ICD-10-CM Official Guidelines for Coding and Reporting
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Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the April 2026, FY 2026 version
***Italics* are used to indicate revisions to heading changes**

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. 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. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. 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.

The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

The guidelines are organized into sections. Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II includes guidelines for selection of principal diagnosis for non-outpatient settings. Section III includes guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is for outpatient coding and reporting. It is necessary to review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly.

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Section I. Conventions, general coding guidelines and chapter specific guidelines

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 instructional notes.

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: the 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. **Neoplasms***
See Section I.C.19. Adverse effects, poisoning, underdosing 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 categories 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 subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.

The ICD-10-CM uses an indented format for ease in reference.

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 underdosing codes, categories T36-T50. Where 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 6 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

[ ] 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.

( ) 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. The 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 Enteritis, "acute" is a nonessential modifier and "chronic" is a subentry. In this case, the nonessential modifier "acute" does not apply to the subentry "chronic".

: 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 assignable to a given category.

, Commas are used in the Alphabetic Index and have different meanings based on the context of the Index entry, including alternate verbiage, modifier (essential and nonessential), or alternative for "and/or."

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 designate "other" codes 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 that 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 each other are independent of each other.

a. Excludes1

A type 1 Excludes 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 (G47.63)," 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 so it would be appropriate to report F45.8 and G47.63 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. 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.

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 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 with Parkinson’s disease. In the Alphabetic Index, a code from category G20 is listed first, followed by code F02.80 or F02.81- in brackets. A code from category G20- represents the

underlying etiology, Parkinson's disease, and must be sequenced first, whereas codes F02.80 and F02.81- 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 I.B.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 A18.0, Tuberculosis of bones and joints.

15. "With"

The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index (either under a main term or subterm), 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 or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis").
For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, 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 or subterm, 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. The sequencing depends on the circumstances of the encounter.

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. If there is conflicting medical record documentation, query the provider.

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 and to the highest level of specificity documented in the medical record.

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 A00.0 through T88.9, Z00-Z99.8, U00-U85

The appropriate code or codes from A00.0 through T88.9, Z00-Z99.8, and U00-U85 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 R00.0 - R99) contains many, but not all, codes for symptoms.

See Section I.B.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. “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**,** if known.

For example, for bacterial infections that are not included in chapter 1, a secondary code from category B95, Streptococcus, Staphylococcus, and Enterococcus, as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, 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 manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first, if known.

“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 sequela, complication codes and obstetric 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 subterm entries 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 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 residual may be apparent early, such as in cerebral infarction, 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 sequela 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 levels) 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 entries for “Impending” and for “Threatened.”

If the subterms are listed, assign the given code.

If the subterms 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 is 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.

When laterality is not documented by the patient’s provider, code assignment for the affected side may be based on medical record documentation from other clinicians. If there is conflicting medical record documentation regarding the affected side, the patient’s provider should be queried for clarification. Codes for “unspecified” side should rarely be used, such as when the documentation in the record is insufficient to determine the affected side and it is not possible to obtain clarification.

14. Documentation by Clinicians Other than the Patient's Provider

Code assignment is based on the documentation by the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis). There are a few exceptions when 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). In this context, “clinicians” other than the patient’s provider refer to healthcare professionals permitted, based on regulatory or accreditation

requirements or internal hospital policies, to document in a patient's official medical record.

These exceptions include codes for:

- Body Mass Index (BMI)
- Depth of non-pressure chronic ulcers
- Pressure ulcer stage
- Coma scale
- NIH stroke scale (NIHSS)
- Social determinants of health (SDOH) classified to Chapter 21
- Laterality
- Blood alcohol level
- Underimmunization status
- Firearm injury intent

This information is typically**,** or may be, 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 stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke, pressure ulcer, or a condition classifiable to category F10, Alcohol related disorders) 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 provider should be queried for clarification.

The BMI, coma scale, NIHSS, blood alcohol level codes, codes for social determinants of health and underimmunization status should only be reported as secondary diagnoses.

See Section I.C.21.c.17. for additional information regarding coding social determinants of health.

15. 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.

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 the documentation must support that the condition is clinically significant. It is not necessary for the provider to explicitly document the term "complication." For example, if the condition alters the course of the surgery as documented in the operative report, then it would be appropriate to report a complication code. Query the provider for

clarification if the documentation is not clear as to the relationship between the condition and the care or procedure.

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 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.

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.

As stated in the introductory section of these official coding guidelines, 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. 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.

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 isn’t 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.

19. Coding for Healthcare Encounters in Hurricane Aftermath

a. Use of External Cause of Morbidity Codes

An external cause of morbidity code should be assigned to identify the cause of the injury(ies) incurred as a result of the hurricane. The use of external cause of morbidity codes is supplemental to the application of ICD-10-CM codes. External cause of morbidity codes are never to be recorded as a principal diagnosis (first-listed in non-inpatient settings). The appropriate injury code should be sequenced before any external cause codes. The external cause of morbidity codes capture how

the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event, and the person's status (e.g., civilian, military). They should not be assigned for encounters to treat hurricane victims' medical conditions when no injury, adverse effect or poisoning is involved. External cause of morbidity codes should be assigned for each encounter for care and treatment of the injury. External cause of morbidity codes may be assigned in all health care settings. For the purpose of capturing complete and accurate ICD-10-CM data in the aftermath of the hurricane, a healthcare setting should be considered as any location where medical care is provided by licensed healthcare professionals.

b. Sequencing of External Causes of Morbidity Codes

Codes for cataclysmic events, such as a hurricane, take priority over all other external cause codes except child and adult abuse and terrorism and should be sequenced before other external cause of injury codes. Assign as many external cause of morbidity codes as necessary to fully explain each cause. For example, if an injury occurs as a result of a building collapse during the hurricane, external cause codes for both the hurricane and the building collapse should be assigned, with the external causes code for hurricane being sequenced as the first external cause code. For injuries incurred as a direct result of the hurricane, assign the appropriate code(s) for the injuries, followed by the code X37.0-, Hurricane (with the appropriate 7th character), and any other applicable external cause of injury codes. Code X37.0- also should be assigned when an injury is incurred as a result of flooding caused by a levee breaking related to the hurricane. Code X38.-, Flood (with the appropriate 7th character), should be assigned when an injury is from flooding resulting directly from the storm. Code X36.0.-, Collapse of dam or man-made structure, should not be assigned when the cause of the collapse is due to the hurricane. Use of code X36.0- is limited to collapses of man-made structures due to earth surface movements, not due to storm surges directly from a hurricane.

c. Other External Causes of Morbidity Code Issues

For injuries that are not a direct result of the hurricane, such as an evacuee that has incurred an injury as a result of a motor vehicle accident, assign the appropriate external cause of morbidity code(s) to describe the cause of the injury, but do not assign code X37.0-, Hurricane. If it is not clear whether the injury was a direct result of the hurricane, assume the injury is due to the hurricane and assign code X37.0-, Hurricane, as well as any other applicable external cause of morbidity codes. In addition to code X37.0-, Hurricane, other possible applicable external cause of morbidity codes include:

X30-, Exposure to excessive natural heat
X31-, Exposure to excessive natural cold
X38-, Flood

d. Use of Z codes

Z codes (other reasons for healthcare encounters) may be assigned as appropriate to further explain the reasons for presenting for healthcare services, including transfers

between healthcare facilities, or provide additional information relevant to a patient encounter. The ICD-10-CM Official Guidelines for Coding and Reporting identify which codes maybe assigned as principal or first-listed diagnosis only, secondary diagnosis only, or principal/first-listed or secondary (depending on the circumstances). Possible applicable Z codes include:

Z59.0-, Homelessness
Z59.1, Inadequate housing
Z59.5, Extreme poverty
Z75.1, Person awaiting admission to adequate facility elsewhere
Z75.3, Unavailability and inaccessibility of health-care facilities
Z75.4, Unavailability and inaccessibility of other helping agencies
Z76.2, Encounter for health supervision and care of other healthy infant and child
Z99.12, Encounter for respirator [ventilator] dependence during power failure

The external cause of morbidity codes and the Z codes listed above are not an all-inclusive list. Other codes may be applicable to the encounter based upon the documentation. Assign as many codes as necessary to fully explain each healthcare encounter. Since patient history information may be very limited, use any available documentation to assign the appropriate external cause of morbidity and Z codes.

20. Multiple Sites Coding

The classification defines "multiple" as involving two or more sites. Follow chapter-specific guidelines for assigning codes for "multiple sites." In the absence of chapter-specific guidelines, assign codes describing specified sites individually when documented. When the specified site(s) are not documented, assign the appropriate code for "multiple sites."

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), U07.1, U09.9

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 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.

2) Selection and sequencing of HIV codes

(a) **HIV disease**

If the term "AIDS" or "HIV disease" is documented or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from the patient's HIV positive status; code B20, Human immunodeficiency virus [HIV] disease, should be assigned.

(b) **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.

An exception to this guideline is if the reason for admission is hemolytic-uremic syndrome associated with HIV disease. Assign code D59.31, Infection-associated hemolytic-uremic syndrome, followed by code B20, Human immunodeficiency virus [HIV] disease.

(c) **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. Code B20 would be reported as a secondary diagnosis. Codes for other documented conditions should also be reported as secondary diagnoses.

(d) **Patient newly diagnosed with HIV disease**

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

(e) **Asymptomatic human immunodeficiency virus**

When "HIV positive," "HIV test positive," or similar terminology is documented, and there is no documentation of symptoms or HIV-related illness, code Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, should be assigned.

(f) **Inconclusive HIV serology**

Patients with documentation of inconclusive HIV serology, may be assigned code R75, Inconclusive laboratory evidence of human immunodeficiency virus [HIV].

(g) **Previously diagnosed HIV-related illness**

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

(h) **HIV Infection in Pregnancy, Childbirth and the Puerperium**

When a patient presents during pregnancy, childbirth or the puerperium with documented symptomatic HIV disease or an HIV related illness, assign a code from subcategory O98.7, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by code B20 and additional code(s) for any HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

When a patient presents during pregnancy, childbirth or the puerperium with documented asymptomatic HIV infection status or is HIV-positive, assign a code from subcategory O98.7 followed by code Z21.

(i) **Encounters for HIV testing**

If a patient without signs or symptoms is tested for HIV, assign code Z11.4, Encounter for screening for human immunodeficiency virus [HIV]. Use additional codes for any associated high-risk behavior**,** if applicable.

If a patient with signs or symptoms of HIV presents for HIV testing, code the signs and symptoms. An additional counseling code Z71.7, Human immunodeficiency virus [HIV] counseling, may be assigned if counseling is provided during the encounter for the test. Code Z11.4, Encounter for screening for human immunodeficiency virus [HIV], should not be assigned if HIV signs or symptoms are present.

When a patient presents for follow up regarding their HIV test results and the test result is negative, assign code Z71.7, Human immunodeficiency virus [HIV] counseling.

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

(j) **HIV disease or HIV positive status managed by antiretroviral medication**

If a patient with documented HIV disease, HIV-related illness or AIDS is currently managed on antiretroviral medications, assign code B20, Human immunodeficiency virus [HIV] disease.

If a patient with documented HIV positive status is currently managed on antiretroviral medication, assign code Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, in the absence of any additional documentation of HIV disease, HIV-related illness or AIDS.

Code Z79.899, Other long term (current) drug therapy, may be assigned as an additional code to identify the long-term (current) use of antiretroviral medications.

