2024 coding guidelines included

Expert

ICD-10-CM Expert for Physicians

The complete official code set

Codes valid from October 1, 2023 through September 30, 2024

SAMPLE

2024

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Code Also

A "code also" note alerts the coder that more than one code may be required to fully describe the condition. The sequencing depends on the circumstances of the encounter. Factors that may determine sequencing include severity and reason for the encounter.

Revised Text

The revised text ▶◀ "bow ties" alert the user to changes in official notations for the current year. Revised text may include the following:

- A change in a current parenthetical description
- A change in the code(s) associated with a current parenthetical note
- A change in how a current parenthetical note is classified (e.g., an Excludes 1 note that changed to an Excludes 2 note)
- Addition of a new parenthetical note(s) to a code

Deleted Text

~~Strikethrough~~ on official notations indicate a deletion from the classification for the current year.

Optum Notations

AHA Coding Clinic Citations

Coding Clinics are official American Hospital Association (AHA) publications that provide coding advice specific to ICD-10-CM and ICD-10-PCS.

Coding Clinic citations included in this manual are current up to the second quarter of 2022.

These citations identify the year, quarter, and page number of one or more *Coding Clinic* publications that may have coding advice relevant to a particular code or group of codes. With the most current citation listed first, these notations are preceded by the symbol **AHA:** and appear in purple type.

> **I15.1 Hypertension secondary to other renal disorders**
> **AHA:** 2Ø16, 3Q, 22

Definitions

Definitions explain a specific term, condition, or disease process in layman's terms. These notations are preceded by the symbol **DEF:** and appear in purple type.

> ✓5th **M51.4 Schmorl's nodes**
> **DEF:** Irregular bone defect in the margin of the vertebral body that causes herniation into the end plate of the vertebral body.

Coding Tips

The tips in the tabular list offer coding advice that is not readily available within the ICD-10-CM classification. It may relate official coding guidelines, indexing nuances, or advice from *AHA's Coding Clinic for ICD-10-CM/PCS*. These notations are preceded by the symbol **TIP:** and appear in brown type.

> ✓5th **B97.2 Coronavirus as the cause of diseases classified elsewhere**
> **TIP:** Do not report a code from this subcategory for COVID-19, refer to UØ7.1.

Icons

Note: The following icons are placed to the left of the code.

Changes to ICD-10-CM codes, since the last published edition of this manual, are highlighted in two ways:

The following green icons identify new or revised codes effective April 1, 2022:

- ● **New Code – Midyear**
- ▲ **Revised Code – Midyear**

The following black icons identify new or revised codes effective October 1, 2022:

- ● **New Code**
- ▲ **Revised Code**
- ✓ **Additional Characters Required**
  - ✓4th This symbol indicates that the code requires a 4th character.
  - ✓5th This symbol indicates that the code requires a 5th character.
  - ✓6th This symbol indicates that the code requires a 6th character.
  - ✓7th This symbol indicates that the code requires a 7th character.

> ✓5th **H6Ø.3 Other infective otitis externa**
> ✓6th **H6Ø.31 Diffuse otitis externa**
> **H6Ø.311 Diffuse otitis externa, right ear**
> **H6Ø.312 Diffuse otitis externa, left ear**
> **H6Ø.313 Diffuse otitis externa, bilateral**
> **H6Ø.319 Diffuse otitis externa, unspecified ear**

✓x7th **Placeholder Alert**

This symbol indicates that the code requires a 7th character following the placeholder "X". Codes with fewer than six characters that require a 7th character must contain placeholder "X" to fill in the empty character(s).

> ✓x7th **T16.1 Foreign body in right ear**

This manual provides the most current information that was available at the time of publication. Except where otherwise noted, the icons and/or color bars reflect edits provided in the Integrated Outpatient Code Editor (IOCE) quarterly files utilized under the outpatient prospective payment system (OPPS). Because the October 2022 quarterly files were not available at the time this book was printed, the edits in this manual are based on the July 2022 quarterly files.

