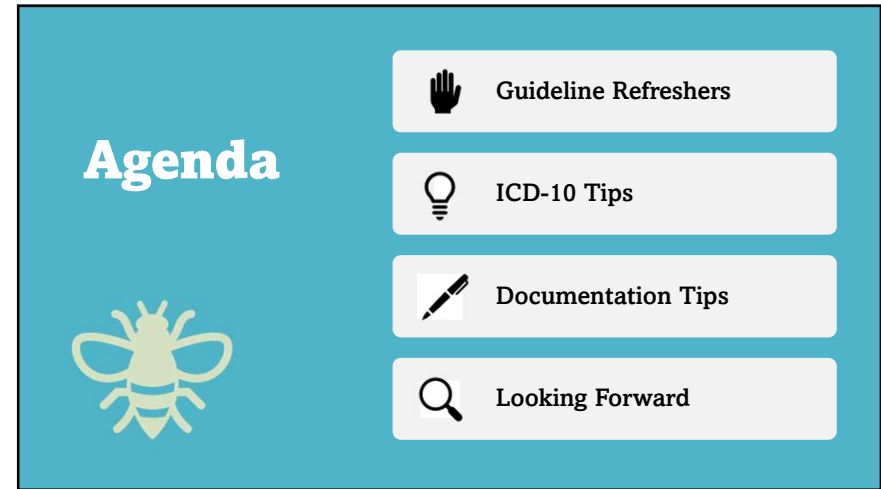
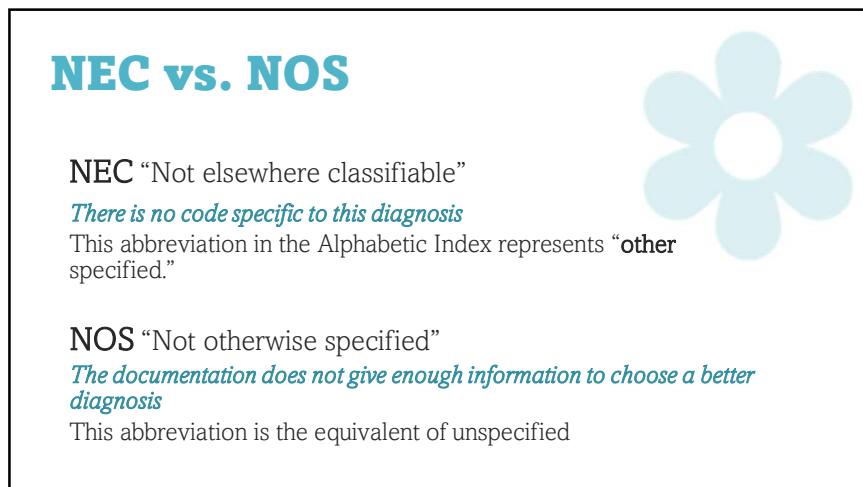


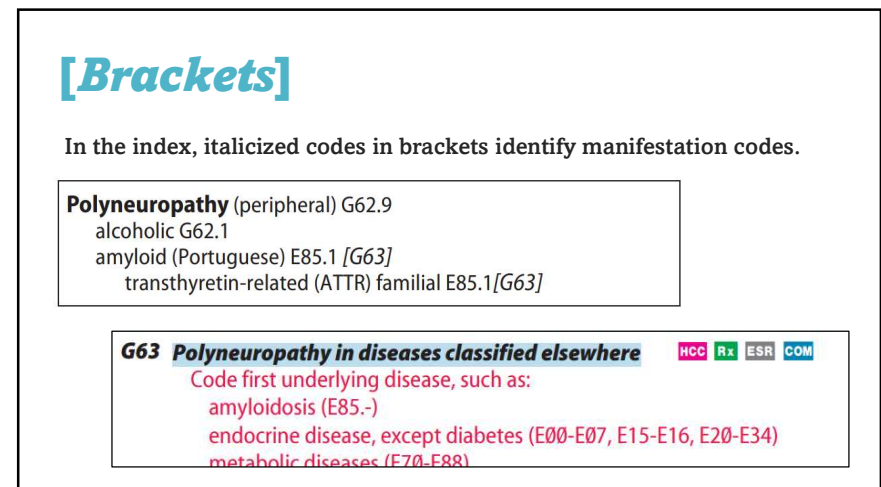
1



2



3



4

Manifestation Vs. Sequela

A **manifestation** is a *secondary condition* that is an extension of the primary illness.

Example: diabetes with diabetic polyneuropathy. The neuropathy is a manifestation. It would not have happened if the diabetes were not there.

In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere."

E11.42 Type 2 diabetes mellitus with diabetic **polyneuropathy**

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.

Unless there is a combination code, coding may require two codes sequenced in the following order:

1. the condition or nature of the sequela
2. the sequela code is sequenced second.

