ICD-10

ICD-10-CM Chapters 1 to 5: Hints, tips and guidelines (Part I)

by Gloryanne Bryant, RHIA, CDIP, CCS, CCDS

We are now at a stage of ICD-10- CM (Internal Classification of Diseases, 10th revision, Clinical Modification) readiness to get into the depths of the code set chapters and learn more about the similarities to and differences or changes from ICD-9-CM. In addition, learning more about the specific chapters can help identify documentation improvement areas and where the coding or clinical documentation improvement (CDI) professionals need to be more attentive or cautious. This article will highlight some key concepts, guidelines, and documentation elements that will be focal points to success with ICD-10-CM. Note there are 117 pages in the **ICD-10-CM Official Guidelines for Coding and Reporting for 2014 and reading through them is imperative for the coding professional.**

ICD-10-CM is based on the ICD-10, the statistical classification of diseases published by the World Health Organization (WHO) that replaces ICD-9. The structure of ICD- 10-CM for diagnosis coding is a minimum of three characters for a given code all the way up to seven characters in some situations. ICD-10, as the new code set is called commonly, is made up of codes that have both alpha and numeric characters. ICD-10-CM is the diagnosis code set, which now has 21 chapters and contains some new conventions that guide code assignment. Diagnosis codes are to be used and reported at their highest number of characters available. They are composed of codes with 3, 4, 5, 6, or 7 characters.

Overall there are many sections of the official conventions and guidelines that are the same as ICD-9-CM. Within ICD-10-CM the Excludes I and Excludes II conventions are particularly interesting and important to understand. ICD-10-CM official conventions and guidelines include:

- 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.

  - *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
    .
  - 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.

- The official ICD-10-CM convention regarding the 7th character states:

  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.

- The good news is that locating a code in ICD-10-CM is similar to ICD-9-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.

In addition, many of the chapters have codes in blocks, which are groupings or clusters of codes classifying a series of codes with a particular range of diseases or conditions.

Let us take a look at **Chapter I: Certain Infectious and Parasitic Diseases (A00- B99)**. This chapter covers infectious diseases like hepatitis, human immunodeficiency virus (HIV), meningitis, and tuberculosis. In addition, you will find the sepsis codes and those for organisms (bacteria).

ICD-10-CM Official Coding Guidelines state that 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.

In California, we continue to follow specific rules regarding the reporting of positive HIV test results. According to the Office of State Health Planning and Development (OSHPD), reporting requirements for ICD- 10 HIV screening codes will be the same as the requirements for reporting ICD-9 HIV screening codes. Currently, if HIV test-result codes V08 or 795.71 are reported, they receive a warning edit flag SW05 (Principal Diagnosis field) or SW06 (Secondary Diagnosis field). The same edits will be applied if ICD-10 HIV test results Z21 and R75 are reported. Unless the facility has written consent from the patient, these codes should not be reported to OSHPD. Please note that if these HIV screening codes are not removed from the data by the facility, OSHPD will remove them during the standardization process when the data are made available to the public.

Other HIV codes: ICD-10 B20 Human immunodeficiency virus [HIV] disease: May be reported to OSHPD. Report this code according to the physician's documentation in the medical record. (ICD-9 equivalent: 042). ICD-10 Z20.6 Contact with and (suspected) exposure to human immunodeficiency virus [HIV]: may be reported to OSHPD because it does not reveal HIV test results. (ICD-9 equivalent: V01.79)

The California Health and Safety Code (law) prohibits disclosure of any HIV test results (whether positive, negative, or inconclusive) without the patient's written authorization for each disclosure. OSHPD's SW05 and SW06 warning edits are designed to protect health facilities from liability if these codes are inadvertently reported to OSHPD. The only exception to the Health and Safety Code is that the HIV test result must be reported to the public health agency. OSHPD is not a public health agency and is not held liable for the reported codes. Health facilities, however, could ultimately be held responsible for disclosing that information without the patient's signed consent.

Sepsis continues to be classified in chapter I and the guidelines specific to this chapter are similar to those we use today. Note however, under R65.2 Sepsis, with organ dysfunction (Chapter 18), there is a "code first underlying infection" note; therefore, A41.50 should be listed as the principal diagnosis followed by R65.20 as a secondary diagnosis. SIRS and Septic Shock subcategories are in Chapter 18, Symptoms, Signs and Abnormal and Laboratory Findings, Not Elsewhere Classified.