(k) **Encounter for HIV Prophylaxis Measures**

When a patient presents for administration of pre-exposure prophylaxis medication for HIV, assign code Z29.81, Encounter for HIV pre-exposure prophylaxis. Pre-exposure prophylaxis (PrEP) is intended to prevent infection in people who are at risk for getting HIV through sex or injection drug use. Any risk factors for HIV should also be coded.

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, Streptococcus, Staphylococcus, and Enterococcus 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 Z16, Resistance to antimicrobial drugs, following the infection code only if the infection code does not identify drug resistance.

d. Sepsis, Severe Sepsis, and Septic Shock

1) Coding of Sepsis and Severe Sepsis

(a) **Sepsis**

For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further 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.

(iv) 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 a code for 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

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.

For infection-associated hemolytic-uremic syndrome with severe sepsis, see guideline I.C.1.d.9.

4) Sepsis or severe sepsis with a localized infection

If the reason for admission is 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.

For hemolytic-uremic syndrome associated with sepsis, see guideline I.C.1.d.9.

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 sepsis following a postprocedural wound (surgical site) infection, a code from T81.41 to T81.43, Infection following a procedure, T81.49, Infection following a procedure, other surgical site, or a code from O86.00 to O86.03, Infection of obstetric surgical wound, or code O86.09, Infection of obstetric surgical wound, other surgical site, that identifies the site of the infection should be sequenced first, if known. Assign an additional code for sepsis following a procedure (T81.44) or sepsis following an obstetrical procedure (O86.04). Use an additional code to identify the infectious agent. 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.

For infections following infusion, transfusion, therapeutic injection, or immunization, a code from subcategory T80.2, Infections following infusion, transfusion, and therapeutic injection, or code T88.0-, Infection following immunization, 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 codes(s) for any acute organ dysfunction.

(c) **Postprocedural infection and postprocedural septic shock**

If a postprocedural infection has resulted in postprocedural septic shock, assign the codes indicated above for sepsis due to a postprocedural infection, followed by code T81.12-, Postprocedural septic shock. Do not assign code R65.21, Severe sepsis with septic shock. Additional code(s) should be assigned for any acute organ dysfunction.

6) Sepsis and severe sepsis associated with a noninfectious process (condition)

In some cases, a noninfectious process (condition) such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a noninfectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the noninfectious condition 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) codes. It is not necessary to assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin, for these cases.

If the infection meets the definition of principal diagnosis, it should be sequenced before the non-infectious condition. 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 I.C.18. SIRS due to non-infectious process

7) Sepsis and septic shock complicating abortion, pregnancy, childbirth, and the puerperium

See Section I.C.15. Sepsis and septic shock complicating abortion, pregnancy, childbirth and the puerperium

8) Newborn sepsis

See Section I.C.16. f. Bacterial sepsis of Newborn

9) Hemolytic-uremic syndrome associated with sepsis

If the reason for admission is hemolytic-uremic syndrome that is associated with sepsis, assign code D59.31, Infection-associated hemolytic-uremic syndrome, as the principal diagnosis. Codes for the underlying systemic infection and any other conditions (such as severe sepsis) should be assigned as secondary diagnoses**.**

e. Methicillin Resistant Staphylococcus aureus (MRSA) Conditions

1) Selection and sequencing of MRSA codes

(a) Combination codes for MRSA infection

When a patient is diagnosed with an infection that is due to methicillin resistant *Staphylococcus aureus* (MRSA), and that infection has a combination code that includes the causal organism (e.g., sepsis, pneumonia) assign the appropriate combination code for the condition (e.g., code A41.02, Sepsis due to Methicillin resistant Staphylococcus aureus or code J15.212, Pneumonia due to Methicillin resistant Staphylococcus aureus). Do not assign code B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere, as an additional code, because the combination code includes the type of infection and the MRSA organism. Do not assign a code from subcategory Z16.11, Resistance to penicillins, as an additional diagnosis.

See Section C.1. for instructions on coding and sequencing of sepsis and severe sepsis.

(b) Other codes for MRSA infection

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. Do not assign a code from subcategory Z16.11, Resistance to penicillins.

(c) Methicillin susceptible Staphylococcus aureus (MSSA) and MRSA colonization

The condition or state of being colonized or carrying MSSA or MRSA is called colonization or carriage, while an individual person is described as being colonized or being a carrier.

Colonization means that MSSA or MSRA is present on or in the body without necessarily causing illness. A positive MRSA colonization test might be documented by the provider as "MRSA screen positive" or "MRSA nasal swab positive".

Assign code Z22.322, Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus, for patients documented as having MRSA colonization. Assign code Z22.321, Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus, for patients documented as having MSSA colonization. Colonization is not necessarily indicative of a disease process or

as the cause of a specific condition the patient may have unless documented as such by the provider.

(d) **MRSA colonization and infection**

If a patient is documented as having both MRSA colonization and infection during a hospital admission, code Z22.322, Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus, and a code for the MRSA infection may both be assigned.

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 II, H. In this context, “confirmation” does not require documentation of the type of test performed; the provider’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", "possible" 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 Z20.821, Contact with and (suspected) exposure to Zika virus.

g. Coronavirus infections

1) COVID-19 infection (infection due to SARS-CoV-2)

(a) **Code only confirmed cases**

Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider. For a confirmed diagnosis, assign code U07.1, COVID-19. This is an exception to the hospital inpatient guideline Section II, H. In this context, “confirmation” does not require documentation of a positive test result for COVID-19; the provider’s documentation that the individual has COVID-19 is sufficient.

If the provider documents "suspected," "possible," "probable," or “inconclusive” COVID-19, do not assign code U07.1. Instead, code the signs and symptoms reported. See guideline I.C.1.g.1.g.

(b) **Sequencing of codes**

When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except when another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications.

For a COVID-19 infection that progresses to sepsis, see Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock

See Section I.C.15.s. for COVID-19 infection in pregnancy, childbirth, and the puerperium

See Section I.C.16.h. for COVID-19 infection in newborn

For a COVID-19 infection in a lung transplant patient, see Section I.C.19.g.3.a. Transplant complications other than kidney.

(c) **Acute respiratory manifestations of COVID-19**

When the reason for the encounter/admission is a respiratory manifestation of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the respiratory manifestation(s) as additional diagnoses.

The following conditions are examples of common respiratory manifestations of COVID-19.

(i) Pneumonia

For a patient with pneumonia confirmed as due to COVID-19, assign codes U07.1, COVID-19, and J12.82, Pneumonia due to coronavirus disease 2019.

(ii) Acute bronchitis

For a patient with acute bronchitis confirmed as due to COVID-19, assign codes U07.1, and J20.8, Acute bronchitis due to other specified organisms.

Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using code U07.1 and J40, Bronchitis, not specified as acute or chronic.

(iii)Lower respiratory infection

If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22, Unspecified acute lower respiratory infection, should be assigned.

If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J98.8, Other specified respiratory disorders, should be assigned.

(iv) Acute respiratory distress syndrome

For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, Acute respiratory distress syndrome.

(v) Acute respiratory failure

For acute respiratory failure due to COVID-19, assign code U07.1, and code J96.0-, Acute respiratory failure.

(d) **Non-respiratory manifestations of COVID-19**

When the reason for the encounter/admission is a non-respiratory manifestation (e.g., viral enteritis) of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the manifestation(s) as additional diagnoses.

(e) **Exposure to COVID-19**

For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.822, Contact with and (suspected) exposure to COVID-19.

For symptomatic individuals with actual or suspected exposure to COVID-19 and the infection has been ruled out, or test results are inconclusive or unknown, assign code Z20.822, Contact with and (suspected) exposure to COVID-19. See guideline I.C.21.c.1, Contact/Exposure, for additional guidance regarding the use of category Z20 codes.

If COVID-19 is confirmed, see guideline I.C.1.g.1.a.

(f) **Screening for COVID-19**

For screening for COVID-19, including preoperative testing, assign code Z11.52, Encounter for screening for COVID-19.

(g) **Signs and symptoms without definitive diagnosis of COVID-19**

For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:

- R05.1, Acute cough, or R05.9, Cough, unspecified
- R06.02**,** Shortness of breath
- R50.9, Fever, unspecified

If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to COVID-19, assign Z20.822, Contact with and (suspected) exposure to COVID-19, as an additional code.

(h) **Asymptomatic individuals who test positive for COVID-19**

For asymptomatic individuals who test positive for COVID-19 and there is no provider documentation of a diagnosis of COVID-19, query the provider as to whether or not the individual has COVID-19. A false positive laboratory test is possible, and it is the provider's responsibility to confirm the diagnosis and document accordingly.

(i) **Personal history of COVID-19**

For patients with a history of COVID-19, assign code Z86.16, Personal history of COVID-19.

(j) **Follow-up visits after COVID-19 infection has resolved**

For individuals who previously had COVID-19, without residual symptom(s) or condition(s), and are being seen for follow-up evaluation, and COVID-19 test results are negative, assign codes Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, and Z86.16, Personal history of COVID-19.

For follow-up visits for individuals with symptom(s) or condition(s) related to a previous COVID-19 infection, see guideline I.C.1.g.1.m.

See Section I.C.21.c.8, Factors influencing health states and contact with health services, Follow-up

(k) **Encounter for antibody testing**

For an encounter for antibody testing that is not being performed to confirm a current COVID-19 infection, nor is a follow-up test after resolution of COVID-19, assign Z01.84, Encounter for antibody response examination.

Follow the applicable guidelines above if the individual is being tested to confirm a current COVID-19 infection.

For follow-up testing after a COVID-19 infection, see guideline I.C.1.g.1.j.

(l) **Multisystem Inflammatory Syndrome**

For individuals with multisystem inflammatory syndrome (MIS) and COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code M35.81, Multisystem inflammatory syndrome, as an additional diagnosis.

If an individual with a history of COVID-19 develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and U09.9, Post COVID-19 condition, unspecified.

If an individual with a known or suspected exposure to COVID-19, and no current COVID-19 infection or history of COVID-19, develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and Z20.822, Contact with and (suspected) exposure to COVID-19.

Additional codes should be assigned for any associated complications of MIS.

(m) **Post COVID-19 Condition**

For sequela of COVID-19, or associated symptoms or conditions that develop following a previous COVID-19 infection, assign a code(s) for the specific symptom(s) or condition(s) related to the previous COVID-19 infection, if known, and code U09.9, Post COVID-19 condition, unspecified.

Code U09.9 should not be assigned for manifestations of an active (current) COVID-19 infection.

If a patient has a condition(s) associated with a previous COVID-19 infection and develops a new active (current) COVID-19 infection, code U09.9 may be assigned in conjunction with code U07.1, COVID-19, to identify that the patient also has a condition(s) associated with a previous COVID-19 infection. Code(s) for the specific condition(s) associated with the previous COVID-19 infection and code(s) for manifestation(s) of the new active (current) COVID-19 infection should also be assigned.

(n) **Underimmunization for COVID-19 Status**

Code Z28.310, Unvaccinated for COVID-19, may be assigned when the patient has not received a COVID-19 vaccine of any type. Code Z28.311, Partially vaccinated for COVID-19, may be assigned when the patient has been partially vaccinated for COVID-19 as per the recommendations of the Centers for Disease Control and Prevention (CDC) in place at the time of the encounter. For information, visit the CDC's website **https://www.cdc.gov/covidschedule**.

