postthrombotic syndrome
  - Varicose ulcer
Non pressure ulcer limited to breakdown of the skin

Non pressure ulcer with fat layer (subcutaneous layer) exposed

Non pressure ulcer with necrosis of muscle or bone

Arterial Ulcer Example

Patient admitted with arterial skin ulcer of left calf due to atherosclerosis
• I70.242 Atherosclerosis of native arteries of left leg with ulceration of calf
• L97.221 Non pressure ulcer of left calf limited to skin

Ulcer Severity

L97.22- Non-pressure chronic ulcer of left calf
• 1Non-pressure chronic ulcer of left calf limited to breakdown of skin
• 2Non-pressure chronic ulcer of left calf with fat layer exposed
• 3Non-pressure chronic ulcer of left calf with necrosis of muscle
• 4Non-pressure chronic ulcer of left calf with necrosis of bone
• 9Non-pressure chronic ulcer of left calf with unspecified severity

Information needed

• Intake:
  — Site of wound, laterality
  — Etiology of wound, complicating factors
  — If an area is an abscess, carbuncle, furuncle, and infectious organism.
• Clinician assessment:
  — Stage of pressure ulcer
  — Depth of tissue damage for non-pressure ulcer
**M = Musculoskeletal**

**CHAPTER 13 GUIDELINES**
**M – MUSCULOSKELETAL**

**Musculoskeletal**
- Bone, joint or muscle conditions that are the result of a prior healed injury
- Chronic or recurrent bone, joint or muscle conditions
  - Any current, acute injury should be coded to the appropriate injury code from chapter 19.
- Site by the bone, joint or muscle involved, multiple sites code for some conditions

**7th Characters for Pathological Fractures**
- 7th character A is for use as long as the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, evaluation and treatment by a new physician.
- 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 treatment of problems associated with the healing, such as malunions, nonunions, and sequelae.

**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, if that fall or trauma would not usually break a normal, healthy bone.

**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.

**Osteomyelitis**
- Notable Omissions:
  - No mention of osteomyelitis in diabetes in the alpha index or the tabular list.
  - ONE code for unspecified
- Specify as acute, subacute or chronic
- Osteomyelitis of vertebra is in different location from other sites.
- Osteomyelitis
  - Use additional code to identify infectious agent
  - Use additional code to identify major osseous defect, if applicable
Osteoarthritis

- Most common DJD
- Many differences between ICD-9 and ICD-10
- Types
  - Polyosteoarthritis (generalized)
  - Osteoarthritis, coded by site
    - M16.-OA of hip
    - M17.-OA of knee
  - Primary or secondary
  - Post-traumatic
  - Unspecified OA  M19.90 – don’t use!

Other Items to Note

- Gout—M10.-
  Code chronic gout with tophi  M1A.9xx1
- Charcot’s joint, R foot M14.671
  - Check out the Excludes 1
- Joint derangements and ligament issues are due to OLD injuries or are spontaneous, i.e. without injury

Information needed

- Intake:
  - Site of disease or condition
  - Type of arthritis or osteoarthritis
  - For osteomyelitis, identify if acute or chronic, infectious organism
  - For osteoporosis, identify site, history of any pathological fracture(s)
- Clinician assessment:
  - Obtain history and query physician to verify

N17-N19-Acute kidney (renal) failure and chronic kidney disease

Acute kidney failure is the rapid loss of the kidneys' ability to remove waste and help balance fluids and electrolytes in the body. In this case, rapid means less than 2 days. Many causes, may include: decreased blood flow due to hypotension, infections that directly injure the kidney, urinary tract blockage, medications, among other reasons.