M24.521 Contracture, **right elbow**

T22.321 Burn of third degree of **right elbow**

I69.392 **Facial weakness** following cerebral infarction

5

Manifestation Codes

- Do not report a manifestation code as the only diagnosis.
- Do not report a manifestation code as a first-listed or principal diagnosis.
- Code the underlying disease first.
- A "code first underlying disease" instructional note will appear with the underlying disease codes identified.

✓4th F02 Dementia in other diseases classified elsewhere

INCLUDES major neurocognitive disorder in other diseases classified elsewhere

Code first the underlying physiological condition, such as:

Alzheimer's (G30.-)
cerebral lipidosis (E75.4)
Creutzfeldt-Jakob disease (A81.0-)
dementia with Lewy bodies (G31.83)
dementia with Parkinsonism (G31.83)

F02.811 Dementia in other diseases classified elsewhere, unspecified severity, **with agitation**

6

(Parentheses)



Parentheses in the indexes enclose nonessential modifiers, supplementary words that may be present or absent in the statement of a disease without affecting the code.

Diarrhea, diarrheal (disease) (infantile) (inflammatory)
R19.7

R19.7 Diarrhea, unspecified

Diarrhea NOS

EXCLUDES 1 functional diarrhea (K59.1)
neonatal diarrhea (P78.3)
psychogenic diarrhea (F45.8)

7

"And"



The word "and" should be interpreted to mean either "and" or "or" when it appears in a title

✓5th S00.1 Contusion of **eyelid and periorcular area**

Black eye

EXCLUDES 2 contusion of eyeball and orbital tissues (S05.1-)

✓x7th S00.10 Contusion of unspecified eyelid and periorcular area



✓6th S67.4 Crushing injury of **wrist and hand**

EXCLUDES 1 crushing injury of hand alone (S67.2-)
crushing injury of wrist alone (S67.3-)
EXCLUDES 2 crushing injury of fingers (S67.1-)
crushing injury of thumb (S67.0-)

✓x7th S67.40 Crushing injury of unspecified wrist and hand

8

“With”



The word “with” or “in” should be interpreted to mean “associated with” or “due to.”

The classification **presumes a causal relationship between the two conditions linked by these terms in the 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.

Diabetes, diabetic (mellitus) (sugar) E11.9
with
amyotrophy E11.44
~~arthropathy NEC E11.618~~
autonomic (poly)neuropathy E11.43
cataract E11.36
Charcot's joints E11.610
chronic kidney disease E11.22
~~circulatory complication NEC E11.59~~
coma due to
 hyperosmolarity E11.01
 hypoglycemia E11.641
 ketoacidosis E11.11
~~complication E11.8~~
~~specified NEC E11.69~~
dermatitis E11.620
foot ulcer E11.621
gangrene E11.52
gastroparalysis E11.43
gastroparesis E11.43

9

EXCLUDES 1



An Excludes 1 note means **“NOT CODED HERE!”**

An Excludes 1 note indicates mutually exclusive codes: two conditions that cannot be reported together.

An Excludes 1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

10

EXCLUDES 2



An Excludes 2 note means **“NOT INCLUDED HERE.”**

An Excludes 2 note indicates that although the excluded condition is not part of the condition it is excluded from, a patient may have both conditions at the same time.

Therefore, when an Excludes 2 note appears under a code, it may be acceptable to use both the code and the excluded code together if supported by the medical documentation.

WRONG WAY

11

✓4th J20 Acute bronchitis



EXCLUDES 1 bronchitis NOS (J40)

tracheobronchitis NOS (J40)

EXCLUDES 2 acute bronchitis with bronchiectasis (J47.0)

acute bronchitis with chronic obstructive asthma (J44.0)

acute bronchitis with chronic obstructive pulmonary disease (J44.0)

allergic bronchitis NOS (J45.909-)

bronchitis due to chemicals, fumes and vapors (J68.0)

chronic bronchitis NOS (J42)

chronic mucopurulent bronchitis (J41.1)

chronic obstructive bronchitis (J44.-)

chronic obstructive tracheobronchitis (J44.-)

chronic simple bronchitis (J41.0)

chronic tracheobronchitis (J42)

12

Chapter 2: Neoplasms

I.C.2.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.

I.C.2.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.

13

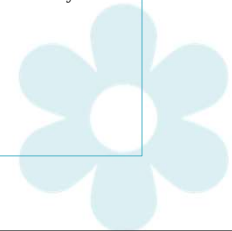
Adjuvant vs. Prophylactic

Adjuvant (additional)

Adjuvant therapy targets cancer cells that primary cancer treatment didn't destroy. Having adjuvant therapy means more time spent in cancer treatment but reduces the chance you'll have the same cancer again. Adjuvant therapy is often used as follow-up treatment for breast, colon and lung cancers.