See Section I.B.14. for underimmunization documentation by clinicians other than patient's provider.

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 malignant neoplasm of 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 neoplasm, by site, benign.” The table provides the proper code based on the type of neoplasm 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 Z15.0, codes for genetic susceptibility to cancer.

a. Admission/Encounter for treatment of primary site

If the malignancy is chiefly responsible for occasioning the patient admission/encounter and treatment is directed at the primary site, designate the primary malignancy as the principal/first-listed diagnosis.

The only exception to this guideline is if the administration of chemotherapy, immunotherapy or external beam radiation therapy is chiefly responsible for occasioning the admission/encounter. In that case, assign the appropriate Z51.-- code as the first-listed or principal diagnosis, and the underlying diagnosis or problem for which the service is being performed as a secondary diagnosis.

b. Admission/Encounter for 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.

c. 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:

1) 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 or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease**).**

2) 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 Y84.2, Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.

3) 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 (intravenous rehydration), 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 at that site, a code from category Z85,

Personal 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 diagnosis with the Z85 code used as a secondary code.

See section I.C.2.t. Secondary malignant neoplasm of lymphoid tissue.

e. Admissions/Encounters involving *antineoplastic* 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, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the code for the neoplasm should be assigned as principal or first-listed diagnosis**.**

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

If a patient admission/encounter is chiefly for the administration of chemotherapy, immunotherapy or external beam radiation therapy for the treatment of a neoplasm, 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 reason for the encounter is more than one type of antineoplastic therapy, code Z51.0 and codes from subcategory Z51.1 may be assigned together, in which case one of these codes would be reported as a secondary diagnosis.

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

If a patient admission/encounter is for the insertion or implantation of radioactive elements (e.g., brachytherapy) the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis. Code Z51.0 should not be assigned.

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

When a patient is admitted for the purpose of external beam radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled 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.

When a patient is admitted for the purpose of insertion or implantation of radioactive elements (e.g., brachytherapy) and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is the appropriate code for the malignancy 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, Encounter for prophylactic organ removal.

h. Admission/encounter for pain control/management

See Section I.C.6. for information on coding admission/encounter for pain control/management.

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

j. Disseminated malignant neoplasm, unspecified

Code C80.0, 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.

k. Malignant neoplasm without specification of site

Code C80.1, 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.

l. Sequencing of neoplasm codes

1) Encounter for treatment of primary malignancy

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.

2) Encounter for treatment of secondary malignancy

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.

3) Malignant neoplasm in a pregnant patient

When a pregnant patient 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.

4) Encounter for complication associated with a neoplasm

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.

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 or first-listed diagnosis followed by code D63.0, Anemia in neoplastic disease.

5) Complication from surgical procedure for treatment of a neoplasm

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 the guideline regarding the coding of a current malignancy versus personal history to determine if the code for the neoplasm should also be assigned.

6) Pathologic fracture due to a neoplasm

When an encounter is for a pathological 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.

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.

m. Current malignancy versus personal history of malignancy

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.

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 at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

Codes from subcategories Z85.0 – Z85.85 should only be assigned for the former site of a primary malignancy, not the site of a secondary malignancy. Code Z85.89 may be assigned for the former site(s) of either a primary or secondary malignancy.

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

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

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 Z85.6, Personal history of leukemia, and Z85.79, 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)

o. Aftercare following surgery for neoplasm

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

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

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

q. Prophylactic organ removal for prevention of malignancy

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

r. Malignant neoplasm associated with transplanted organ

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 C80.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy.

s. Breast Implant Associated Anaplastic Large Cell Lymphoma

Breast implant associated anaplastic large cell lymphoma (BIA-ALCL) is a type of lymphoma that can develop around breast implants. Assign code C84.7A, Anaplastic large cell lymphoma, ALK-negative, breast, for BIA-ALCL or C84.7B, Anaplastic large cell lymphoma, ALK-negative, in remission, for BIA-ALCL in remission. Do not assign a complication code from chapter 19.

t. Secondary malignant neoplasm of lymphoid tissue

When a malignant neoplasm of lymphoid tissue metastasizes beyond the lymph nodes, a code from categories C81-C85 with a final character identifying "extranodal and solid organ sites" should be assigned rather than a code for the secondary neoplasm of the affected solid organ. For example, for metastasis of diffuse large B-cell lymphoma to the lung, brain and left adrenal gland, assign code C83.398, Diffuse large B-cell lymphoma of other extranodal and solid organ sites.

3. Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)

Reserved for future guideline expansion

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

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 as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a 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 a 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 diabetes.

(a) **Presymptomatic Type 1 Diabetes Mellitus**

Codes E10.A-, Type 1 diabetes mellitus, presymptomatic, are assigned for early-stage type 1 diabetes that predates the onset of symptoms.

(b) **Type 2 diabetes mellitus in remission**

Code E11.A, Type 2 diabetes mellitus without complications in remission, is assigned based on provider documentation that the diabetes mellitus is in remission. If the documentation is unclear as to whether the Type 2 diabetes mellitus has achieved remission, the provider should be queried. For example, the term "resolved" is not synonymous with remission.

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, oral hypoglycemics, and injectable non-insulin drugs

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. Additional code(s) should be assigned from category Z79 to identify the long-term (current) use of insulin, oral hypoglycemic drugs, or injectable non-insulin antidiabetic, as follows:

If the patient is treated with both oral hypoglycemic drugs and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs, should be assigned.

If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long term (current) use of insulin, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.

If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long term (current) use of oral hypoglycemic drugs, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic 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

See Section I.C.15. Diabetes mellitus in pregnancy.
See Section I.C.15. Gestational (pregnancy induced) diabetes

5) Complications due to insulin pump malfunction

(a) **Underdose of insulin due to insulin pump failure**

An underdose of insulin due to an insulin pump failure should be assigned to a code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic

devices, implants and grafts, that specifies the type of pump malfunction, as the principal or first-listed code, followed by code T38.3X6-, Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs. Additional codes for the type of diabetes mellitus and any associated complications due to the underdosing should also be assigned.

(b) **Overdose of insulin due to insulin pump failure**

The principal or first-listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be T85.6-, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, followed by code T38.3X1-, Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional).

6) Secondary diabetes mellitus

Codes under categories E08, Diabetes mellitus due to underlying condition, E09, Drug or chemical induced diabetes mellitus, and E13, Other specified diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

(a) **Secondary diabetes mellitus and the use of insulin, oral hypoglycemic drugs, or injectable non-insulin drugs**

For patients with secondary diabetes mellitus who routinely use insulin, oral hypoglycemic drugs, or injectable non-insulin drugs, additional code(s) from category Z79 should be assigned to identify the long-term (current) use of insulin, oral hypoglycemic drugs**,** or non-injectable non-insulin drugs as follows:

If the patient is treated with both oral hypoglycemic drugs and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs, should be assigned.

If the patient is treated with both insulin and an injectable non- insulin antidiabetic drug, assign codes Z79.4, Long-term (current) use of insulin, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.

If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long-term (current) use of oral hypoglycemic drugs, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.

Code Z79.4 should not be assigned if insulin is given temporarily to bring a secondary diabetic patient's blood sugar under control during an encounter**.**

(b) **Assigning and sequencing secondary diabetes codes and its causes**

The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the Tabular List instructions for categories E08, E09 and E13.

(i) **Secondary diabetes mellitus due to pancreatectomy**

For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code E89.1, Postprocedural hypoinsulinemia. Assign a code from category E13 as the principal or first-listed diagnosis and a code from subcategory Z90.41, Acquired absence of pancreas, as an additional code.

(ii) **Secondary diabetes due to drugs**

Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or sequela of poisoning.
See section I.C.19.e. for coding of adverse effects and poisoning, and section I.C.20 for external cause code reporting.

b. Obesity

The obesity codes in category E66, Overweight and obesity, include codes related to the cause of obesity, such as drug-induced obesity (E66.1), and codes related to effects of obesity, such as code E66.2, Morbid (severe) obesity with alveolar hypoventilation. There are other codes related to obesity in other categories of the classification, such as E88.82, Obesity due to disruption of MC4R pathway; and codes in fifth character subcategory O99.21, Obesity complicating pregnancy, childbirth, and the puerperium.

1) Obesity class

The obesity class codes in subcategory E66.81, Obesity class, require a fifth character to convey the severity of obesity. The obesity class should be documented in the medical record by the provider for these codes to be assigned. The obesity class codes can be reported with other obesity codes in the classification found in Chapters 4 and 15 to fully describe the condition. However, if both class 3 obesity and morbid obesity are documented, only a code for class 3 obesity should be assigned as it is more specific.

5. Chapter 5: Mental, Behavioral and Neurodevelopmental disorders (F01 – F99)

a. Pain disorders related to psychological factors

Assign code F45.41, for pain that is exclusively related to psychological disorders. As indicated by the Excludes 1 note under category G89, a code from category G89 should not be assigned with code F45.41.

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.

See Section I.C.6. Pain

b. Mental and behavioral disorders due to psychoactive substance use

1) In Remission

Selection of codes describing "in remission" for categories F10-F19, Mental and behavioral disorders due to psychoactive substance use (categories F10-F19 with -.11, -.21, -.91) requires the provider's clinical judgment and are assigned only on the basis of provider documentation (as defined in the Official Guidelines for Coding and Reporting), unless otherwise instructed by the classification.

Mild substance use disorders in early or sustained remission are classified to the appropriate codes for substance abuse in remission, and moderate or severe substance use disorders in early or sustained remission are classified to the appropriate codes for substance dependence in remission.

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

3) Psychoactive Substance Use, Unspecified

As with all other unspecified diagnoses, the codes for unspecified psychoactive substance use (F10.9-, F11.9-, F12.9-, F13.9-, F14.9-, F15.9-, F16.9-, F18.9-, F19.9-) should only be assigned based on provider documentation and when they meet the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). These codes are to be used only when the psychoactive substance use is associated with a substance related disorder (chapter 5 disorders such as sexual dysfunction, sleep disorder, or a mental or behavioral disorder) or medical condition, and such a relationship is documented by the provider.

4) Medical Conditions Due to Psychoactive Substance Use, Abuse and Dependence

Medical conditions due to substance use, abuse, and dependence are not classified as substance-induced disorders. Assign the diagnosis code for the medical condition as directed by the Alphabetical Index along with the appropriate psychoactive substance use, abuse or dependence code. For example, for alcoholic pancreatitis due to alcohol dependence, assign the appropriate code from subcategory K85.2, Alcohol induced acute pancreatitis, and the appropriate code from subcategory F10.2, such as code F10.20, Alcohol dependence, uncomplicated. It would not be appropriate to assign code F10.288, Alcohol dependence with other alcohol-induced disorder.

5) Blood Alcohol Level

A code from category Y90, Evidence of alcohol involvement determined by blood alcohol level, may be assigned when this information is documented and the patient's provider has documented a condition classifiable to category F10, Alcohol related disorders. The blood alcohol level does not need to be documented by the patient's provider in order for it to be coded.

See Section I.B.14. for blood alcohol level documentation by clinicians other than patient's provider.

c. Factitious Disorder

Factitious disorder imposed on self or Munchausen's syndrome is a disorder in which a person falsely reports or causes his or her own physical or psychological signs or symptoms. For patients with documented factitious disorder on self or Munchausen's syndrome, assign the appropriate code from subcategory F68.1-, Factitious disorder imposed on self.