Note: In an effort to provide the most current edit information, Optum has provided a searchable data file that includes the final edit designations for all ICD-10-CM codes based on the IOCE October 2022 quarterly files. The edits included in the data file are as follows:

- Age
- Sex
- Manifestation
- Unacceptable principal diagnosis

This data file can be accessed at the following:

https://www.optumcoding.com/ProductUpdates/

Title: "2023 ICD-10-CM Outpatient Edits Data File"

Password: Provider23

SAMPLE

Color Bars

Manifestation Code

Codes defined as manifestation codes appear in italic type, with a blue color bar over the code description. A manifestation cannot be reported as a first-listed code; it is sequenced as a secondary diagnosis with the underlying disease code listed first.

> *G32.89* ***Other specified degenerative disorders of nervous system in diseases classified elsewhere***
> Degenerative encephalopathy in diseases classified elsewhere

Unspecified Diagnosis

Codes that appear with a gray color bar over the alphanumeric code identify unspecified diagnoses. These codes should be used in limited circumstances, when neither the diagnostic statement nor the documentation provides enough information to assign a more specific diagnosis code. The abbreviation NOS, "not otherwise specified," in the tabular list may be interpreted as "unspecified."

> **GØ3.9** **Meningitis, unspecified**
> Arachnoiditis (spinal) NOS

Footnotes

Certain codes in the tabular section have a numerical superscript located to the upper left of the code. This numerical superscript corresponds to a specific footnote description.

For example:

> [1] ✓7th **M48.51** **Collapsed vertebra, not elsewhere classified, occipito-atlanto-axial region** HCC

For convenience, the footnote descriptions are provided on the front cover.

The following list also provides the footnote descriptions of all numerical superscripts found in the Tabular List of Diseases:

1. These codes are considered an HCC when reported as an initial encounter (7th character A, B, or C).
2. These codes are considered an HCC when reported as an initial encounter (7th character A or B) OR sequela (7th character S).
3. These codes are considered an HCC when reported as a sequela (7th character S).

Chapter-Level Notations

Chapter-specific Guidelines with Coding Examples

Each chapter begins with the Official Guidelines for Coding and Reporting specific to that chapter, where provided. Coding examples specific to outpatient care settings have been provided to illustrate the coding and/or sequencing guidance in these guidelines.

Muscle and Tendon Table

ICD-10-CM categorizes certain muscles and tendons in the upper and lower extremities by their action (e.g., extension or flexion) as well as their anatomical location. The Muscle/Tendon table is provided at the beginning of chapter 13 and chapter 19 to help users when code selection depends on the action of the muscle and/or tendon.

Note: This table is not all-inclusive, and proper code assignment should be based on the provider's documentation.

Appendixes

The additional resources described below have been included as appendixes for this book. These resources further instruct the professional coder on the appropriate application of the ICD-10-CM code set.

Appendix A: Valid 3-character ICD-10-CM Codes

The user may consult this table to confirm that no further specificity, such as the use of 4th, 5th, 6th, or 7th characters or placeholders (X), is necessary. All ICD-10-CM codes that are valid at the three-character level are listed.

Appendix B: Pharmacology List 2023

This reference is a comprehensive but not all-inclusive list of pharmacological agents used to treat acute and/or chronic conditions. Drugs are listed in alphabetical order by their brand and/or generic names along with their drug action and indications for which they may commonly be prescribed. Some drugs have also been mapped to their appropriate Z code for long-term drug use.

Appendix C: Z Codes for Long-Term Drug Use with Associated Drugs

This resource correlates Z codes that are used to identify current long-term drug use with a list of drugs that are typically categorized to that class of drug.

Note: These tables are not all-inclusive but list some of the more commonly used drugs.

Appendix D: Z Codes Only as Principal/First-Listed Diagnosis

This resource provides a comprehensive list of Z codes that are primarily used as first-listed diagnoses for outpatient encounters.

Appendix E: Centers for Medicare & Medicaid Services Hierarchical Condition Categories (CMS-HCC)

This resource provides the framework behind the Centers for Medicare and Medicaid Services' (CMS) Medicare Advantage (MA) program, a risk-adjustment model developed as a means of compensating health care plans with large numbers of Medicare Part C beneficiaries. It includes a brief synopsis of the evolution of the program from its inception; insight into the various elements needed to predict risk, including the principles used to develop the hierarchical condition categories (HCCs), which make up one of the fundamental components of the risk-adjustment model. This appendix also outlines the audit process used to ensure the accuracy of payments made to MA plans.