Prophylaxis/tic (preventive)

In medicine, something that prevents or protects.
I.e., prophylactic mastectomy



14

Internal Guidance?

Sample:

In summary, we interpret the ICD-10 rule to use a malignant neoplasm code when the patient has evidence of the disease or is still receiving **treatment** for the cancer.

In some scenarios where a patient is receiving adjuvant therapy/treatment, we consider this ongoing "**treatment** directed at the site" and support the use of an active cancer diagnosis over a code reflecting a personal history.

This may include scenarios where the cancer may not be detectable due to effectiveness of the adjuvant therapy/treatment.

The medical record should be clear that there is ongoing therapeutic treatment/therapy for the cancer. An example of a statement to support this might be:

"This patient is receiving ongoing anti-estrogen therapy for her breast cancer. A significant portion of this visit was spent assessing the efficacy of this therapy as well as management of toxicity of this treatment."

15

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

Diabetes:

? What do you do when the type of diabetes is not documented? Default to Type II

Z79.4, *Long term* (current) use of **insulin**

Z79.84, *Long term* (current) use of **oral hypoglycemic** drugs

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

16

Diabetic Manifestation (2 codes)

E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy HCC Rx ESR COM Q

Type 2 diabetes mellitus with diabetic gastroparesis

K31.84 Gastroparesis

Gastroparalysis

Code first underlying disease, if known, such as:

anorexia nervosa (F50.0-)

diabetes mellitus (E08.43, E09.43, E10.43, E11.43)

17

Diabetic Manifestation (2 codes)

G63 Polyneuropathy in diseases classified elsewhere HCC Rx ESR COM

→ Code first underlying disease, such as:

amyloidosis (E85.-)

endocrine disease, except diabetes (E00-E07, E15-E16, E20-E34)

metabolic diseases (E70-E88)

neoplasm (C00-D49)

nutritional deficiency (E40-E64)

EXCLUDES 1 polyneuropathy (in):

diabetes mellitus (E08-E13 with .42)

18

Diabetic Manifestation (combo code)

E10.52 Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene HCC Rx ESR COM Q

Type 1 diabetes mellitus with diabetic gangrene

19

Chapter 5: Mental, Behavioral, and Neurodevelopment disorders F01-F99

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, unless otherwise instructed by the classification.**

✓40 **F17 Nicotine dependence**

EXCLUDES 1 history of tobacco dependence (Z87.891)
tobacco use NOS (Z72.0)

F17.201 Nicotine dependence, unspecified, in remission

Z87.891 Personal history of nicotine dependence



20

AHA Coding Clinic 2017,2Q,27

History of Nicotine Dependence versus Drug Dependence in Remission

Question: In the ICD-10-CM Index to Diseases, history of drug dependence has a note to "see Dependence, drug, by type, in remission." However, history of tobacco/nicotine dependence is indexed to code Z87.891. Personal history of nicotine dependence. The instructions to code history of drug dependence as remission, and history of tobacco dependence as history, appear to be inconsistent and seem to conflict with the guideline to assign a code for remission when documented by the provider. **When do you report drug remission versus drug history?**

Answer: Codes for drug dependence with remission and history of nicotine dependence are assigned based on how the condition is indexed in the classification. For example, if the provider documents history of cocaine dependence, assign code F14.21. Cocaine dependence, in remission. Assign code Z87.891. Personal history of nicotine dependence, for history of tobacco dependence. The ICD-10-CM classifies a history of nicotine dependence differently than other types of drug dependence, and there is a unique code for "history of nicotine dependence." This is an exception, to drug dependence, as history of drug dependence is classified by "type of drug, in remission."

Question: The Index entries for history of drug and nicotine dependence appear to be inconsistent. **Should history of nicotine dependence be coded as a personal history of nicotine dependence or as nicotine dependence in remission?** What about history of dependence on other types of drugs, such as cocaine dependence?

Answer: As directed by the Index, **history of nicotine dependence should be coded as a personal history (Z87.891)**, and history of dependence on other types of drugs, such as cocaine, should be coded as drug dependence in remission. **The codes for nicotine dependence in remission should only be assigned when "in remission" is specifically documented by the provider.**

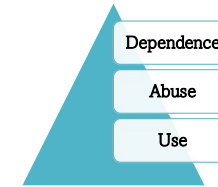
The Index entries are not inconsistent, but rather, they reflect clinical differences between dependence on nicotine versus other types of drugs. The ICD-10-CM Official Guidelines for Coding and Reporting will be revised to state that codes for drug dependence "in remission" should be assigned when instructed by the classification (as well as when the provider specifically documents "in remission").