Munchausen's syndrome by proxy (MSBP) is a disorder in which a caregiver (perpetrator) falsely reports or causes an illness or injury in another person (victim) under his or her care, such as a child, an elderly adult, or a person who has a disability. The condition is also referred to as "factitious disorder imposed

on another" or "factitious disorder by proxy." The perpetrator, not the victim, receives this diagnosis. Assign code F68.A, Factitious disorder imposed on another, to the perpetrator's record. For the victim of a patient suffering from MSBP, assign 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.

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

d. Dementia

The ICD-10-CM classifies dementia (categories F01, F02, and F03) on the basis of the etiology and severity (unspecified, mild, moderate or severe). Selection of the appropriate severity level requires the provider's clinical judgment and codes should be assigned only on the basis of provider documentation (as defined in the *Official Guidelines for Coding and Reporting*), unless otherwise instructed by the classification. If the documentation does not provide information about the severity of the dementia, assign the appropriate code for unspecified severity.

If a patient is admitted to an inpatient acute care hospital or other inpatient facility setting with dementia at one severity level and it progresses to a higher severity level, assign one code for the highest severity level reported during the stay.

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

a. Dominant/nondominant side

Codes from category G81, Hemiplegia and hemiparesis, and subcategories G83.1, Monoplegia of lower limb, G83.2, Monoplegia of upper limb, and G83.3, Monoplegia, unspecified, 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.

b. Pain - Category G89

1) General coding information

Codes in category G89, 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 and neoplasm-related pain, unless otherwise indicated below.

If the pain is not specified as acute or chronic, post-thoracotomy, postprocedural, or neoplasm-related, do not assign codes from category G89.

A code from category G89 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/ management and not management of the underlying condition.

When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis. No code from category G89 should be assigned.

(a) **Category G89 Codes as Principal or First-Listed Diagnosis**

Category G89 codes are acceptable as principal diagnosis or the first-listed code:

- When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.
- 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. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

(b) **Use of Category G89 Codes in Conjunction with Site Specific Pain Codes**

(i) **Assigning Category G89 and Site-Specific Pain Codes**

Codes from category G89 may be used in conjunction with codes that identify the site of pain (including codes from chapter 18) if the category G89 code provides additional information. For example, if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes should be assigned.

(ii) **Sequencing of Category G89 Codes with Site-Specific Pain Codes**

The sequencing of category G89 codes with site- specific pain codes (including chapter 18 codes), is dependent on the circumstances of the encounter/admission as follows:

- If the encounter is for pain control or pain management, assign the code from category G89 followed by the code identifying the specific site of pain (e.g., encounter for pain management for acute neck pain from trauma is assigned code G89.11, Acute pain due to trauma, followed by code M54.2, Cervicalgia, to identify the site of pain).
- If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category G89.

2) Pain due to devices, implants and grafts

See Section I.C.19. Pain due to medical devices

3) 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.*

The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form.

Routine or expected postoperative pain immediately after surgery should not be coded.

(a) **Postoperative pain not associated with specific postoperative complication**

Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category G89.

(b) **Postoperative pain associated with specific postoperative complication**

Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. If appropriate, use additional code(s) from category G89 to identify acute or chronic pain (G89.18 or G89.28).

4) 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.

5) Neoplasm Related Pain

Code G89.3 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.

This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter is 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 G89.3 may be assigned as an additional diagnosis. It is not necessary to assign an additional code for the site of the pain.

See Section I.C.2. for instructions on the sequencing of neoplasms for all other stated reasons for the admission/encounter (except for pain control/pain management).

6) Chronic pain syndrome

Central pain syndrome (G89.0) and chronic pain syndrome (G89.4) are different than the term "chronic pain," and therefore codes should only be used when the provider has specifically documented this condition.

See Section I.C.5. Pain disorders related to psychological factors

7. 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 being 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, 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 a different type or stage, and the classification distinguishes laterality, assign the appropriate code for each eye rather than the code for bilateral glaucoma.

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

When a patient has bilateral glaucoma and each eye is documented as having the same type, but different stage, and the classification does not distinguish laterality (i.e., subcategories H40.10 and H40.20), assign a code for the type of glaucoma for each eye with the seventh character for the specific glaucoma stage documented for each eye.

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 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.

b. Blindness

If "blindness" or "low vision" of both eyes is documented but the visual impairment category is not documented, assign code H54.3, Unqualified visual loss, both eyes. If "blindness" or "low vision" in one eye is documented but the visual impairment category is not documented, assign a code from H54.6-, Unqualified visual loss, one eye. If "blindness" or "visual loss" is documented without any information about whether one or both eyes are affected, assign code H54.7, Unspecified visual loss.

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 involvement 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 **one or more** heart conditions classified to I50.-, Heart failure, I51.4, Myocarditis, unspecified, I51.89, Other ill-defined heart diseases, **or** I51.9, Heart disease, unspecified, is assigned to a code from category I11, Hypertensive heart disease. Use additional code(s) from category I50, Heart failure, or I51, Complications and ill-defined descriptions of heart disease, to identify the heart condition.

Hypertension with **one or more** heart conditions classified to I51.5, Myocardial degeneration, or I51.7, Cardiomegaly, is assigned to a code from category I11, Hypertensive heart disease. No additional code is assigned to identify the specific heart condition.

The same heart conditions (I50.-, I51.4-I51.7, I51.89, I51.9) with hypertension are coded separately if the provider has documented they are unrelated to the hypertension**.** The applicable hypertension code I10, Essential (primary) hypertension, or a code from category I15, Secondary hypertension, should be assigned. 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 provider indicates the CKD is not related to the hypertension.

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.

See Section I.C.14. Chronic kidney disease.

If a patient has hypertensive chronic kidney disease and acute renal failure, the acute renal failure should also be coded. Sequence according to the circumstances of the admission/encounter.

3) Hypertensive Heart and 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. Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and chronic kidney disease. If heart failure is present, assign an additional code from category I50 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.

See Section I.C.14. 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 codes from I11 or I12.

For patients with both acute renal failure and chronic kidney disease, the acute renal failure should also be coded. Sequence according to the circumstances of the admission/encounter.

4) Hypertensive Cerebrovascular Disease

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

5) Hypertensive Retinopathy

Subcategory H35.0, Background retinopathy and retinal vascular changes, should be used along with a code from categories I10 – I15, in the Hypertensive diseases section, to include the systemic hypertension. The sequencing is based on the reason for the encounter.

6) Hypertension, Secondary

Secondary hypertension is due to an underlying condition. Two codes are required: one to identify the underlying etiology and one from category I15 to identify the hypertension. Sequencing of codes is determined by the reason for admission/encounter.

7) Hypertension, Transient

Assign code R03.0, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code O13.-, Gestational [pregnancy-induced] hypertension without significant proteinuria, or O14.-, Pre-eclampsia, for transient hypertension of pregnancy.

8) Hypertension, Controlled

This diagnostic statement usually refers to an existing state of hypertension under control by therapy. Assign the appropriate code from categories I10-I15, Hypertensive diseases.

9) Hypertension, Uncontrolled

Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign the appropriate code from categories I10-I15, Hypertensive diseases.

10) Hypertensive Crisis

Assign a code from category I16, Hypertensive crisis, for documented hypertensive urgency, hypertensive emergency or unspecified hypertensive crisis. Code also any identified hypertensive disease (I10-I15, **I1A**). The sequencing is based on the reason for the encounter.

11) Pulmonary Hypertension

Pulmonary hypertension is classified to category I27, Other pulmonary heart diseases. For secondary pulmonary hypertension (I27.1, I27.2-), code also any associated conditions or adverse effects of drugs or toxins. The sequencing is based on the reason for the encounter, except for adverse effects of drugs (See Section I.C.19.e.).

12) Hypertension, Resistant

Resistant hypertension refers to blood pressure of a patient with hypertension that remains above goal in spite of the use of antihypertensive medications. Assign code I1A.0, Resistant hypertension, as an additional code when apparent treatment resistant hypertension, treatment resistant hypertension, or true resistant hypertension is documented by the provider. A code for the specific type of existing hypertension is sequenced first, if known.

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 I25.11, 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.

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.

See Section I.C.9. Acute myocardial infarction (AMI)

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 infarction or hemorrhage and whether it occurred intraoperatively or postoperatively. If it was a cerebral 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 I60-I67 as the causes of sequela (neurologic deficits), themselves classified elsewhere. These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-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 I60-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 I60-I67

Codes from category I69 may be assigned on a health care record with codes from I60-I67, 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 (Z86.73)

Codes from category I69 should not be assigned if the patient does not have neurologic deficits.

See Section I.C.21.4. History (of) for use of personal history codes

e. Acute myocardial infarction (AMI)

1) Type 1 ST elevation myocardial infarction (STEMI) and non-ST elevation myocardial infarction (NSTEMI)

The ICD-10-CM codes for type 1 acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories I21.0-I21.2 and code I21.3 are used for type 1 ST elevation myocardial infarction (STEMI). Code I21.4, Non-ST elevation (NSTEMI) myocardial infarction, is used for type 1 non-ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.

If a type 1 NSTEMI evolves to STEMI, assign the STEMI code. If a type 1 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 setting or a postacute setting, and the myocardial infarction meets the definition for "other diagnoses" (see Section III, Reporting Additional Diagnoses), codes from category I21 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 I21. For old or healed myocardial infarctions not requiring further care, code I25.2, Old myocardial infarction, may be assigned.

2) Acute myocardial infarction, unspecified

Code I21.9, Acute myocardial infarction, unspecified, is the default for unspecified acute myocardial infarction or unspecified type. If only type 1 STEMI or transmural MI without the site is documented, assign code I21.3, ST elevation (STEMI) myocardial infarction of unspecified site.

3) AMI 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 AMI.

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 I22, Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction, is to be used when a patient who has suffered a type 1 or unspecified AMI has a new AMI within the 4 week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21. The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.

Do not assign code I22 for subsequent myocardial infarctions other than type 1 or unspecified. For subsequent type 2 AMI assign only code I21.A1. For subsequent type 4 or type 5 AMI, assign only code I21.A9.

If a subsequent myocardial infarction of one type occurs within 4 weeks of a myocardial infarction of a different type, assign the appropriate codes from category I21 to identify each type. Do not assign a code from I22. Codes from category I22 should only be assigned if both the initial and subsequent myocardial infarctions are type 1 or unspecified.

5) Other Types of Myocardial Infarction

The ICD-10-CM provides codes for different types of myocardial infarction. Type 1 myocardial infarctions are assigned to codes I21.0-I21.4.

Type 2 myocardial infarction **(**myocardial infarction due to demand ischemia or secondary to ischemic imbalance**)** is assigned to code I21.A1, Myocardial infarction type 2 with the underlying cause coded first**,** if applicable. Do not assign code I24.89, Other forms of acute ischemic heart disease**,** for the demand ischemia. If a type 2 AMI is described as NSTEMI or STEMI, only assign code I21.A1. Codes I21.01-I21.4 should only be assigned for type 1 AMIs.

Acute myocardial infarctions type 3, 4a, 4b, 4c and 5 are assigned to code I21.A9, Other myocardial infarction type.

The "Code also" and "Code first" notes should be followed related to complications, and for coding of postprocedural myocardial infarctions during or following cardiac surgery.