Appendix F: Centers for Medicare & Medicaid Services Quality Payment Program

This resource provides an overview of the Medicare Access and CHIP Reauthorization Act (MACRA), which replaced Medicare's sustainable growth rate (SGR) methodology with the Quality Payment Program (QPP). It summarizes the Merit-based Incentive Payment System (MIPS) track used by those who opt to participate in traditional Medicare and not an advanced alternative payment model (APM). This includes eligibility requirements and an overview of the four performance categories that combine to make up the MIPS.

Illustrations

This section includes illustrations of normal anatomy with ICD-10-CM-specific terminology.

SAMPLE

Note: The list below gives the code number for neoplasms by anatomical site. For each site there are six possible code numbers according to whether the neoplasm in question is malignant, benign, in situ, of uncertain behavior, or of unspecified nature. The description of the neoplasm will often indicate which of the six columns is appropriate; e.g., malignant melanoma of skin, benign fibroadenoma of breast, carcinoma in situ of cervix uteri. Where such descriptors are not present, the remainder of the Index should be consulted where guidance is given to the appropriate column for each morphological (histological) variety listed; e.g., Mesonephroma – see Neoplasm, malignant; Embryoma — see also Neoplasm, uncertain behavior; Disease, Bowen's – see Neoplasm, skin, in situ. However, the guidance in the Index can be overridden if one of the descriptors mentioned above is present; e.g., malignant adenoma of colon is coded to C18.9 and not to D12.6 as the adjective "malignant" overrides the Index entry "Adenoma — *see also* Neoplasm, benign, by site." Codes listed with a dash -, following the code have a required additional character for laterality. The tabular list must be reviewed for the complete code.