- If documentation of Acute and chronic kidney failure, code both.
- Code also associated underlying condition

N18-Chronic kidney disease

- Code first any associated:
  - Diabetic chronic kidney disease (does not presume a cause-effect relationship and must be documented)
  - Hypertensive chronic kidney disease (DOES assume a cause-effect relationship and if the patient has HTN and CKD documented, code as such)
- Use additional code to identify kidney transplant status, if applicable (Z94.Ø)
- If ESRD is documented, then use N18.6 (regardless whether receiving dialysis).
- If stage V, use N18.5 unless undergoing dialysis, then use N18.6. (use additional code to identify dialysis status-Z99.2)
N18-Chronic kidney disease
- N18.1- Stage I
- N18.2- Stage II (mild)
- N18.3- Stage III (moderate)
- N18.4- Stage IV (severe)
- N18.5- Stage V without mention of dialysis
- N18.6- ESRD or Stage V with dialysis
- N18.9- Unspecified degree of chronic kidney disease
  - Uremia NOS

Other Urinary Conditions
- N20-N23: Urolithiasis
  - N20.- Calculus of kidney, ureter, or both, and unspecified (upper tract)
  - N21.- Calculus of bladder, urethra, other lower tract or unspecified (lower)
- N3Ø.- Cystitis-has 5 characters to identify specific type of cystitis
  - Use additional code to identify infectious agent (B95-B97)

N31-Neuromuscular dysfunction of bladder, NEC
- Neurogenic bladder is a dysfunction of the nervous system or peripheral nerves involved in the control of urination.
  - Excludes 1-neurogenic bladder due to cauda equina syndrome, neuromuscular dysfunction due to spinal cord lesion
  - Use additional code to identify any associated urinary incontinence (N39.3-N39.4-)

N39.4- other specified urinary incontinence
- N39.41-Urge incontinence
- N39.42-Incontinence without sensory awareness
- N39.43- Post-void dribbling
- N39.44- Nocturnal enuresis
- N39.45- Continuous leakage
- N39.46- Mixed incontinence (urge and stress incontinence)
- N39.49Ø-Overflow incontinence
- N39.498- other specified urinary incontinence
  - Reflex incontinence
  - Total incontinence

Information needed
- Intake:
  - Any relationship between CKD and underlying DM, or other condition
  - Stage of CKD
  - History of acute renal failure
  - Specific type of incontinence
  - Location of any urinary stones
- Clinician assessment:
  - If eGFR known, query stage of CKD

Q = Quirky conditions

CHAPTER 17 GUIDELINES
Q—CONGENITAL MALFORMATIONS
Guidelines

• When a code does not describe the condition entirely, use additional codes to identify the manifestations.
• These codes may be used throughout the life of the patient.
• If it has been corrected, a personal history code should be used.

Information needed

• Intake:
  — Identify any congenital malformations, deformations and chromosomal abnormalities
  — Verify conditions are congenital and not acquired after birth
• Clinician assessment:
  — Obtain history, query physician to verify

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.
• Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the s/sx is not routinely associated with that diagnosis.
• The definitive diagnosis code should be sequenced before the symptom code.
• Remember the proximate diagnosis vs underlying condition rule?

Do not code the symptoms

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

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.
SSI Equivalent Codes

- 783.41 (R62.51) Failure to thrive
- 783.7 (R62.7) Adult failure to thrive
- 799.3 (R53.81) Debility Unspecified
- 799.89 Other ill-defined conditions
- 799.9 (R99) Other unknown and unspecified cause of morbidity or mortality
  - (ICD-10—used only for those who have already died)
- R54 Age related physical debility (old age)
  - Don’t use as terminal dx for hospice

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 is at risk for future falls. When appropriate, both codes R29.6 and Z91.81 may be assigned together.

Abnormality of Gait

- R26 Abnormalities of Gait and Mobility
  - Excludes 1
  - R26.0 Ataxic gait
  - R26.1 Paralytic gait
  - R26.2 Difficulty in walking, NEC
  - R26.8 Other abnormalities of gait and mobility
    - R26.81 Unsteadiness on feet
    - R26.89 Other abnormalities of gait and mobility
  - R26.9 unspecified abnormalities of gait and mobility

Will the definitions still stand?