6) Myocardial Infarction with Coronary Microvascular Dysfunction

Coronary microvascular dysfunction (CMD) is a condition that impacts the microvasculature by restricting microvascular flow and increasing microvascular resistance. Code I21.B, Myocardial infarction with coronary microvascular dysfunction, is assigned for myocardial infarction with coronary microvascular disease, myocardial infarction

with coronary microvascular dysfunction, and myocardial infarction with non-obstructive coronary arteries (MINOCA) with microvascular disease.

10. Chapter 10: Diseases of the Respiratory System (J00-J99), U07.0

a. Chronic Obstructive Pulmonary Disease [COPD] and Asthma

1) Acute exacerbation of chronic obstructive bronchitis and asthma

The codes in categories J44 and J45 distinguish between uncomplicated cases and those in 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 J96.0, Acute respiratory failure, or subcategory J96.2, 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, HIV, 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, (e.g., 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. Influenza 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 II, H. (Uncertain 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 "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.

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 J12-J18 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 unclear as to whether the patient has a pneumonia that is a complication attributable to the mechanical ventilator, query the provider.

2) Ventilator associated Pneumonia Develops after Admission

A patient may be admitted with one type of pneumonia (e.g., code J13, Pneumonia due to Streptococcus pneumonia) and subsequently develop VAP. In this instance, the principal diagnosis would be the appropriate code from categories J12-J18 for the pneumonia diagnosed at the time of admission. Code J95.851, Ventilator associated pneumonia, would be assigned as an additional diagnosis when the provider has also documented the presence of ventilator associated pneumonia.

e. Vaping-related disorders

For patients presenting with condition(s) related to vaping, assign code U07.0, Vaping-related disorder, as the principal diagnosis. For lung injury due to vaping, assign only code U07.0. Assign additional codes for other manifestations, such as acute respiratory failure (subcategory J96.0-) or pneumonitis (code J68.0).

Associated respiratory signs and symptoms due to vaping, such as cough, shortness of breath, etc., are not coded separately, when a definitive diagnosis has been established. However, it would be appropriate to code separately any gastrointestinal symptoms, such as diarrhea and abdominal pain.

See Section I.C.1.g.1.c.i. for Pneumonia confirmed as due to COVID-19

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

Reserved for future guideline expansion

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

a. Pressure ulcer stage codes

1) Pressure ulcer stages

Codes in category L89, Pressure ulcer, identify the site and stage of the pressure ulcer.

The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, deep tissue pressure injury**,** unspecified stage, and unstageable.

Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.

See Section I.B.14. for pressure ulcer stage documentation by clinicians other than patient's provider.

2) Unstageable pressure ulcers

Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for

pressure ulcers whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft). This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.-- 9).

If during an encounter, the stage of an unstageable pressure ulcer is revealed after debridement, assign only the code for the stage revealed following debridement.

3) Documented pressure ulcer stage

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.

4) Patients admitted with pressure ulcers documented as healed

No code is assigned if the documentation states that the pressure ulcer is completely healed at the time of admission.

5) Pressure ulcers documented as healing

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.

For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission.

6) Patient admitted with pressure ulcer evolving into another stage during the admission

If a patient is admitted to an inpatient hospital with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned: one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay.

7) Pressure-induced deep tissue damage

For pressure-induced deep tissue damage or deep tissue pressure injury, assign only the appropriate code for pressure-induced deep tissue damage (L89.--6).

b. Non-Pressure Chronic Ulcers

1) Patients admitted with non-pressure ulcers documented as healed

No code is assigned if the documentation states that the non-pressure ulcer is completely healed at the time of admission.

2) Non-pressure ulcers documented as healing

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

If the documentation is unclear as to whether the patient has a current (new) non-pressure ulcer or if the patient is being treated for a healing non-pressure ulcer, query the provider.

For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and severity of the non-pressure ulcer at the time of admission.

3) Patient admitted with non-pressure ulcer that progresses to another severity level during the admission

If a patient is admitted to an inpatient hospital with a non-pressure ulcer at one severity level and it progresses to a higher severity level, two separate codes should be assigned: one code for the site and severity level of the ulcer on admission and a second code for the same ulcer site and the highest severity level reported during the stay.

See Section I.B.14. for pressure ulcer stage documentation by clinicians other than patient's provider

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

1) Bone versus joint

For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M80, M81).

Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.

2) Multiple sites

Codes describing specified sites are assigned individually by site when documented. When the specified site(s) are not documented, assign the appropriate code for "multiple sites."

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. If 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 seeing the patient for the first time.

7th character D is to be used for encounters after the patient has completed active treatment for the fracture and is receiving routine care for the fracture during the healing or recovery phase. 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.

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 M81, 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, if that fall or trauma would not usually break a normal, healthy bone.

e. Multisystem Inflammatory Syndrome

See Section I.C.1.g.1.l. for Multisystem Inflammatory Syndrome

14. Chapter 14: Diseases of 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 1-5. Stage 2, code N18.2, equates to mild CKD; stage 3, codes N18.30-N18.32, equate 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 Z94.0, Kidney transplant status. If a transplant complication such as failure or rejection or other transplant complication is documented, see section I.C.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 I.C.9. Hypertensive chronic kidney disease.
See I.C.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-O9A, 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, Pregnant state, 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 the 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" option for the obstetric complication being coded, the "in childbirth" code should be assigned. When the classification does not

provide an obstetric code with an "in childbirth" option, it is appropriate to assign a code describing the current trimester.

4) Selection of trimester for inpatient admissions that encompass more than one trimester

In instances when a patient is admitted to a hospital for complications of pregnancy during one trimester and remains in the hospital into a subsequent trimester, the trimester character for the antepartum complication code should be assigned on the basis of the trimester when the complication developed, not the trimester of the discharge. If the condition developed prior to the current admission/encounter or represents a pre-existing condition, the trimester character for the trimester at the time of the admission/encounter should be assigned.

5) 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.

6) 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.

7) Completed weeks of gestation

In ICD-10-CM, "completed" weeks of gestation refers to full weeks. For example, if the provider documents gestation at 39 weeks and 6 days, the code for 39 weeks of gestation should be assigned, as the patient has not yet reached 40 completed weeks.

b. Selection of OB Principal or First-listed Diagnosis

1) Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present, a code from category Z34, Encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis. These codes should not be used in conjunction with chapter 15 codes.

2) Supervision of High-Risk Pregnancy

Codes from category O09, Supervision of high-risk pregnancy, are intended for use only during the prenatal period. For complications during the labor or delivery episode as a result of a high-risk pregnancy, assign the applicable complication codes from Chapter 15. If there are no complications during the labor or delivery episode, assign code O80, Encounter for full-term uncomplicated delivery.

For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 15 codes may be used in conjunction with these codes if appropriate.

3) Episodes when no delivery occurs

In episodes when no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complication codes may be sequenced first.

4) When a delivery occurs

When an obstetric patient is admitted and delivers during that admission, the condition that prompted the admission should be sequenced as the principal diagnosis. If multiple conditions prompted the admission, sequence the one most related to the delivery as the principal diagnosis. A code for any complication of the delivery should be assigned as an additional diagnosis. In cases of cesarean delivery, if the patient was admitted with a condition that resulted in the performance of a cesarean procedure, that condition should be selected as the principal diagnosis. If the reason for the admission was unrelated to the condition resulting in the cesarean delivery**,** the condition related to the reason for the admission should be selected as the principal diagnosis.

5) Outcome of delivery

A code from category Z37, Outcome of delivery, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on the newborn record.

c. Pre-existing conditions versus conditions due to the pregnancy

Certain categories in Chapter 15 distinguish between conditions of the mother that existed prior to pregnancy (pre-existing) and those that are a direct result of pregnancy. When assigning codes from Chapter 15, it is important to assess if a condition was pre-existing prior to pregnancy or developed during or due to the pregnancy in order to assign the correct code.

Categories that do not distinguish between pre-existing and pregnancy-related conditions may be used for either. It is acceptable to use codes specifically for

the puerperium with codes complicating pregnancy and childbirth if a condition arises postpartum during the delivery encounter.

d. Pre-existing hypertension in pregnancy

Category O10, Pre-existing hypertension complicating pregnancy, childbirth and the puerperium, includes codes for hypertensive heart and hypertensive chronic kidney disease. When assigning one of the O10 codes that includes hypertensive heart disease or hypertensive chronic kidney disease, it is necessary to add a secondary code from the appropriate hypertension category to specify the type of heart failure or chronic kidney disease.

See Section I.C.9. Hypertension.

e. Fetal Conditions Affecting the Management of the Mother

1) Codes from categories O35 and O36

Codes from categories O35, Maternal care for known or suspected fetal abnormality and damage, and O36, Maternal care for other fetal problems, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, i.e., by requiring diagnostic studies, additional observation, special care, or termination of pregnancy. The fact that the fetal condition exists does not justify assigning a code from this series to the mother's record.

2) In utero surgery

In cases when surgery is performed on the fetus, a diagnosis code from category O35, Maternal care for known or suspected fetal abnormality and damage, should be assigned identifying the fetal condition. Assign the appropriate procedure code for the procedure performed.

No code from Chapter 16, the perinatal codes, should be used on the mother's record to identify fetal conditions. Surgery performed in utero on a fetus is still to be coded as an obstetric encounter.

f. HIV Infection in Pregnancy, Childbirth and the Puerperium

During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis from subcategory O98.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by the code(s) for the HIV-related illness(es).

Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of O98.7- and Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.

g. Diabetes mellitus in pregnancy

Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant patients who are diabetic should be assigned a code from category O24,

Diabetes mellitus in pregnancy, childbirth, and the puerperium, first, followed by the appropriate diabetes code(s) (E08-E13) from Chapter 4.

h. Long term use of insulin and oral hypoglycemics

See section I.C.4.a.3 for information on the 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 patients 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 patient 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 O24.4 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 is required. If a patient with gestational diabetes is treated with both diet and oral hypoglycemic medications, only the code for "controlled by oral hypoglycemic drugs" is required. Codes Z79.4, Long-term (current) use of insulin, Z79.84, Long-term (current) use of oral hypoglycemic drugs, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic 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 causal organism (e.g., for a bacterial infection, assign a code from category B95-B96, Bacterial infections in conditions classified elsewhere). A code from category A40, 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.

Code O85 should not be assigned for sepsis following an obstetrical procedure (See Section I.C.1.d.5.b., Sepsis due to a postprocedural infection).

l. Alcohol, tobacco and drug 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 patient uses alcohol during the pregnancy or postpartum. A secondary code from category F10, Alcohol related disorders, 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 patient 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.

3) Drug use during pregnancy, childbirth and the puerperium

Codes under subcategory O99.32, Drug use complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a patient uses drugs during the pregnancy or postpartum. This can involve illegal drugs, or inappropriate use or abuse of prescription drugs. Secondary code(s) from categories F11-F16 and F18-F19 should also be assigned to identify manifestations of the drug use.

m. Poisoning, toxic effects, adverse effects and underdosing in a pregnant patient

A code from subcategory O9A.2, Injury, poisoning and certain other consequences of external causes complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate injury**,** poisoning, toxic effect, adverse effect or underdosing code, and then the additional code(s) that specifies the condition caused by the poisoning, toxic effect, adverse effect or underdosing.

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

n. Normal Delivery, Code O80

1) Encounter for full term uncomplicated delivery

Code O80 should be assigned when a patient is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the

delivery episode. Code O80 is always a principal diagnosis. It is not to be used if any other code from chapter 15 is needed to describe a current complication of the antenatal, delivery, or postnatal period. Additional codes from other chapters may be used with code O80 if they are not related to or are in any way complicating the pregnancy.