21

Use/Abuse/Dependence

ICD-10 guidelines also provide a hierarchy for coding Use/Abuse/Dependence:

- 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



22

2023: New Dementia Codes



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, 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

What's causing it? Alzheimer's
Are there behavioral disturbances? Agitation
What is the severity? Mild

F02 Dementia in other diseases classified elsewhere
INCLUDES major neurocognitive disorder in other diseases classified elsewhere
Code first the underlying physiological condition, such as:
Alzheimer's (G30.-)
cerebral ischemia (I67.-)

G30.9 Alzheimer's disease, unspecified

F02.A11 Dementia in other diseases classified elsewhere, mild, with agitation

23

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

I10 Essential (primary) hypertension

Rx U

INCLUDES high blood pressure
hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)

EXCLUDES 1 hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O16)

EXCLUDES 2 essential (primary) hypertension involving vessels of brain (I60-I69)
essential (primary) hypertension involving vessels of eye (H35.0-)

24

Hypertension with...

Assume the connection!

I11

- **Hypertension with Heart Disease**
- Hypertension with heart conditions classified to I50.- or I51.4-I51.7, I51.89, I51.9, are assigned to a code from category I11, Hypertensive heart disease.

I12


- **Hypertension and 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.

I13

- **Hypertension, heart disease and chronic kidney disease**
- If a patient has hypertension, heart disease and chronic kidney disease, then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12

25

I15: Secondary Hypertension

 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 encounter.

Renovascular hypertension due to renal artery atherosclerosis

I15 Secondary hypertension
 Code also underlying condition
EXCLUDES1 postprocedural hypertension (I97.3)
EXCLUDES2 secondary hypertension involving vessels of brain (I60-I69)
 secondary hypertension involving vessels of eye (H35.0-)

I15.0 Renovascular hypertension

I70.1 Atherosclerosis of renal artery

26

Myocardial Infarction (MI)

ACUTE

MIs are considered acute for 4 weeks/28 days

Through day 28, use the appropriate acute MI code such as:

- I21.01 ST elevation (STEMI) myocardial infarction involving left main coronary artery
- I21.4 Non-ST elevation (NSTEMI) myocardial infarction

HISTORY

After 4 weeks:

Z51.89 Other specified aftercare if the patient still requiring active care after the 4-week period (symptomatic)

I25.2 Old MI if the patient is considered healed (asymptomatic)

There is no time limit on the use of I25.2

27

CVA

Acute CVA codes should be used for inpatient setting only



In the clinic setting:

- Use **Z86.73**, Personal history of TIA or CVA without residual deficits if the patient is asymptomatic
- Code from **I69.3x** – Sequela of cerebral infarction, if the patient is symptomatic (has a late effect) such as:
 - I69.321 Dysphasia following cerebral infarction (non-HCC)
 - I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (HCC)

Generic terms such as “CVA” or “stroke” without additional clarification should be avoided. These terms will code to I63.9, Cerebral infarction, unspecified, which is an active (HCC) code.

28

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

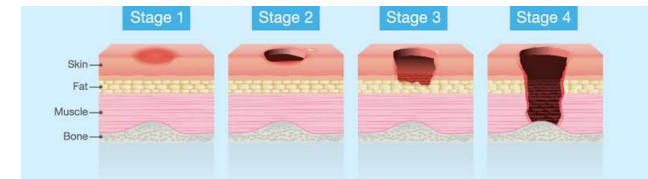
Pressure Ulcers

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

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).

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Pressure Ulcers



TIP: The stage of a diagnosed pressure ulcer can be based on documentation from clinicians who are not the patient's provider.

30

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

🖐️ Site and laterality

Most of the codes within Chapter 13 have site and laterality designations.

The site represents the bone, joint or the muscle involved.

For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a "multiple sites" code available.

For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

31

Chapter 18: Symptoms, signs, and abnormal clinical and laboratory findings, NEC (R00-R99)

🖐️ Chapter 18 includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which **no diagnosis classifiable elsewhere is recorded**.


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

Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis



32

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

 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.

- 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.

33

7th Characters

A

• **Initial** encounter: As long as patient is receiving **active** treatment for the condition.
Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

D

• **Subsequent** encounter: *After* patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.

S

• **Sequela:** Complications or conditions that arise as a direct result of a condition (e.g., scar formation after a burn). *Note: For aftercare of injury, assign acute injury code with 7th character for subsequent encounter*

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Table of Drugs & Chemicals

Substance	Poisoning, Accidental (unintentional)	Poisoning, Intentional Self-harm	Poisoning, Assault	Poisoning, Undetermined	Adverse Effect	Under-dosing
Antiepilepsy agent — continued specified, NEC	T42.6X1	T42.6X2	T42.6X3	T42.6X4	T42.6X5	T42.6X6
Antiestrogen NEC	T38.6X1	T38.6X2	T38.6X3	T38.6X4	T38.6X5	T38.6X6
Antifertility pill	T38.4X1	T38.4X2	T38.4X3	T38.4X4	T38.4X5	T38.4X6
Antifibrinolytic drug	T45.621	T45.622	T45.623	T45.624	T45.625	T45.626
Antifilarial drug	T37.4X1	T37.4X2	T37.4X3	T37.4X4	T37.4X5	T37.4X6
Antiflatulent	T47.5X1	T47.5X2	T47.5X3	T47.5X4	T47.5X5	T47.5X6
Antifreeze	T65.91	T65.92	T65.93	T65.94	—	—