	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
Neoplasm, neoplastic	C8Ø.1	C79.9	DØ9.9	D36.9	D48.9	D49.9
abdomen, abdominal	C76.2	C79.8-☑	DØ9.8	D36.7	D48.7	D49.89
cavity	C76.2	C79.8-☑	DØ9.8	D36.7	D48.7	D49.89
organ	C76.2	C79.8-☑	DØ9.8	D36.7	D48.7	D49.89
viscera	C76.2	C79.8-☑	DØ9.8	D36.7	D48.7	D49.89
wall — *see also* Neoplasm, abdomen, wall, skin	C44.5Ø9	C79.2	DØ4.5	D23.5	D48.5	D49.2
connective tissue	C49.4	C79.8-☑	—	D21.4	D48.1	D49.2
skin	C44.5Ø9	—	—	—	—	—
basal cell carcinoma	C44.519	—	—	—	—	—
specified type NEC	C44.599	—	—	—	—	—
squamous cell carcinoma	C44.529	—	—	—	—	—
abdominopelvic	C76.8	C79.8-☑	—	D36.7	D48.7	D49.89
accessory sinus — *see* Neoplasm, sinus						
acoustic nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
adenoid (pharynx) (tissue)	C11.1	C79.89	DØØ.Ø8	D1Ø.6	D37.Ø5	D49.Ø
adipose tissue — *see also* Neoplasm, connective tissue	C49.4	C79.89	—	D21.9	D48.1	D49.2
adnexa (uterine)	C57.4	C79.89	DØ7.39	D28.7	D39.8	D49.59
adrenal	C74.9-☑	C79.7-☑	DØ9.3	D35.Ø-☑	D44.1-☑	D49.7
capsule	C74.9-☑	C79.7-☑	DØ9.3	D35.Ø-☑	D44.1-☑	D49.7
cortex	C74.Ø-☑	C79.7-☑	DØ9.3	D35.Ø-☑	D44.1-☑	D49.7
gland	C74.9-☑	C79.7-☑	DØ9.3	D35.Ø-☑	D44.1-☑	D49.7
medulla	C74.1-☑	C79.7-☑	DØ9.3	D35.Ø-☑	D44.1-☑	D49.7
ala nasi (external) — *see also* Neoplasm, skin, nose	C44.3Ø1	C79.2	DØ4.39	D23.39	D48.5	D49.2
alimentary canal or tract NEC	C26.9	C78.8Ø	DØ1.9	D13.9	D37.9	D49.Ø
alveolar	CØ3.9	C79.89	DØØ.Ø3	D1Ø.39	D37.Ø9	D49.Ø
mucosa	CØ3.9	C79.89	DØØ.Ø3	D1Ø.39	D37.Ø9	D49.Ø
lower	CØ3.1	C79.89	DØØ.Ø3	D1Ø.39	D37.Ø9	D49.Ø
upper	CØ3.Ø	C79.89	DØØ.Ø3	D1Ø.39	D37.Ø9	D49.Ø
ridge or process	C41.1	C79.51	—	D16.5	D48.Ø	D49.2
carcinoma	CØ3.9	C79.8-☑	—	—	—	—
lower	CØ3.1	C79.8-☑	—	—	—	—
upper	CØ3.Ø	C79.8-☑	—	—	—	—
lower	C41.1	C79.51	—	D16.5	D48.Ø	D49.2
mucosa	CØ3.9	C79.89	DØØ.Ø3	D1Ø.39	D37.Ø9	D49.Ø
lower	CØ3.1	C79.89	DØØ.Ø3	D1Ø.39	D37.Ø9	D49.Ø
upper	CØ3.Ø	C79.89	DØØ.Ø3	D1Ø.39	D37.Ø9	D49.Ø
upper	C41.Ø	C79.51	—	D16.4	D48.Ø	D49.2
sulcus	CØ6.1	C79.89	DØØ.Ø2	D1Ø.39	D37.Ø9	D49.Ø
alveolus	CØ3.9	C79.89	DØØ.Ø3	D1Ø.39	D37.Ø9	D49.Ø
lower	CØ3.1	C79.89	DØØ.Ø3	D1Ø.39	D37.Ø9	D49.Ø
upper	CØ3.Ø	C79.89	DØØ.Ø3	D1Ø.39	D37.Ø9	D49.Ø
ampulla of Vater	C24.1	C78.89	DØ1.5	D13.5	D37.6	D49.Ø
ankle NEC	C76.5-☑	C79.89	DØ4.7-☑	D36.7	D48.7	D49.89
anorectum, anorectal (junction)	C21.8	C78.5	DØ1.3	D12.9	D37.8	D49.Ø
antecubital fossa or space	C76.4-☑	C79.89	DØ4.6-☑	D36.7	D48.7	D49.89