2) Uncomplicated delivery with resolved antepartum complication

Code O80 may be used if the patient had a complication at some point during the pregnancy, but the complication is not present at the time of the admission for delivery.

3) Outcome of delivery for O80

Z37.0, Single live birth, is the only outcome of delivery code appropriate for use with O80.

o. The Peripartum and Postpartum Periods

1) Peripartum and Postpartum periods

The postpartum period begins immediately after delivery and continues for six weeks following delivery. The peripartum period is defined as the last month of pregnancy to five months postpartum.

2) Peripartum and postpartum complication

A postpartum complication is any complication occurring within the six-week period.

3) Pregnancy-related complications after 6-week period

Chapter 15 codes may also be used to describe pregnancy-related complications after the peripartum or postpartum period if the provider document**s** that a condition is pregnancy related.

4) Admission for routine postpartum care following delivery outside hospital

When the mother delivers outside the hospital prior to admission and is admitted for routine postpartum care and no complications are noted, code Z39.0, Encounter for care and examination of mother immediately after delivery, should be assigned as the principal diagnosis.

5) Pregnancy associated cardiomyopathy

Pregnancy associated cardiomyopathy, code O90.3, is unique in that it may be diagnosed in the third trimester of pregnancy but may continue to progress months after delivery. For this reason, it is referred to as peripartum cardiomyopathy. Code O90.3 is only for use when the cardiomyopathy develops as a result of pregnancy in a patient who did not have pre-existing heart disease.

p. Code O94, Sequelae of complication of pregnancy, childbirth, and the puerperium

1) Code O94

Code O94, Sequelae of complication of pregnancy, childbirth, and the puerperium, is for use in those cases when an initial complication of a pregnancy develops a sequela or sequelae requiring care or treatment at a future date.

2) After the initial postpartum period

This code may be used at any time after the initial postpartum period.

3) Sequencing of Code O94

This code, like all sequela codes, is to be sequenced following the code describing the sequelae of the complication.

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 Z37, 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**,** without complications are assigned O03.4, Incomplete spontaneous abortion without complication, or code O07.4, Failed attempted termination of pregnancy without complication. This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion. If the patient has a specific complication associated with the spontaneous abortion or elective termination of pregnancy in addition to retained products of conception, assign the appropriate complication code (e.g., O03.-, O04.-, O07.-) instead of code O03.4 or O07.4.

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 in O04**,** O07 and O08.

4) Hemorrhage following elective abortion

For hemorrhage post elective abortion, assign code O04.6, Delayed or excessive hemorrhage following (induced) termination of pregnancy. Do not assign code O72.1, Other immediate postpartum hemorrhage, as this code should not be assigned for post abortion conditions.

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.

s. COVID-19 infection in pregnancy, childbirth, and the puerperium

During pregnancy, childbirth or the puerperium, when COVID-19 is the reason for admission/encounter, code O98.5-, Other viral diseases complicating pregnancy, childbirth and the puerperium, should be sequenced as the principal/first-listed diagnosis, and code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) should be assigned as additional diagnoses. Codes from Chapter 15 always take sequencing priority.

If the reason for admission/encounter is unrelated to COVID-19 but the patient has been diagnosed with COVID-19 during the admission/encounter, the appropriate code for the reason for admission/encounter should be sequenced as the principal/first-listed diagnosis, and codes O98.5- and U07.1, as well as the appropriate codes for associated COVID-19 manifestations, should be assigned as additional diagnoses.

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

For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth. The following guidelines are provided for reporting purposes.

a. General Perinatal Rules

1) Use of Chapter 16 Codes

Codes in this chapter are never for use on 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 birth episode in a newborn record, assign a code from category Z38, Liveborn infants according to place of birth and type of delivery, as the principal diagnosis. A code from category Z38 is assigned only once, to a newborn at the time of birth. If a newborn is

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

A code from category Z38 is used only on the newborn record, not on the mother's record.

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 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.

For COVID-19 infection in a newborn, see guideline I.C.16.h.

6) 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 treatment; 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) Use of Z05 codes

Assign a code from category Z05, Observation and evaluation of newborn for suspected diseases and conditions ruled out, to identify those instances when a healthy newborn is evaluated for a suspected condition/disease that is determined after study not to be present. Do not use a code from category Z05 when the patient is documented to have signs or symptoms of a suspected problem; in such cases code the sign or symptom.

2) Z05 on other than the birth record

A code from category Z05 may also be assigned as a principal or first-listed code for readmissions or encounters when the code from category Z38 no longer applies. Codes from category Z05 are for use only for healthy newborns and infants for which no condition is found to be present after study.

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, prolong 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 needs.

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

d. Prematurity and Fetal Growth Retardation

Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented. Assignment of codes in categories P05, Disorders of newborn related to slow fetal growth and fetal malnutrition, and P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified, should be based on the recorded birth weight and estimated gestational age.

When both birth weight and gestational age are available, two codes from category P07 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 P07, 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 I.C.21. Factors influencing health status and contact with health services, Status.

f. 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 B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified elsewhere, or B96, 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 (R65.2-) and any associated acute organ dysfunction.

g. 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.

h. COVID-19 Infection in Newborn

For a newborn that tests positive for COVID-19, assign code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) in neonates/newborns in the absence of documentation indicating a specific type of transmission. For a newborn that tests positive for COVID-19 and the provider documents the condition was contracted in utero or during the birth process, assign codes P35.8, Other congenital viral diseases, and U07.1, COVID-19. When coding the birth episode in a newborn record, the appropriate code from category Z38, Liveborn infants according to place of birth and type of delivery, should be assigned as the principal diagnosis.

17. Chapter 17: Congenital malformations, deformations, chromosomal abnormalities, *and genetic disorders* (Q00-*QA1*)

Assign an appropriate code(s) from categories Q00-QA1, Congenital malformations, deformations, chromosomal abnormalities**, and genetic disorders** when a malformation/deformation, chromosomal abnormality**, or genetic disorder** is documented. A malformation/deformation/chromosomal abnormality, **or genetic disorder** may be the principal/first-listed diagnosis or secondary diagnosis on a record.

When a malformation/deformation, chromosomal abnormality**, or genetic disorder** 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, chromosomal abnormality**, or genetic disorder**, 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 or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity. Although present at birth, a malformation/deformation, chromosomal abnormality**, or genetic disorder** may not be identified until later in life. Whenever the condition is diagnosed by the provider, it is appropriate to assign a code from categories Q00-**QA1**. 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 **in categories** Q00-**QA1**.

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

e. Coma

Code R40.20, Unspecified coma, should be assigned when the underlying cause of the coma is not known, or the cause is a traumatic brain injury and the coma scale is not documented in the medical record.

Do not report codes for unspecified coma, individual or total Glasgow coma scale scores for a patient with a medically induced coma or a sedated patient.

1) Coma Scale

The coma scale codes (R40.21- to R40.24-) can be used in conjunction with traumatic brain injury codes. These codes cannot be used with code R40.2A, Nontraumatic coma due to underlying condition. They are primarily for use by trauma registries, but they may be used in any setting where this information is collected. The coma scale codes should be sequenced after the diagnosis code(s).

These codes, one from each subcategory, are needed to complete the scale. The 7th character indicates when the scale was recorded. The 7th character should match for all three 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).

If multiple coma scores are captured within the first 24 hours after hospital admission, assign only the code for the score at the time of admission. ICD-10-CM does not classify coma scores that are reported after admission but less than 24 hours later.

See Section I.B.14. for coma scale documentation by clinicians other than patient's provider

f. Functional quadriplegia

GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2017

g. 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 pancreatitis. 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 R65.10, 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 acute 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.

h. Death NOS

Code R99, Ill-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.

i. NIHSS Stroke Scale

The NIH stroke scale (NIHSS) codes (R29.7- -) can be used in conjunction with acute stroke codes (I60-I63) to identify the patient's neurological status and the severity of the stroke. The stroke scale codes should be sequenced 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 NIHSS stroke scale documentation by clinicians other than patient's provider

19. Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00-T88)

a. Application of 7th Characters in Chapter 19

Most categories in chapter 19 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela. Categories for traumatic fractures have additional 7th character values. While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

For complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating

problem. For example, code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, is used when active treatment is provided for the infection, even though the condition relates to the prosthetic device, implant or graft that was placed at a previous encounter.

7th character "A", initial encounter is used for each encounter where the patient is receiving active treatment for the condition.

7th character "D" subsequent encounter is used for encounters after the patient has completed active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care. For example, for aftercare of an injury, assign the acute injury code with the 7th character "D" (subsequent encounter).

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

See Section I.B.10. Sequelae, (Late Effects)

b. Coding of Injuries

When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Codes from category T07, Unspecified multiple injuries should not be assigned in the inpatient setting unless information for a more specific code is not available. Traumatic injury codes (S00- T14.9) are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.

1) Superficial injuries

Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

2) Primary injury with damage to nerves/blood vessels

When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) for injuries to nerves and spinal cord (such as category S04), and/or injury to blood vessels (such as category S15). When the primary

injury is to the blood vessels or nerves, that injury should be sequenced first.

3) Iatrogenic injuries

Injury codes from Chapter 19 should not be assigned for injuries that occur during, or as a result of, a medical intervention. Assign the appropriate complication code(s).

c. Coding of Traumatic Fractures

The principles of multiple coding of injuries should be followed in coding fractures. Fractures of specified sites are coded individually by site in accordance with both the provisions within categories S02, S12, S22, S32, S42, S49, S52, S59, S62, S72, S79, S82, S89, S92 and the level of detail furnished by medical record content.

A fracture not indicated as open or closed should be coded to closed. A fracture not indicated whether displaced or not displaced should be coded to displaced.

More specific guidelines are as follows:

1) Initial vs. subsequent encounter for fractures

Traumatic fractures are coded using the appropriate 7th character for initial encounter (A, B, C) for each encounter where the patient is receiving active treatment for the fracture. The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.

Fractures are coded using the appropriate 7th character for subsequent care for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase.

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

Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate 7th character for subsequent care with nonunion (K, M, N,) or subsequent care with malunion (P, Q, R).

Malunion/nonunion: The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.

The open fracture designations in the assignment of the 7th character for fractures of the forearm, femur and lower leg, including ankle are based on the Gustilo open fracture classification. When the Gustilo

classification type is not specified for an open fracture, the 7th character for open fracture type I or II should be assigned (B, E, H, M, Q).

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.

See Section I.C.13. Osteoporosis.

The aftercare Z codes should not be used for aftercare for traumatic fractures. For aftercare of a traumatic fracture, assign the acute fracture code with the appropriate 7th character.

2) Multiple fractures sequencing

Multiple fractures are sequenced in accordance with the severity of the fracture.

3) Physeal fractures

For physeal fractures, assign only the code identifying the type of physeal fracture. Do not assign a separate code to identify the specific bone that is fractured.

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 and corrosions.

Current burns (T20-T25) are classified by depth, extent and by agent (X code). Burns are classified by depth as 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 anatomic site

Classify burns of the same anatomic site and on the same side but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis (e.g., for second and third degree burns of right thigh, assign only code T24.311-).

3) Non-healing burns

Non-healing burns are coded as acute burns.