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Table of Drugs & Chemicals

Poisoning

- Improper use
- Sequencing:
1.T-code
2.Symptoms

Adverse Effect

- Correctly prescribed/taken
- Sequencing:
1.Symptoms
2.T-code

Underdosing

- Taking less than prescribed or discontinuing use
- Use T-code, but not as primary diagnosis

Unacceptable Principal Diagnosis

36

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)

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.

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ICD-10-CM 2023
Chapter 20. External Causes of Morbidity

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

NOTE This chapter permits the classification of environmental events and circumstances as the cause of injury, and other adverse effects. Where a code from this section is applicable, it is intended that it shall be used secondary to a code from another chapter of the Classification indicating the nature of the condition. Most often, the condition will be classifiable to Chapter 19, injury, poisoning and certain other consequences of external causes (S00-T88). Other conditions that may be stated to be due to external causes are classified in Chapters 1 to XVIII. For these conditions, codes from Chapter 20 should be used to provide additional information as to the cause of the condition.

AHA: 2018.4Q.58-60

This chapter contains the following blocks:

- V00-X58 Accidents
- V00-Y99 Transport accidents
- V08-V09 Pedestrian injured in transport accident
- V18-V19 Pedal cycle rider injured in transport accident
- V20-V29 Motorcycle rider injured in transport accident
- V30-V39 Occupant of three-wheeled motor vehicle injured in transport accident
- V40-V49 Car occupant injured in transport accident
- V50-V59 Occupant of pick-up truck or van injured in transport accident
- V60-V69 Occupant of heavy transport vehicle injured in transport accident
- V70-V79 Bus occupant injured in transport accident
- V80-V89 Other land transport accidents
- V90-V94 Water transport accidents
- V95-V97 Air and space transport accidents
- V98-V99 Other and unspecified transport accidents
- W00-X58 Other external causes of accidental injury
- W00-W19 Shipping, tripping, stumbling and falls
- W20-W49 Exposure to inanimate mechanical forces

(b) A public highway (trafficway) or street is the entire width between property lines (or other boundary lines) of land open to the public, as a matter of right or custom for purposes of moving persons or property from one place to another. A roadway is that part of the public highway designed, improved and customarily used for vehicular traffic.

(c) A traffic accident is any vehicle accident occurring on the public highway (i.e., originating on, terminating on, or involving a vehicle partially on the highway). A vehicle accident is assumed to have occurred on the public highway unless another place is specified, except in the case of accidents involving only off-road motor vehicles, which are classified as nontraffic accidents unless the contrary is stated.

(d) A nontraffic accident is any vehicle accident that occurs entirely in any place other than a public highway.

(e) A pedestrian is any person involved in an accident who was not at the time of the accident riding in or on a motor vehicle, railway train, streetcar or animal-drawn or other vehicle, or on a pedal cycle or animal. This includes, a person changing a tire, working on a parked car, or a person on foot. It also includes the user of a pedestrian conveyance such as a baby stroller, ice-skates, skis, sled, roller skates, a skateboard, nonmotorized or motorized wheelchair, motorized mobility scooter, or nonmotorized scooter.

(f) A driver is an occupant of a transport vehicle who is operating or intending to operate it.

(g) A passenger is any occupant of a transport vehicle other than the driver, except a person traveling on the outside of the vehicle.

(h) A person on the outside of a vehicle is any person being transported by a vehicle but not occupying the space normally reserved for the driver or passengers, or the space intended

Chapter 20. External Causes of Morbidity

38

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

Z-Codes indicate a reason for an encounter or provide additional information about a patient encounter.

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.

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Z - Codes



Z codes (other reasons for healthcare encounters) may be assigned as appropriate, to further explain the reasons for presenting for healthcare services... or to provide additional information relevant to a patient encounter.



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

40

Social Determinants of Health




These codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor. For example, not every individual living alone would be assigned code Z60.2, Problems related to living alone.

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.

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Social Determinants of Health

- 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
- 

42

? Trivia Time

If the ICD-10 code **X98.1XXA** is listed in your record, what type of assault did you suffer?

- A. Hot tap water
- B. Food as a projectile
- C. Strike by hockey stick
- D. Venomous toad bite



43

? Documentation Issues & other ICD- Questions

44

Clinical vs. Coding 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.