	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
Neoplasm, neoplastic — *continued*						
antrum (Highmore) (maxillary)	C31.Ø	C78.39	DØ2.3	D14.Ø	D38.5	D49.1
pyloric	C16.3	C78.89	DØØ.2	D13.1	D37.1	D49.Ø
tympanicum	C3Ø.1	C78.39	DØ2.3	D14.Ø	D38.5	D49.1
anus, anal	C21.Ø	C78.5	DØ1.3	D12.9	D37.8	D49.Ø
canal	C21.1	C78.5	DØ1.3	D12.9	D37.8	D49.Ø
cloacogenic zone	C21.2	C78.5	DØ1.3	D12.9	D37.8	D49.Ø
margin — *see also* Neoplasm, anus, skin	C44.5ØØ	C79.2	DØ4.5	D23.5	D48.5	D49.2
overlapping lesion with rectosigmoid junction or rectum	C21.8	—	—	—	—	—
skin	C44.5ØØ	C79.2	DØ4.5	D23.5	D48.5	D49.2
basal cell carcinoma	C44.51Ø	—	—	—	—	—
specified type NEC	C44.59Ø	—	—	—	—	—
squamous cell carcinoma	C44.52Ø	—	—	—	—	—
sphincter	C21.1	C78.5	DØ1.3	D12.9	D37.8	D49.Ø
aorta (thoracic)	C49.3	C79.89	—	D21.3	D48.1	D49.2
abdominal	C49.4	C79.89	—	D21.4	D48.1	D49.2
aortic body	C75.5	C79.89	—	D35.6	D44.7	D49.7
aponeurosis	C49.9	C79.89	—	D21.9	D48.1	D49.2
palmar	C49.1-☑	C79.89	—	D21.1-☑	D48.1	D49.2
plantar	C49.2-☑	C79.89	—	D21.2-☑	D48.1	D49.2
appendix	C18.1	C78.5	DØ1.Ø	D12.1	D37.3	D49.Ø
arachnoid	C7Ø.9	C79.49	—	D32.9	D42.9	D49.7
cerebral	C7Ø.Ø	C79.32	—	D32.Ø	D42.Ø	D49.7
spinal	C7Ø.1	C79.49	—	D32.1	D42.1	D49.7
areola	C5Ø.Ø-☑	C79.81	DØ5-☑	D24-☑	D48.6-☑	D49.3
arm NEC	C76.4-☑	C79.89	DØ4.6-☑	D36.7	D48.7	D49.89
artery — *see* Neoplasm, connective tissue						
aryepiglottic fold	C13.1	C79.89	DØØ.Ø8	D1Ø.7	D37.Ø5	D49.Ø
hypopharyngeal aspect	C13.1	C79.89	DØØ.Ø8	D1Ø.7	D37.Ø5	D49.Ø
laryngeal aspect	C32.1	C78.39	DØ2.Ø	D14.1	D38.Ø	D49.1
marginal zone	C13.1	C79.89	DØØ.Ø8	D1Ø.7	D37.Ø5	D49.Ø
arytenoid (cartilage)	C32.3	C78.39	DØ2.Ø	D14.1	D38.Ø	D49.1
fold — *see* Neoplasm, aryepiglottic						
associated with transplanted organ	C8Ø.2	—	—	—	—	—
atlas	C41.2	C79.51	—	D16.6	D48.Ø	D49.2
atrium, cardiac	C38.Ø	C79.89	—	D15.1	D48.7	D49.89
auditory						
canal (external) (skin)	C44.2Ø-☑	C79.2	DØ4.2-☑	D23.2-☑	D48.5	D49.2
internal	C3Ø.1	C78.39	DØ2.3	D14.Ø	D38.5	D49.1
nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
tube	C3Ø.1	C78.39	DØ2.3	D14.Ø	D38.5	D49.1
opening	C11.2	C79.89	DØØ.Ø8	D1Ø.6	D37.Ø5	D49.Ø
auricle, ear — *see also* Neoplasm, skin, ear	C44.2Ø-☑	C79.2	DØ4.2-☑	D23.2-☑	D48.5	D49.2
auricular canal (external) — *see also* Neoplasm, skin, ear	C44.2Ø-☑	C79.2	DØ4.2-☑	D23.2-☑	D48.5	D49.2
internal	C3Ø.1	C78.39	DØ2.3	D14.Ø	D38.5	D49.2
autonomic nerve or nervous system NEC (see Neoplasm, nerve, peripheral)						
axilla, axillary	C76.1	C79.89	DØ9.8	D36.7	D48.7	D49.89
fold — *see also* Neoplasm, skin, trunk	C44.5Ø9	C79.2	DØ4.5	D23.5	D48.5	D49.2
back NEC	C76.8	C79.89	DØ4.5	D36.7	D48.7	D49.89
Bartholin's gland	C51.Ø	C79.82	DØ7.1	D28.Ø	D39.8	D49.59
basal ganglia	C71.Ø	C79.31	—	D33.Ø	D43.Ø	D49.6
basis pedunculi	C71.7	C79.31	—	D33.1	D43.1	D49.6
bile or biliary (tract)	C24.9	C78.89	DØ1.5	D13.5	D37.6	D49.Ø

SAMPLE

Chapter 2. Neoplasms (CØØ-D49)

NOTE

Functional activity

All neoplasms are classified in this chapter, whether they are functionally active or not. An additional code from Chapter 4 may be used, to identify functional activity associated with any neoplasm.