- Abnormality of gait
  - Usually neuro when the definitive diagnosis is unknown or resolved
- Difficulty in walking
  - Chronic condition of the bone and joint
  - (moved from MS chapter)
- But where does that definition come from??

Information needed

- Intake:
  - If you get a symptom at referral, ask for the underlying condition that is causing the symptom(s)
- Clinician assessment:
  - Do not list symptoms that are integral to the condition on the diagnosis list

Will the definitions still stand?

- Weakness, generalized—R53.1
  - Asthenia NOS (malaise, fatigue, dizziness)
  - Excludes 1
    - age related weakness*
    - Muscle weakness M62.8- (symptom of a muscular condition)
- Muscle weakness (generalized)—M62.81
CHAPTER 19 GUIDELINES
S,T – INJURY AND POISONING

This chapter consists of:

- NO aftercare codes.
- All kinds of injuries
- Organized by body part (instead of type of injury) with the exception of burns and corrosions
  - Superficial
  - Contusions
  - Open wounds
  - Fractures

- burns and Corrosions
- Poisoning by, adverse effects of and underdosing

- Dislocations and sprains
- Traumatic hemorrhages
- Traumatic amputations
- Blast injuries
- Crushing

- Application of 7th Characters in Chapter 19

Most (but not all) categories in chapter 19 have a 7th character requirement for each applicable code.

No aftercare code for injuries
- A = Initial encounter
- D = Subsequent encounter
- S = Sequela (p.55)
Different 7th characters for fractures

- External Cause Codes

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.
Guidelines: Trauma Injury

• Traumatic injury codes (S00-T14.9) are not used for normal, healing surgical wounds or to identify complications of surgical wounds.
• Alphabetic index—Wound, open, by site, by type of injury
  – Amputation
  – Bite
  – Laceration—A jagged wound or cut
  – Puncture

Burn Guidelines

• Burns=Thermal Burns, except sunburns (see includes note for T20-T32)
• Corrosions=chemical
• First degree (erythema), second degree (blistering), and third degree (full-thickness involvement)
• Classify burns of the same local site but different degrees to the highest degree burn identified of that site
• Code the worst (highest degree) burn first

Burn Guidelines

• Burns of the eye and internal organs (T26-T28) are classified by site, but not by degree.
• Do NOT use T30! Assign separate codes for each burn site
• Non-healing burns are coded as acute burns
• Necrosis of burned skin should be coded as a non-healed burn
• If infected, add the ‘B’ code
• No aftercare codes for burns

Burn Guidelines

• 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. Use Rule of Nines
• May code a sequela of a burn and a current burn at the same time
• The external cause code should be used with burns and corrosions

Non-Healing Burn Example

Patient has an ulcer on his left lower leg where he left a heating pad and burned his leg. Because of his atherosclerosis (with claudication) the second degree burn has never healed. The focus of home care is the care of the ulcer/burn.
• T24.232D Burn of second degree left lower leg
• I70.212 Atherosclerosis of native arteries extremities w/intermittent claudication, left leg
• Y63.5 Inappropriate temp in local application (optional)

Sequela of Burn Example

Patient had a burn of right wrist last year. The burn has healed but the patient has a skin contracture at the wrist. PT/OT are ordered.
• L90.5 Scar conditions and fibrosis of skin
• T23.371S Burn of 3rd degree of R wrist, sequela

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

- When appropriate, both a code for a current burn or corrosion with 7th character “A” 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.

Example

Patient had third degree burns on back of right hand and wrist. Burn on back of hand has never healed, burn on wrist has healed but there is a skin contracture. Nursing will provide wound care to burn and OT will work on contracture.