Necrosis of burned skin should be coded as a non-healed burn.

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 T30, Burn and corrosion, body region unspecified is extremely vague and should rarely be used.

Codes for burns of "multiple sites" should only be assigned when the medical record documentation does not specify the individual sites.

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, for acute burns or corrosions when the site of the burn or corrosion 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. Codes from categories T31 and T32 should not be used for sequelae of burns or corrosions.

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 abdomen that involve burns.

7) Encounters for treatment of sequela of burns

Encounters for the 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.

8) Sequelae with a late effect code and current 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 sequelae 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.B.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.

3) If the same code would describe the causative agent

If the same code would describe the causative agent for more than one adverse reaction, poisoning, toxic effect or underdosing, assign the code only once.

4) If two or more drugs, medicinal or biological substances

If two or more drugs, medicinal or biological substances are taken, code each individually unless a combination code is listed in the Table of Drugs and Chemicals.

If multiple unspecified drugs, medicinal or biological substances were taken, assign the appropriate code from subcategory T50.91, Poisoning by, adverse effect of and underdosing of multiple unspecified drugs, medicaments and biological substances.

5) The occurrence of drug toxicity is classified in ICD-10-CM as follows:

(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-T50). The code for the drug should have a 5th or 6th character "5" (for example T36.0X5-) 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.

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

Examples of poisoning include:

(i) 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.

(ii) Overdose of a drug intentionally taken

If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning.

(iii) 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.

(iv) 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 malfunctions.

For Sequela (Late Effects) see Section I.B.10.

(c) **Underdosing**

Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer's instruction. Discontinuing the use of a prescribed medication on the patient's own initiative (not directed by the patient's provider) is also classified as an underdosing. For underdosing, assign the code from categories T36-T50 (fifth or sixth character "6"). Documentation of a change in the patient's condition is not required in order to assign an underdosing code. Documentation that the patient is taking less of a medication than is prescribed or discontinued the prescribed medication is sufficient for code assignment.

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-, Z91.14- and Z91.A4-) 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. When coding a toxic effect, assign the toxic effect code first, followed by codes for all associated manifestations of the toxic effect.

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

For Sequela (Late Effects) see Section I.B.10. Sequela

f. 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 (X92-Y09**)** 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 Z04.41, Encounter for examination and observation following alleged adult rape or code Z04.42, Encounter for examination and observation following alleged child rape, should be used, not a code from T76.

If a suspected case of forced sexual exploitation or forced labor exploitation is ruled out during an encounter, code Z04.81, Encounter for examination and observation of victim following forced sexual exploitation, or code Z04.82, Encounter for examination and observation of victim following forced labor exploitation, should be used, not a code from T76.

See Section I.C.15. Abuse in a pregnant patient.

g. 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.21. for transplant organ removal status

See I.C.2. for malignant neoplasm associated with transplanted organ.

See I.C.1.d.4. for sequencing of sepsis due to infection in transplanted organ

(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 be assigned for documented complications of a kidney transplant, such as transplant failure or rejection or other transplant complication. 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 subcategory

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 I.C.14. Chronic kidney disease and kidney transplant status*.

See I.C.1.d.4. for sequencing of sepsis due to infection in transplanted organ

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.

Complication codes from the body system chapters should be assigned for intraoperative and postprocedural complications (e.g., the appropriate complication code from chapter 9 would be assigned for a vascular intraoperative or postprocedural complication) unless the complication is specifically indexed to a T code in chapter 19.

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

The external causes of morbidity codes 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 the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred 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 A00.0-T88.9, Z00-Z99

An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that represents a health condition due to an external cause. Though 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 sequela) 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, sequela. 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., T36.0X1-, Poisoning by penicillins, accidental (unintentional)).

b. Place of Occurrence Guideline

Codes from category Y92, Place of occurrence of the external cause, are secondary codes for 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 7^{th} 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 during hospitalization, an additional place of occurrence code may be assigned.

e. 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 capture of 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:

If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:

External codes for child and adult abuse take priority over all other external cause codes.

See Section I.C.19., Child and Adult abuse guidelines.

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

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

External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, 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 Guideline

Adult and child abuse, neglect and maltreatment are classified as assault. Any of the assault codes may be used to indicate the external cause of any injury resulting from the confirmed abuse.

For confirmed cases of abuse, neglect and maltreatment, when the perpetrator is known, a code from Y07, Perpetrator of maltreatment and neglect, should accompany any other assault codes.

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

h. 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 accidental intent. All transport accident categories assume accidental intent.

1) 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**.**

i. Sequelae (Late Effects) of External Cause Guidelines

1) Sequelae 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)

2) Sequela external cause code with a related current injury

A sequela external cause code should never be used with a related current nature of injury code.

3) Use of sequela external cause codes 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, 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 or Provide Additional Information about a Patient 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 Z20 indicates contact with, and suspected exposure to, communicable diseases. These codes are for patients who are suspected to have been exposed to a disease by close personal contact with an infected individual or are in an area where a disease is epidemic.

Category Z77, 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) Inoculations and vaccinations

Code Z23 is for encounters for inoculations 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 prosthetic 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 weaning 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 Z 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 that 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 generally 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 procreative management, code Z31.5, 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 category indicates that a patient has a condition that is resistant to antimicrobial drug treatment. Sequence the infection code first.

Z17 Estrogen, and other hormones and factors 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.

Z28.3 Underimmunization status

See Section I.B.14. for underimmunization documentation by clinicians other than the patient's provider.

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)
BMI codes should only be assigned when there is an associated, reportable diagnosis (such as obesity or anorexia) documented by the patient's provider.
Do not assign BMI codes during pregnancy. When the documentation reflects fluctuating BMI values during the current encounter for an associated reportable condition, assign a code for the most severe value.

See Section I.B.14. for BMI documentation by clinicians other than the patient's provider.

Z74.01 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 addictions to drugs. This subcategory is not for use of medications for detoxification or maintenance programs to prevent withdrawal symptoms (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug use, abuse, or 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 acute 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
Z91.0- Z92.82	Allergy status, other than to drugs and biological substances Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility Assign code Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility, as a secondary diagnosis when a patient is received by transfer into a facility and documentation indicates they were administered tissue plasminogen activator (tPA) within the last 24 hours prior to admission to the 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. Code Z92.82 is only applicable to the receiving facility record and not to the transferring facility record.
Z93	Artificial opening status
Z94	Transplanted organ and tissue status
Z95	Presence of cardiac and vascular implants and grafts
Z96	Presence of other functional implants
Z97	Presence of other devices
Z98	Other postprocedural states Assign code Z98.85, Transplanted organ removal status, to indicate that a transplanted organ has been previously removed. This code should not be assigned for the encounter in which the transplanted organ is removed. The complication necessitating removal of the transplant organ should be assigned for that encounter. *See section I.C.19. for information on the coding of organ transplant complications.*

Z99 Dependence on enabling machines and devices, not elsewhere classified
Note: Categories Z89-Z90 and Z93-Z99 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent.

4) History (of)

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

Personal history codes may be used in conjunction with follow-up codes and family 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 regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

The reason for the encounter (for example, screening or counseling) should be sequenced first and the appropriate personal and/or family history code(s) should be assigned as additional diagnos(es).

The history Z code categories are:

Z80 Family history of primary malignant neoplasm
Z81 Family history of mental and behavioral disorders
Z82 Family history of certain disabilities and chronic diseases (leading to disablement)
Z83 Family history of other specific disorders
Z84 Family history of other conditions
Z84.A Family history of exposure to diethylstilbestrol
Note: Code Z84.A, Family history of exposure to diethylstilbestrol (DES), is assigned when the patient has a family member that was exposed to DES that could cause the patient to be at a higher risk for a condition related to the exposure. This code is used, for example, when the patient's maternal grandmother was exposed to DES
Z85 Personal history of malignant neoplasm
Z86 Personal history of certain other diseases
Z87 Personal history of other diseases and conditions
Z91.4- Personal history of psychological trauma, not elsewhere classified
Z91.5- Personal history of self-harm
Z91.81 History of falling

Z91.82 Personal history of military deployment
Z91.85 Personal history of military service
Z92 Personal history of medical treatment
Except: Z92.0, Personal history of contraception
Except: Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility

5) Screening

Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram).

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.

A screening code may be a first-listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.

The Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.

The screening Z codes/categories:

Z11 Encounter for screening for infectious and parasitic diseases
Z12 Encounter for screening for malignant neoplasms
Z13 Encounter for screening for other diseases and disorders
Except: Z13.9, Encounter for screening, unspecified
Z36 Encounter for antenatal screening for mother

6) Observation

There are three observation Z code categories. They are for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out. 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 primarily to be used as a principal/first-listed diagnosis. An observation code may be assigned as a secondary

diagnosis code when the patient is being observed for a condition that is ruled out and is unrelated to the principal/first-listed diagnosis. Also, 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 Z05, 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 Z03.7**,** Encounter for suspected maternal and fetal conditions ruled out, may either be used as a first-listed or as an additional code assignment depending on the case. They are for use in very limited circumstances on a maternal record when an encounter is for a suspected maternal or fetal condition that is ruled out during that encounter (for example, a maternal or fetal condition may be suspected due to an abnormal test result). These codes should not be used when the condition is confirmed. In those cases, the confirmed condition should be coded. In addition, these codes are not for use if an illness or any signs or symptoms related to the suspected condition or problem are present. In such cases the diagnosis/symptom code is used.

Additional codes may be used in addition to the code from subcategory Z03.7, but only if they are unrelated to the suspected condition being evaluated.

Codes from subcategory Z03.7 may not be used for encounters for antenatal screening of mother. *See Section I.C.21. Screening.*

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

The observation Z code categories:

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

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 these cases.

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

The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be reported as an additional code when a specific type of aftercare is provided in addition to the reason for the encounter. 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 an aftercare encounter visit, unless otherwise directed by the classification. 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 category terms 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. A status code should not be used when the aftercare code indicates the type of status, such as using Z43.0, Encounter for attention to tracheostomy, with Z93.0, Tracheostomy status.

The aftercare codes are generally found in the following 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 imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes, or injury codes with a 7th character for subsequent encounter, that explain ongoing 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**s**/categories:

Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z09	Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Codes Z08, Encounter for follow-up examination after completed treatment for malignant neoplasm, and Z09, Encounter for follow up examination after completed treatment for conditions other than malignant neoplasm, may be assigned following any type of completed treatment modality (including both medical and surgical treatments).

Z39	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 tissue. These codes are for individuals donating for others, as well as 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.

The counseling Z codes/categories:

Z30.0-	Encounter for general counseling and advice on contraception
Z31.5	Encounter for procreative genetic counseling
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

Note: Code Z71.84, Encounter for health counseling related to travel, is to be used for health risk and safety counseling for future travel purposes.

Code Z71.85, Encounter for immunization safety counseling, is to be used for counseling of the patient or caregiver regarding the safety of a vaccine. This code should not be used for the provision of general information regarding risks and potential side effects during routine encounters for the administration of vaccines.

Code Z71.87, Encounter for pediatric-to-adult transition counseling, should be assigned when pediatric-to-adult transition counseling is the sole reason for the encounter or when this counseling is provided in addition to other services, such as treatment of a chronic condition. If both transition counseling and treatment of a medical condition are provided during the same encounter, the code(s) for the medical condition(s) treated and code Z71.87 should be assigned, with sequencing depending on the circumstances of the encounter.