45

“History of”



“Patient is a 67-year-old male with a personal history of hypertension, type II diabetes with CKD, prostate cancer and low back pain...”

46

Non- Clinician Documentation

There are a few exceptions when code assignment may be based on medical record documentation from clinicians who are not the patient's provider

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)
- Laterality
- Blood alcohol level
- **Underimmunization status (new for 2023)**



•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.

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Combination Codes

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

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.

Examples:

- I25.110 Atherosclerotic heart disease of native coronary artery **with** unstable angina
- E11.311 Type 2 DM **with** unspecified diabetic retinopathy w/ macular edema
- K71.51 Toxic liver disease **with** chronic active hepatitis with ascites

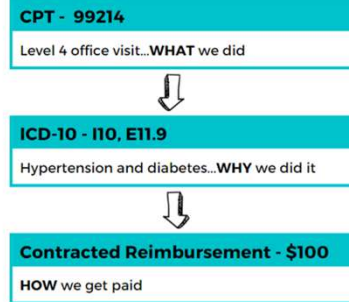


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Why ICD-10 Matters

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Medical Necessity



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What is Value Based Healthcare?

Payers: Value based **payment** is made up of different models that incentivizes a focus on quality over quantity by providing incentives to providers

Providers: Value based **care** is changing the way we give care and get reimbursed. High performing providers can see increases in revenue.



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Coding & Claims in a Value Based World

Accurate & Specific Coding leads to:
Good, reliable data to plan for


- Care programs needed
- Resources needed
- Prediction of costs & reimbursement



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Coding vs. Contracting

**"BUT I AM JUST A CODER."
"BUT WE GET PAID BY THE CPT CODE."
"BUT I HAVE NOTHING TO DO WITH CONTRACTS."**



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RAF Scores

Demographics

+

Disease

=

RAF Score

- RAF scores are used by payers to help predict costs and determine future payments.
- A patient with limited health conditions could be expected to have lower medical costs for a given time. However, a patient with multiple chronic conditions would be expected to have higher health care utilization and costs.
- Correct documentation and coding is key to ensure accurate RAF scores and payments.

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HCC	DESCRIPTION	HIERARCHIES	RAF (v24)
1	HIV/AIDS	N/A	0.335
2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	N/A	0.352
6	Opportunistic Infections	N/A	0.424
8	Metastatic Cancer and Acute Leukemia	9,10,11,12	2.659
9	Lung and Other Severe Cancers	10,11,12	1.024
10	Lymphoma and Other Cancers	11,12	0.675
11	Colorectal, Bladder, and Other Cancers	12	0.307
12	Breast, Prostate, and Other Cancers and Tumors	N/A	0.150
17	Diabetes with Acute Complications	18,19	0.302
18	Diabetes with Chronic Complications	19	0.302
19	Diabetes without Complication	N/A	0.105
21	Protein-Calorie Malnutrition	N/A	0.455
22	Morbid Obesity	N/A	0.250

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The Tale of Two Charts

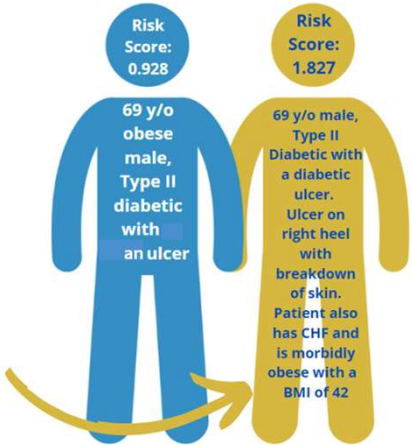
Risk Score: 0.928

69 y/o obese male, Type II diabetic with an ulcer

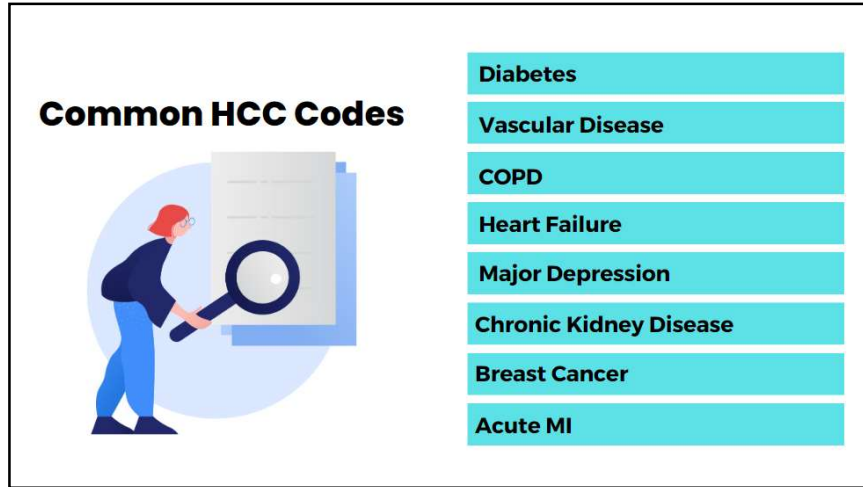
Risk Score: 1.827

69 y/o male, Type II Diabetic with a diabetic ulcer. Ulcer on right heel with breakdown of skin. Patient also has CHF and is morbidly obese with a BMI of 42