- T23.361D Burn of 3rd degree of R dorsum of hand
- L90.5 Scar conditions and fibrosis of skin
- T23.371S Burn of 3rd degree of R wrist, sequela

Information Needed - Wounds

- Type of injury
- Location, including laterality
- Burns: degree, complications
- Any infection, causative organism
- How injury happened
  - External cause code optional but recommended
- Treatment orders

Traumatic Fracture Guideline

- Classifications of fractures:
  - Open or closed
    - Default is closed
  - Gustilo grade, if open
  - Displaced or non-displaced
    - Default is displaced
- Traumatic or pathological
  - Traumatic: bone breaks due to fall or injury
  - Pathological: bone breaks due to a disease of the bone, a tumor or infection

7th Character for Fractures

- A = Initial encounter for closed fracture
- B = Initial encounter for open fracture
- D = Subsequent encounter for fracture with routine healing
- G = Subsequent encounter for fracture with delayed healing
- K = Subsequent encounter for fracture with nonunion
- P = Subsequent encounter for fracture with malunion
- S = Sequela

7th Character Open Fractures

Look at 7th character for S72

- Type I
- Type II
- Type IIIA
- Type IIIB
- Type IIIC
Gustilo Grades for Fractures

<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</td>
</tr>
<tr>
<td>III</td>
<td>Open fracture with extensive soft-tissue laceration/damage/loss or avulsions</td>
</tr>
<tr>
<td>IIIA</td>
<td>Type III fracture with adequate periosteal coverage of the fracture bone</td>
</tr>
<tr>
<td>IIIB</td>
<td>Type III fracture with extensive soft-tissue loss and periosteal stripping</td>
</tr>
<tr>
<td>IIIC</td>
<td>Type III fracture associated with an arterial injury requiring repair</td>
</tr>
</tbody>
</table>

Traumatic Hip Fracture Example

Patient admitted for aftercare of traumatic right hip (neck of femur) fracture after falling out of wheelchair

- S72.001D Subsequent encounter for closed fracture of unspecified part of neck of right femur with routine healing
- W05.0xxD Fall from wheelchair (optional)

Trauma vs Fragility Fracture

- A code from M80, not a trauma 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 if that fall or trauma would not usually break a normal, healthy bone.

Fracture Example

65 year old male fell down 7 stairs at home twisting his right leg, which resulted in fractures at the proximal and distal ends of the right tibia (medial malleolus). He has a non-wt bearing cast on the right leg. The doctor expects to increase to wt bearing within 10 days. He has a history of type II diabetes (insulin dependent) with neuropathy and has had 4 toes (all except great toe) previously amputated on his left foot as a result. He is receiving home health physical therapy for gait training.

Fracture Answer

<table>
<thead>
<tr>
<th>M102/22</th>
<th>Description</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1021</td>
<td>Tibia upper end unspecified closed</td>
<td>S82.101D</td>
</tr>
<tr>
<td>M1023</td>
<td>Tibia medial malleolus closed</td>
<td>S82.51XD</td>
</tr>
<tr>
<td>M1023</td>
<td>Fall down steps, stairs</td>
<td>W10.8xxD</td>
</tr>
<tr>
<td>M1023</td>
<td>Diabetes type 2 with unspecified neuropathy</td>
<td>E11.40</td>
</tr>
<tr>
<td>M1023</td>
<td>Amputation status toes, left</td>
<td>Z89.422</td>
</tr>
<tr>
<td>M1023</td>
<td>Long term use of insulin</td>
<td>Z79.4</td>
</tr>
</tbody>
</table>

M1011/M1017

- M1011
  - Fx Tibia unspecified upper end closed S82.101A
  - Fx Tibia medial malleolus closed S82.51XA

- M1017
  - Fx Tibia unspecified upper end closed S82.101A
  - Fx Tibia medial malleolus closed S82.51XA
**Fracture of Hip Example**

Patient fell off the bed when his foot got caught in the covers and he has a fracture of the right greater trochanter.

- S72.111D Fracture of greater trochanter of right femur, subsequent encounter for closed fracture with routine healing
- W06.xxxD Fall from bed, subsequent encounter (optional)

---

**Fracture of the Hip, Sequela**

The patient with the broken hip refused a joint replacement. His fracture has healed but his right leg is significantly shorter than his left.