Z76.81 Expectant mother prebirth pediatrician visit

11) Encounters for Obstetrical and Reproductive Services

See Section I.C.15. Pregnancy, Childbirth, and the Puerperium, for further instruction on the use of these codes.

Z codes for pregnancy are for use in those circumstances when none of the problems or complications included in the codes from the Obstetrics chapter exist (a routine prenatal visit or postpartum care). Codes in category Z34, Encounter for supervision of normal pregnancy, are always first listed and are not to be used with any other code from the OB chapter.

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 O00-O08), elective termination of pregnancy (code Z33.2), 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.

Codes in category Z37 should not be used on the newborn record.

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 supervision of normal pregnancy
Z36	Encounter for antenatal screening of mother
Z3A	Weeks of gestation
Z37	Outcome of delivery
Z39	Encounter for maternal postpartum care and examination
Z76.81	Expectant mother prebirth pediatrician visit

12) 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 Z codes are for use only in those situations when a patient is being cleared 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 other special examination without complaint, suspected or reported diagnosis
Z02 Encounter for administrative examination
Except: Z02.9, Encounter for administrative examinations, unspecified
Z32.0- Encounter for pregnancy test

13) 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. Some 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 subcategory Z40.0, Encounter for prophylactic surgery for risk factors related to malignant neoplasms, or subcategory Z40.8, Encounter for other prophylactic surgery. If applicable, assign additional code(s) to identify any 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 metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory Z40.0, Encounter for prophylactic surgery for risk factors related to malignant neoplasms. A Z40.0 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/subcategories/categories:
Z28 Immunization not carried out
Except: Z28.3-, Underimmunization status
Z29 Encounter for other prophylactic measures
Z40 Encounter for prophylactic surgery
Z41 Encounter for procedures for purposes other than remedying health state
Except: Z41.9, Encounter for procedure for purposes other than remedying health state, unspecified
Z53 Persons encountering health services for specific procedures and treatment, not carried out
Z72 Problems related to lifestyle
Note: These codes should be assigned only when the documentation specifies that the patient has an associated problem
Z73 Problems related to life management difficulty

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

Z74 Problems related to care provider dependency
Except: Z74.01, Bed confinement status

Z75 Problems related to medical facilities and other health care

Z76.0 Encounter for issue of repeat prescription

Z76.3 Healthy person accompanying sick person

Z76.4 Other boarder to healthcare facility

Z76.5 Malingerer [conscious simulation]

Z91.1- Patient's noncompliance with medical treatment and regimen

Z91.A- Caregiver's noncompliance with patient's medical treatment and regimen

Z91.B Personal risk factor of exposure to diethylstilbestrol
Note: This code is assigned to show the patient was directly exposed to DES in utero (e.g., when the patient's mother was exposed to DES while the patient was in utero).

Z91.83 Wandering in diseases classified elsewhere

Z91.84- Oral health risk factors

Z91.89 Other specified personal risk factors, not elsewhere classified

See Section I.B.14. for Z55-Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances, documentation by clinicians other than the patient's provider

14) 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.

Nonspecific Z codes/categories:

Z02.9 Encounter for administrative examinations, unspecified

Z04.9 Encounter for examination and observation for unspecified reason

Z13.9 Encounter for screening, unspecified

Z41.9 Encounter for procedure for purposes other than remedying health state, unspecified

Z52.9 Donor of unspecified organ or tissue

Z86.59 Personal history of other mental and behavioral disorders

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

Z92.0 Personal history of contraception

15) Z Codes That May Only be Principal/First-Listed Diagnosis

The following Z codes/subcategories/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 Except: Z00.6
Z01	Encounter for other special examination without complaint, suspected or reported diagnosis
Z02	Encounter for administrative examination
Z04	Encounter for examination and observation for other reasons
Z33.2	Encounter for elective termination of pregnancy
Z31.81	Encounter for male factor infertility in female patient
Z31.83	Encounter for assisted reproductive fertility procedure cycle
Z31.84	Encounter for fertility preservation procedure
Z34	Encounter for supervision of normal pregnancy
Z39	Encounter for maternal postpartum care and examination
Z38	Liveborn infants according to place of birth and type of delivery
Z40	Encounter for prophylactic surgery
Z42	Encounter for plastic and reconstructive surgery following medical procedure or healed injury
Z51.0	Encounter for antineoplastic radiation therapy
Z51.1-	Encounter for antineoplastic chemotherapy and immunotherapy
Z52	Donors of organs and tissues Except: Z52.9, Donor of unspecified organ or tissue
Z76.1	Encounter for health supervision and care of foundling
Z76.2	Encounter for health supervision and care of other healthy infant and child
Z99.12	Encounter for respirator [ventilator] dependence during power failure

16) Newborns and Infants

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

Newborn Z codes/subcategories/categories:

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

17) Social Determinants of Health

Social determinants of health (SDOH) codes describing social problems, conditions, or risk factors that influence a patient's health should be assigned when this information is documented in the patient's medical

record. Assign as many SDOH codes as are necessary to describe all of the social problems, conditions, or risk factors documented during the current episode of care. For example, a patient who lives alone may suffer an acute injury temporarily impacting their ability to perform routine activities of daily living. When documented as such, this would support assignment of code Z60.2, Problems related to living alone. However, merely living alone, without documentation of a risk or unmet need for assistance at home, would not support assignment of code Z60.2. Documentation by a clinician (or patient-reported information that is signed off by a clinician) that the patient expressed concerns with access and availability of food would support assignment of code Z59.41, Food insecurity. Similarly, medical record documentation indicating the patient is experiencing homelessness would support assignment of a code from subcategory Z59.0-, Homelessness.

For social determinants of health classified to chapter 21, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses. For example, coding professionals may utilize documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record.

Patient self-reported documentation may be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the medical record by either a clinician or provider.

Social determinants of health codes are located primarily in these Z code categories:

Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

See Section I.B.14. Documentation by Clinicians Other than the Patient's Provider.

22. Chapter 22: Codes for Special Purposes (U00-U85)

U07.0	Vaping-related disorder (see Section I.C.10.e., Vaping-related disorders)
U07.1	COVID-19 (see Section I.C.1.g.1., COVID-19 infection)
U09.9	Post COVID-19 condition, unspecified (see Section I.C.1.g.1.m.)

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 Alphabetic 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 characteristically associated with 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 the unusual instance 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 those 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

GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2014

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 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,” “compatible with,” “consistent with,” or 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 or observation, 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 for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.

2. Admission Following Post-Operative Observation

When a patient is admitted to an observation unit 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 "that

condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

J. Admission from Outpatient Surgery

When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, 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, assign the reason for the outpatient surgery 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 service is being performed. For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.

If the condition for which the rehabilitation service is being provided is no longer present, report the appropriate aftercare code as the first-listed or principal diagnosis, unless the rehabilitation service is being provided following an injury. For rehabilitation services following active treatment of an injury, assign the injury code with the appropriate seventh character for subsequent encounter as the first-listed or principal diagnosis. For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis. If the patient requires rehabilitation post hip replacement for right intertrochanteric femur fracture, report code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, as the first-listed or principal diagnosis.

See Section I.C.21.c.7., Factors influencing health states and contact with health services, Aftercare.

See Section I.C.19.a., for additional information about the use of 7th characters for injury codes.

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

For reporting purposes, the definition for “other diagnoses” is interpreted as additional clinically significant conditions that affect patient care in terms of requiring:

clinical evaluation; or
therapeutic treatment; or

diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring.

The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded." UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting. The UHDDS definitions are used by acute care short-term 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).

The following guidelines are to be applied in designating "other diagnoses" when neither the Alphabetic Index nor the Tabular List in ICD-10-CM provide direction. The listing of the diagnoses in the patient record is the responsibility of the 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 admissions that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.

However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

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 provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.

C. 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," "compatible with," "consistent with," or 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 or observation, 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.

Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/ providers in coding and reporting hospital-based outpatient services and provider-based office visits. Guidelines in Section I, Conventions, general coding guidelines and chapter-specific guidelines, should also be applied for outpatient services and office visits.

Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-10-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under "Conventions Used in the Tabular List." Section I.B. contains general guidelines that apply to the entire classification. Section I.C. contains chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Information about the correct sequence to use in finding a code is also described in Section I.

The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other.

Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis does not apply to hospital-based outpatient services and provider-based office visits.

Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.

A. Selection of first-listed condition

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.

In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

1. Outpatient Surgery

When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

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 A00.0 through T88.9, Z00-Z99, U00-U85

The appropriate code(s) from A00.0 through T88.9, Z00-Z99 and U00-U85 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 R00-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 (Z00-Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.
See Section I.C.21. 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.

3. Highest level of specificity

Code to the highest level of specificity when supported by the medical record documentation.

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 provider.

H. Uncertain diagnosis

Do not code diagnoses documented as "probable", "suspected," "questionable," "rule out," "compatible with," "consistent with," 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.

I. 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).

J. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit and that require or affect patient care, treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

K. Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the Z code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es)

documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

L. Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

M. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, sequence first a code from subcategory Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

N. Ambulatory surgery

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

O. Routine outpatient prenatal visits

See Section I.C.15. Routine outpatient prenatal visits.

P. Encounters for general medical examinations with abnormal findings

The subcategories for encounters for general medical examinations, Z00.0- and encounter for routine child health examination, Z00.12-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first-listed diagnosis. An examination with abnormal findings refers to a condition/diagnosis that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physical examination. A secondary code for the abnormal finding should also be coded.

Q. Encounters for routine health screenings

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

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 diagnosis 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 **reporting** of a POA indicator **(https://www.cdc.gov/nchs/icd/icd-10-cm/files.html)**. The codes and categories on this exempt list are for circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or that describe conditions that 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.

A POA indicator is assigned to the 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 UHDDS 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)

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 was present on admission
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 **the POA indicator** 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 provider 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.

Chronic condition with acute exacerbation during the admission

If a single code identifies both the chronic condition and the acute exacerbation, see 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".

Conditions documented as impending or threatened at the time of discharge

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were present on admission, assign "Y".

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were not present on admission, assign "N".

Acute and Chronic Conditions

Assign "Y" for acute conditions that are present at time of admission and N for acute conditions that are not present at time of admission.

Assign "Y" for chronic conditions, even though the condition may not be diagnosed until after admission.

If a single code identifies both an acute and chronic condition, see the POA guidelines for codes that contain multiple clinical concepts.

Codes That Contain Multiple Clinical Concepts

Assign "N" if at least one of the clinical concepts included in the code was not 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" if all of the clinical concepts included in the code were present on admission (e.g., duodenal ulcer that perforates prior to admission).

For infection codes that include the causal organism, assign "Y" if the infection (or signs of the infection) were present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with

pneumonia and the provider documents Pseudomonas as the causal organism a few days later).

Same Diagnosis Code for Two or More Conditions

When the same ICD-10-CM diagnosis code applies to two or more conditions during the same encounter (e.g., two separate conditions classified to the same ICD-10-CM diagnosis code):
Assign "Y" if all conditions represented by the single ICD-10-CM code were present on admission (e.g., bilateral unspecified age-related cataracts).

Assign "N" if any of the conditions represented by the single ICD-10-CM code was not present on admission (e.g. traumatic secondary and recurrent hemorrhage and seroma is assigned to a single code T79.2, but only one of the conditions was present on admission).

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 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)

Perinatal conditions

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).

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.

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).