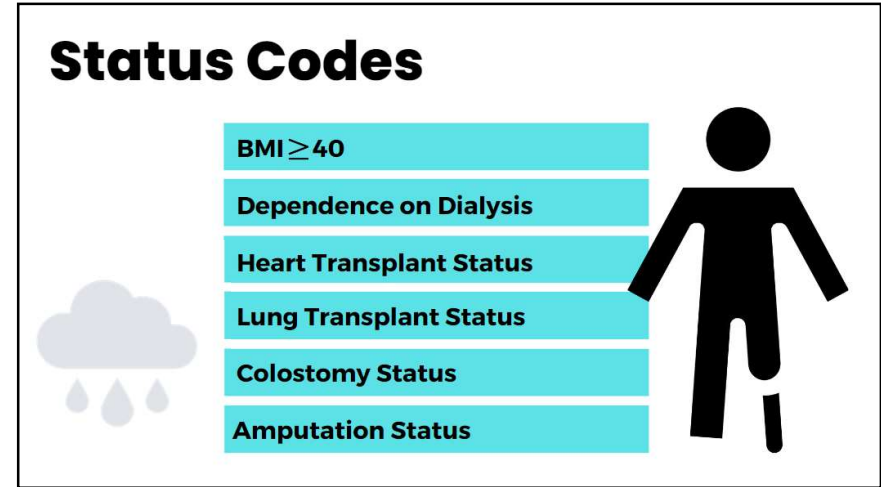
The difference is in the details



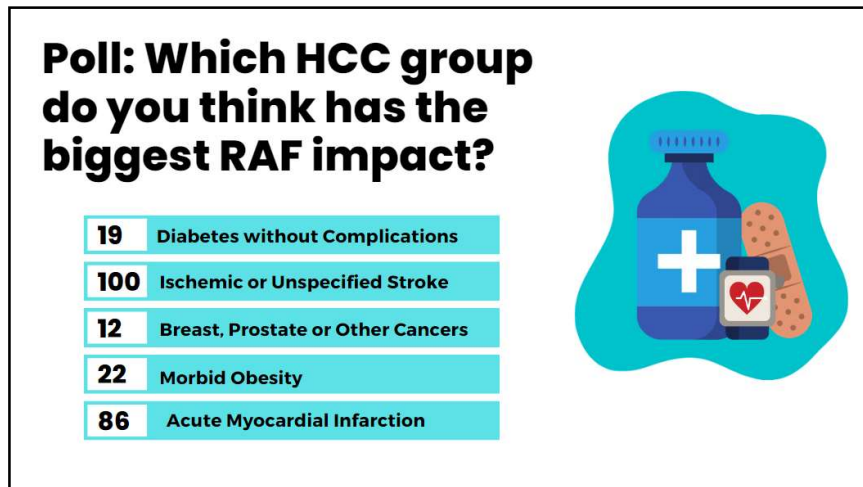
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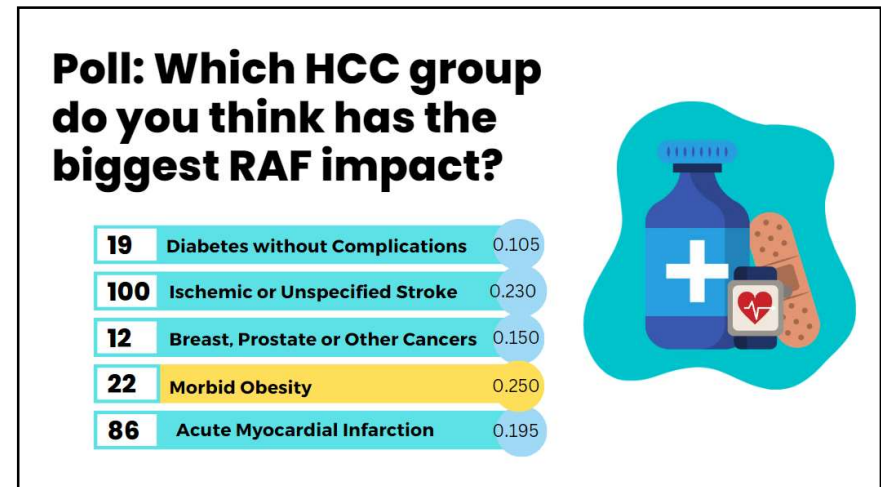
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HCC Tip



HCC 22 - MORBID OBESITY

Morbid Obesity can and should be captured when:

- Adult BMI is ≥ 40 or
- Adult BMI ≥ 35 and with at least one clinically significant and related co-morbidity (i.e., diabetes, hypertension, sleep apnea, etc.)