- M21.751 Unequal limb length (acquired), right femur
- S72.111S Fracture of greater trochanter of right femur, sequela
- W06.xxxS Fall from bed, sequela

---

**Amputations**

**‘Planned’**

- Patient’s right great toe is amputated because of a diabetic ulcer that won’t heal. He also has diabetic PVD.
- Z47.81 Aftercare following amputation
- E11.51 Diabetes with peripheral angiopathy
- Z89.411 Acquired absence of right great toe

**Traumatic**

- Patient’s right great toe was cut off when mowing the lawn (powered lawnmower).
- S98.111D Traumatic amputation of right great toe
- W28.xxxD Contact with powered lawn mower
- (Status code for absence is not used because the traumatic amputation code provides the information)

---

**Guideline: Surgical Complications**

- 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.
- 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.

---

**Amputation Complications**

- Surgical complications are coded to category T81.- complications of procedures NEC
- Amputation complications are NOT appropriately coded with T81 codes
  - Alphabetical index: Complication, amputation stump, by type of complication (infection, dehiscence, necrosis, etc.)
  - Amputation complications are coded to T87.-

---

**Amputation and Surgical Complications**

- Infected R BKA (surgical): T87.43
- Dehiscence of amputation stump T87.81
- Previous Toe amputation-Non healing with eschar T87.54
- Infected and Dehisced (external) Surgical Wound T81.31xD, T81.4xxD
- Dehiscence (internal) post CABG T81.32xD
- Non-healing surgical wound - ???
Mechanical Complication

- The patient has a muscle flap on a stage IV pressure ulcer. The flap is not healing and is breaking down.
- Complication, graft, muscle, breakdown
- T84.410D

Complication

The patient’s peritoneal dialysis catheter is infected with MRSA and has been abandoned. Home health is ordered to change dressings to the infected site. The patient has a new AV fistula and a central line (triple lumen). Home health will teach the patient/caregiver how to administer IV antibiotics through new central line.
- Infection, due to...device, catheter, dialysis, intraperitoneal
- MRSA, infection, as the cause of diseases classified elsewhere
- Admission, adjustment, device, specified NEC, vascular access
- T85.71xD infection and inflammatory reaction due to peritoneal dialysis catheter
- B95.62 MRSA
- Z45.2 Encounter for adjustment and management of vascular access device

Complication of Transplant

- The patient has a rejection of his bone marrow transplant due to graft-versus-host disease.
- Complication, transplant, bone marrow
- T86.01 Bone marrow transplant rejection
- D89.813 Graft-versus-host disease, unspecified

Complication of Joint Prosthesis

The patient's new right hip prosthesis is infected with Staph aureus.
- Complication, joint prosthesis, infection, hip
- T84.51xD Infection and inflammatory reaction due to internal right hip prosthesis
- B95.61 Staph aureus

Complication of Internal Fixation Device

Patient suffered a comminuted fracture of the right humerus at mid shaft in a 4-wheeler accident when riding with her grandson. She had an ORIF and the fixation device has come loose resulting in a nonunion of the fracture.
- Should you code the nonunion or the complication first?
  - Instructional note: Use additional code to identify the specified condition resulting from the complication.
- T84.120D Displacement of internal fixation device of right humerus
- S42.351K Displaced comminuted fracture of shaft of humerus, right arm, nonunion
- V86.69xD Passenger of other special all-terrain or other off road motor vehicle injured in nontraffic accident

Complication of Internal Fixation Device

- T84.51xD Infection and inflammatory reaction due to internal right hip prosthesis
- B95.61 Staph aureus
Intracranial Injury

- Difference between a traumatic intracranial bleed and a CVA type bleed
  - External vs internal
- Coding the acute injury OR the sequela of an injury?
  - What is the focus of your Plan of Care?
  - Seizures, coma and not woken up?
  - Stable?
  - Residual neurological deficits?

Example

Patient fell out of bed and received a subdural hemorrhage. The doctor documented that the wife states that the patient was out for less than 5 minutes. He was admitted for observation and now comes home for further observation.