Documentation and coding efforts include physician awareness and updating your physician queries for the specific language and terminology. Review your current physician query for sepsis and in particular review the subcategories with the septic organism, i.e., MRSA, as these may be valuable to include in your query template or form.

Chapter II covers Neoplasms in the code range of C00-D49.
There continues to be a Neoplasm table to index the site and type of the neoplasm initially. Within the chapter-specific guidelines, there are similarities to ICD-9-CM. Some of the neoplasm guidelines that are new for ICD-10-CM are:

- Malignant neoplasm in a pregnant patient
- Encounter for a complication associated with a malignancy*
- Complication from surgical procedure for treatment of a neoplasm
- Pathologic fracture due to neoplasm
- Current malignancy versus personal history of malignancy
- In remission vs. personal history

There is one particular guideline regarding "Anemia" due to a neoplasm that is very important to know and understand. The following guideline will impact your MS-DRG, which means this would be an area in which to conduct some data mining and analyze the results for a "shift."

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.

Chapter II guidelines to review and become very familiar with are:

- Treatment directed at the malignancy
- Treatment of secondary site\
- Coding and sequencing of complications
- Primary malignancy previously excised
- Admissions/encounters involving chemotherapy, immunotherapy, and radiation therapy
- Admission/encounter to determine extent of malignancy

  - Symptoms, signs, and abnormal findings listed in Chapter 18 associated with neoplasms
  - Admission/encounter for pain control/ management
  - Malignancy in two or more noncontiguous sites
  - Disseminated malignant neoplasm, unspecified\Malignant neoplasm without specification of site
  - Sequencing of neoplasm codes
  - Leukemia, Multiple Myeloma, and Malignant Plasma Cell Neoplasms in remission versus personal history
  - Aftercare following surgery for neoplasm
  - \Follow-up care for completed treatment of a malignancy
  - Prophylactic organ removal for prevention of malignancy
  - Malignant neoplasm associated with transplanted organ

All guidelines for Neoplasm coding should be reviewed carefully, because there are many and some are similar to ICD-9-CM. Documentation and coding for Neoplasm should identify the specific site and with some neoplasms the laterality; for example Malignant neoplasm of bladder:

- Trigone
- Dome
- Lateral wall
- Anterior wall
- Posterior wall
- Bladder neck
- Ureteric orifice
- Overlapping sites

Another example of code set and documentation specificity is malignant neoplasm of ureter:

- **C66.1**: Malignant neoplasm of right ureter
- **C66.2**: Malignant neoplasm of left ureter
- **C66.9**: Malignant neoplasm of unspecified ureter

Chapter III: Disease of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89).
This chapter section has been reserved for future guideline expansion. However, with regard to an anemia diagnosis as discussed above, it is critical to know and understand the sequencing of anemia when due to a Neoplasm.

This chapter contains the following code blocks:

- D50-D53 Nutritional anemias
- D55-D59 Hemolytic anemias\D60-D64 Aplastic and other anemias and other bone marrow failure syndromes
- D65-D69 Coagulation defects, purpura and other hemorrhagic conditions
- D70-D77 Other disorders of blood and blood-forming organs
- D78 Intraoperative and postprocedural complications of spleen
- D80-D89 Certain disorders involving the immune mechanism

Documentation and coding for anemias can at times be nonspecific, so, it will be important to review your current physician query regarding anemia. Look in detail at the tabular section and the new terminology.

- Document:
  - Acute or Chronic
  - Specific type: nutritional, hemolytic, aplastic or as the result of blood loss
  - When hemolytic anemia, specify whether hereditary, acquired, enzyme disorder, autoimmune or non-autoimmune
  - Underlying cause or "unknown cause"
  - The name and purpose of any medication that is causing anemia
  - Link any laboratory finding to the anemia diagnosis if known

Chapter IV: Endocrine, Nutritional, and Metabolic Diseases (E00-E89), which includes Diabetes, malnutrition and obesity conditions. This chapter has many guidelines specific to diabetes that should be reviewed and followed. Many of the guidelines are the same as ICD-9, only the code is different. New in this chapter are more combination codes to capture the diabetes and the complication or manifestation:

- E11.331 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
- The following will be important to know and have documented: when the type of diabetes is not documented, assign Type 2, as we do today. There are many new combination codes available to capture the body system complication that the diabetes has affected:\
  - Type of diabetes
  - Body system affected
  - Complications affecting that body system

Note the new categories in Chapter 4:

- E08 Diabetes mellitus due to underlying cause *
- E09 Drug or chemical induced diabetes mellitus *
- E10 Type 1 diabetes mellitus
- E11 Type 2 diabetes mellitus
- E13 Other specified diabetes mellitus*

*types of secondary diabetes mellitus

For "Long-term Use of Insulin," today we assign in ICD-9-CM code V58.67 and for ICD-10-CM we will assign code Z79.4. Note that it is optional to assign the Z code for long-term use of insulin with type I Diabetes and this needs to be handled consistently within your department, facility or practice, so be sure to discuss the use of Z79.4 with your staff.