BMI

Z68.41- 40.0-44.9
 Z68.42- 45.0-49.9
 Z68.43- 50.0-59.9
 Z68.44- 60.0-69.9
 Z68.45- 70.0+

Morbid Obesity
 E66.01 - Morbid (severe) obesity due to excess calories
 E66.2 - Morbid (severe) obesity with alveolar hypoventilation

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HCC Tip: Compliance




Figure: Analysis of High-Risk Groups

Condition	Not Supported	Supported
Acute Stroke	30	0
Acute Heart Attack	28	2
Embolism	27	3
Vascular Claudication	4	26
Major Depressive Disorder	2	28
Lung Cancer	29	1
Breast Cancer	30	0
Colon Cancer	29	1

Source: <https://oig.hhs.gov/oas/reports/region5/51900039.pdf>

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Reinforce Good Documentation

Assessment and Plan

- Be specific
- Give a status
- Link disease and complications
- Code only what has **MEAT**

"Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management."

M **monitor**
signs, symptoms, ordering or reviewing and referencing of tests/labs, disease progression or disease regression.

E **evaluate**
test results, medication effectiveness, physical exam findings and response to treatment.

A **assess or address**
by discussion, acknowledging, reviewing records, documenting status/level conditions and counseling.

T **treat**
with prescribing/continuation of medications, referral to specialist for treatment/consultation, surgical/other therapeutic interventions and plan for management of condition(s).

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ICD-10 Updates

Effective April 1st, 2023

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RESOURCES

ICD-10 - CM International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) (cdc.gov)

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ICD-10- CM UPDATES 4/1/2023

- T, Y, and Z code changes
- Effective 4-1-2023

Change	Code	Description
Add:	T74A	Financial abuse, confirmed
Add:	T74A1	Adult financial abuse, confirmed
Add:	T74A1XA	Adult financial abuse, confirmed, initial encounter
Add:	T74A1XD	Adult financial abuse, confirmed, subsequent encounter
Add:	T74A1XS	Adult financial abuse, confirmed, sequela
Add:	T74A2	Child financial abuse, confirmed
Add:	T74A2XA	Child financial abuse, confirmed, initial encounter
Add:	T74A2XD	Child financial abuse, confirmed, subsequent encounter
Add:	T74A2XS	Child financial abuse, confirmed, sequela
Add:	T76A	Financial abuse, suspected
Add:	T76A1	Adult financial abuse, suspected
Add:	T76A1XA	Adult financial abuse, suspected, initial encounter
Add:	T76A1XD	Adult financial abuse, suspected, subsequent encounter
Add:	T76A1XS	Adult financial abuse, suspected, sequela
Add:	T76A2	Child financial abuse, suspected
Add:	T76A2XA	Child financial abuse, suspected, initial encounter
Add:	T76A2XD	Child financial abuse, suspected, subsequent encounter
Add:	T76A2XS	Child financial abuse, suspected, sequela
Delete:	Y0702	Husband, perpetrator of maltreatment and neglect
Add:	Y0701	Husband, perpetrator of maltreatment and neglect
Add:	Y0703	Husband, current, perpetrator of maltreatment and neglect
Add:	Y07011	Husband, former, perpetrator of maltreatment and neglect
Delete:	Y0702	Wife, perpetrator of maltreatment and neglect
Add:	Y0702	Wife, perpetrator of maltreatment and neglect
Add:	Y0703	Wife, current, perpetrator of maltreatment and neglect
Add:	Y07021	Wife, former, perpetrator of maltreatment and neglect

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Delete:	Z9114	Patient's other noncompliance with medication regimen
Add:	Z9114	Patient's other noncompliance with medication regimen
Add:	Z91141	Pt other noncompl with meds regimen due to financl hardship
Add:	Z91148	Patient's reason

Z91.13	Patient's unintentional underdosing of medication regimen
	Code first underdosing of medication (T36-T50) with fifth or sixth character 6
	EXCLUDES 1 adverse effect of prescribed drug taken as directed - code to adverse effect poisoning (overdose) - code to poisoning
	AHA: 2018,4Q,72
Z91.130	Patient's unintentional underdosing of medication regimen due to age-related debility
Z91.138	Patient's unintentional underdosing of medication regimen for other reason
Z91.14	Patient's other noncompliance with medication regimen
	Patient's underdosing of medication NOS
	AHA: 2022,1Q,36; 2018,4Q,72
Z91.15	Patient's noncompliance with renal dialysis

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Thanks for having me!

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