- Injury, intracranial

- S06.5x1D Traumatic subdural hemorrhage with loss of consciousness of 30 minutes or less
- W06.xxxD Fall out of bed

Example

Patient fell off the steps at the WWII Memorial when he was visiting. He sustained a subdural hemorrhage and was comatose for 28 days. He has left dominant spastic hemiplegia and speech problems and is coming home after 2 months in rehab.

- G81.12 spastic hemiplegia affecting left dominant side
- Dysphasia
- S06.5x5S traumatic subdural hemorrhage with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela
- W10.8xxS Fall from steps

Information Needed – Fractures and Complications

- Fractures
  - Bone affected, laterality
  - Traumatic or pathological etiology
  - Open/closed, displaced/non-displaced
    - Gustillo Grade if open
  - Any complications of healing
- Complications
  - Requires physician documentation

Poisoning Differences

ICD-9-CM
- Poisoning requires 3 codes
- Therapeutic use
- No underdosing
- Use of external cause codes (E codes)

ICD-10-CM
- Poisoning requires 2 codes
- Adverse Effect
- Underdosing a new concept
- No use of external cause codes (V,W,X,Y)
Table of Drugs and Chemicals

• Combination codes—no need for external cause code
• Look up by name of drug or chemical
• Determine circumstances or intent
  — Poisoning, accidental (default)
  — Poisoning intentional self-harm
  — Poisoning assault
  — Poisoning undetermined
  — Adverse effect (therapeutic use in ICD-9)
  — Underdosing
• Add appropriate 7th character
  — A - Initial encounter
  — D - Subsequent encounter
  — S - Sequela

Poisoning

• Guideline: When coding a poisoning or improper use of a medication first assign the appropriate code from categories T36-T50. Use additional code(s) for manifestations of poisonings.
  • T—code for poisoning, accidental (unless the physician has documented something specific)
  • E—Effect(s) of the poisoning

Adverse Effect

• Guideline: 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-T50 with a 5th or 6th character of 5).
  • E—Effect
  • T—T code for adverse effect of drug

Underdosing

• Guideline: 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.
  • C—Condition
  • T—T code for underdosing of the drug
  • Z—Z code for underdosing reason

Underdosing Example

Patient with diagnosis of Hypertension continued to experience elevated blood pressure while taking blood pressure meds. Upon patient interview, it was found the patient was taking medication once daily instead of twice daily because of the cost of the drug.
Underdosing Answer

- I1Ø Essential (primary) hypertension
- T46.5x6D Underdosing of other antihypertensive drugs, subsequent encounter
- Z91.12Ø Patient's intentional underdosing of medication regimen due to financial hardship

Poisoning Example

Patient has taken his Lasix 40mg every morning and night. The prescription bottle reads 40mg daily. Patient is dehydrated and hypokalemic.

T-- T5Ø.1x1D poisoning by diuretics
E-- E86.Ø dehydration
E87.6 hypokalemia

Adverse Effect Example

Patient has been taking the prescribed amount of Lanoxin, however his pulse rate is now 42 and he is toxic according to lab values. SN for observation and assessment, teaching and venipuncture for monitoring levels.

- R00.1 Bradycardia
- T46.Øx5D cardiotonic glycosides
- Z51.81 Encounter for monitoring
- Z79.899 Long term (current) use of other high risk medication

General Guidelines

- These codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed
- Doesn’t apply for Home Health or Hospice.

Z = codes of last resort, last chapter

CHAPTER 21 GUIDELINES
Z –FACTORS INFLUENCING...

General Guidelines

- These codes are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories AØØ-Y89 are recorded as “diagnoses” or “problems”. They can arise in 2 ways:
  - Patient not sick but requires health services for a specific purpose
  - When problem is present which influences the person’s health status, but is not a current illness/injury
Guidelines

• May be first listed or secondary depending on circumstances.
  – Hospice cannot use a Z-code as principal diagnosis
• Status—either a carrier or has the sequelae or residual of a past disease or condition
  – Informative—may affect the course of treatment/outcome
  – Should not be used if diagnosis code includes the info (status transplant with transplant complication)

Guidelines

• History—past medical condition that no longer exists and is not receiving any treatment, but that has a potential for recurrence and therefore may require continued monitoring.
  – Watch out for personal vs family history
  – History may alter treatment/outcome.