Malnutrition is code range (E40-E46). Within Malnutrition, there are the following code categories:

- E40 – Kwashiorkor
- E41 - Nutritional marasmus
- E42 - Marasmic kwashiorkor
- E43 - Unspecified severe protein-calorie malnutrition
- E44 - Protein-calorie malnutrition of moderate and mild degree
- E45 - Retarded development following protein-calorie malnutrition
- E46 - Unspecified protein-calorie malnutrition

Obesity within ICD-10-CM has the following subcategories to capture more detail:

- E66.01 Morbid (severe) obesity due to excess calories
- E66.09 Other obesity due to excess calories
- E66.1 Drug-induced obesity
- E66.2 Morbid (severe) obesity with alveolar hypoventilation
- E66.3 Overweight
- E66.8 Other obesity
- E66.9 Obesity, unspecified

Be sure that your Medical Staff are aware of these small changes to the code descriptions, so their documentation can reflect the condition appropriately. Also, revise your physician query form to correlate to these changes as well.

ICD-10-CM Chapter V: Mental, Behavioral and Neurodevelopmental disorders (F01 – F99)
Within Chapter 5 there are also more subchapters, categories, subcategories, and codes that provide greater clinical detail. This includes some changes in names and definitions of disorders to reflect more current clinical terminology and standardization of the terms used to diagnosis mental, behavioral and substance use disorders.

Chapter 5 has two specific guidelines that are noteworthy:

- Pain disorders related to psychological factors
- Mental and behavioral disorders due to psychoactive substance use

The section list within Chapter V is:

- Mental disorders due to known physiological conditions (F01-F09)
- Mental and behavioral disorders due to psychoactive substance use (F10-F19)
- Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders (F20-F29)
- Mood [affective] disorders (F30-F39)
- Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders (F40-F48)
- Behavioral syndromes associated with physiological disturbances and physical factors (F50-F59)
- Disorders of adult personality and behavior (F60-F69)
- Intellectual Disabilities (F70-F79)
- Pervasive and specific developmental disorders (F80-F89)
- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)
- Unspecified mental disorder (F99)

The relationship between two or more diagnoses (or associated process) cannot be assumed and provider documentation must clearly state causal relationship of conditions.

The classification of substance use, abuse, and dependence in ICD-10 is different, the terms are not interchangeable as they are in ICD-9; they are separate conditions in ICD- 10.When clinician 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.

The AHA (American Hospital Association) ICD-10-CM *Coding Clinic* has already published additional guidance for the coding professional to follow since 2013. It is imperative to obtain and review the American Hospital Association (AHA) ICD-10-CM/ PCS Coding Clinic quarterly guidance carefully.

Summary
Knowing the coding guidelines is an imperative for the coding professional. Having a thorough understanding of the ICD-10-CM chapter specific guidelines will guide code accuracy and data integrity. It will be critical to obtain physician awareness and then engagement during this final 14 months of readiness.

Stay engaged in learning the ICD-10 code set; remember that repetition is good because it helps with the learning process. Look for the second article on ICD-10-CM, which covers chapters 6 through 10, in a future issue of the *CHIA Journal*.

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References
http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf
AHA ICD-10-CM/PCS Coding Handbook;
http://www.cdc.gov/nchs/icd/icd10cm.htm#10update
http://OSHPD.gov
http://Wikipedia.com;
http://www.ibx.com/pdfs/providers/claims_and_billing/icd_10/icd_10_spotlight.pdf
www.ibx.com/icd10.

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Gloryanne Bryant, RHIA,CDIP, CCS, CCDS, AHIMA-Approved ICD-10/PCS Trainer, Supporter of ICD-10, Past President CHIA, is the National Director Coding Quality, Education, Systems and Support, National Revenue Cycle, Kaiser Foundation Health Plan, Inc. & Hospitals, Oakland, California.