Guidelines

• Aftercare—initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for long term consequences of disease.
• Aftercare code should not be used if treatment is directed at a current, acute disease.
• Not to be used for injuries.

Guidelines

• Aftercare codes should be used in conjunction with other aftercare codes (read Z codes) or diagnosis codes to provide better detail on the specifics of an aftercare encounter visit... The sequencing of multiple aftercare codes depends on the circumstances of the encounter.

Attention to.....

• Attention Z Codes explain a patient’s medical condition that currently exists, is receiving treatment, and is affecting the plan of care
• Feeding/Cleansing/Teaching
• Must be doing something to or about the condition or sequelae

How to Find Z Codes

Look for:

  – Absence
  – Admission
  – Aftercare
  – Attention
  – Examination
  – Exposure
  – History
  – Observation
  – Presence
  – Problem
  – Resistance
  – Status
Aftercare

- No aftercare codes for care following an injury or fracture
- Certain aftercare (Z) code categories need a secondary diagnosis code to describe the resolving condition or sequelae
  - Z48.3-Aftercare following surgery for the neoplasm
    - Use additional code to identify the neoplasm
- For other Z codes, the condition is included in the code title.
  - Z43.3-Encounter for attention to colostomy

Orthopedic aftercare

- Z47.1- Aftercare following joint replacement surgery
- Z47.3- Aftercare following explantation of joint prosthesis
  - 5th character designates location
- Z47.81- Encounter for orthopedic aftercare following surgical amputation
  - Use additional code to identify the limb amputated (Z89.-)

Orthopedic Example

- Patient admitted for surgical aftercare for a right shoulder joint prosthesis insertion following an explantation of a prosthesis due to mechanical failure.
  - Z47.31 Aftercare following explantation of shoulder joint prosthesis
  - Z96.612-Presence of left artificial shoulder joint

Status Codes

- 3 main terms in alphabetical index
  - Status
  - Absence
  - Presence
- Z95.810-presence of automatic implantable cardiac defibrillator
  - Not listed under status; but listed under ‘presence’

Status Codes

- Non compliance codes greatly expanded
  - Z91.11- Patient’s noncompliance with dietary regimen
  - Z91.12-Patient’s intentional underdosing of medication regimen
  - Z91.12Ø-Patient’s unintentional underdosing of medication regimen due to financial hardship.
Z43-Encounter for attention to artificial openings

• Includes:
  – Closure of artificial openings
  – Passage of sounds or bougies through artificial openings
  – Reforming artificial openings
  – Removal of catheter form artificial openings
  – Toilet or cleansing of artificial openings.

Z43 vs. Z93

• Z93 codes are for artificial opening status
• Is the patient receiving treatment or attention to the ostomy site? If so, use a Z43 code instead of Z93
  – Excludes 1 under each category to exclude the other category

More Common Z codes

• Z45.2-Encounter for adjustment and management of vascular access device
• Z46.6 Encounter for fitting and adjustment of urinary device
• Z46.82- Encounter for fitting and adjustment of non-vascular catheter
• Z91.83: Wandering in diseases classified elsewhere
• Z66 – Do not resuscitate

Z74.- Problems related to care provider dependency

• Z74.Ø1- Bed confinement status
• Z74.Ø9- Other reduced mobility
  – Chair ridden

Z79.- Long term (current) drug therapy

• To indicate any long term current use that affects the plan of care
• Length of time for “long term” is up to the clinical judgment

What questions do you have?

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• Selman-Holman & Associates, LLC
  • Home Health Insight
• CoDR—Coding Done Right—home health and hospice outsource for coding and coding audits
• CodeProUniversity—role based comprehensive online ICD-10-CM training for home health and hospice