Morphology [Histology]

Chapter 2 classifies neoplasms primarily by site (topography), with broad groupings for behavior, malignant, in situ, benign, etc. The Table of Neoplasms should be used to identify the correct topography code. In a few cases, such as for malignant melanoma and certain neuroendocrine tumors, the morphology (histologic type) is included in the category and codes.

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 mentioned, e.g., ectopic pancreatic malignant neoplasms are coded to pancreas, unspecified (C25.9).

AHA: 2017,4Q,103; 2017,1Q,4,5-6,8

This chapter contains the following blocks:

- CØØ-C14 Malignant neoplasms of lip, oral cavity and pharynx
- C15-C26 Malignant neoplasms of digestive organs
- C3Ø-C39 Malignant neoplasms of respiratory and intrathoracic organs
- C4Ø-C41 Malignant neoplasms of bone and articular cartilage
- C43-C44 Melanoma and other malignant neoplasms of skin
- C45-C49 Malignant neoplasms of mesothelial and soft tissue
- C5Ø Malignant neoplasms of breast
- C51-C58 Malignant neoplasms of female genital organs
- C6Ø-C63 Malignant neoplasms of male genital organs
- C64-C68 Malignant neoplasms of urinary tract
- C69-C72 Malignant neoplasms of eye, brain and other parts of central nervous system
- C73-C75 Malignant neoplasms of thyroid and other endocrine glands
- C7A Malignant neuroendocrine tumors
- C7B Secondary neuroendocrine tumors
- C76-C8Ø Malignant neoplasms of ill-defined, other secondary and unspecified sites
- C81-C96 Malignant neoplasms of lymphoid, hematopoietic and related tissue
- DØØ-DØ9 In situ neoplasms
- D1Ø-D36 Benign neoplasms, except benign neuroendocrine tumors
- D3A Benign neuroendocrine tumors
- D37-D48 Neoplasms of uncertain behavior, polycythemia vera and myelodysplastic syndromes
- D49 Neoplasms of unspecified behavior

MALIGNANT NEOPLASMS (CØØ-C96)

Malignant neoplasms, stated or presumed to be primary (of specified sites), and certain specified histologies, except neuroendocrine, and of lymphoid, hematopoietic and related tissue (CØØ-C75)

AHA: 2022,1Q,16

TIP: Codes from this code block can be assigned for outpatient encounters based on the diagnosis listed in a pathology or cytology report when authenticated by a pathologist and available at the time of code assignment.

Malignant neoplasms of lip, oral cavity and pharynx (CØØ-C14)

✓4th CØØ Malignant neoplasm of lip

Use additional code to identify:
- alcohol abuse and dependence (F1Ø.-)
- history of tobacco dependence (Z87.891)
- tobacco dependence (F17.-)
- tobacco use (Z72.Ø)

EXCLUDES 1
- *malignant melanoma of lip (C43.Ø)*
- *Merkel cell carcinoma of lip (C4A.Ø)*
- *other and unspecified malignant neoplasm of skin of lip (C44.Ø-)*

CØØ.Ø Malignant neoplasm of external upper lip
- Malignant neoplasm of lipstick area of upper lip
- Malignant neoplasm of upper lip NOS
- Malignant neoplasm of vermilion border of upper lip

CØØ.1 Malignant neoplasm of external lower lip
- Malignant neoplasm of lower lip NOS
- Malignant neoplasm of lipstick area of lower lip
- Malignant neoplasm of vermilion border of lower lip

CØØ.2 Malignant neoplasm of external lip, unspecified
- Malignant neoplasm of vermilion border of lip NOS

CØØ.3 Malignant neoplasm of upper lip, inner aspect
- Malignant neoplasm of buccal aspect of upper lip
- Malignant neoplasm of frenulum of upper lip
- Malignant neoplasm of mucosa of upper lip
- Malignant neoplasm of oral aspect of upper lip

CØØ.4 Malignant neoplasm of lower lip, inner aspect
- Malignant neoplasm of buccal aspect of lower lip
- Malignant neoplasm of frenulum of lower lip
- Malignant neoplasm of mucosa of lower lip
- Malignant neoplasm of oral aspect of lower lip

CØØ.5 Malignant neoplasm of lip, unspecified, inner aspect
- Malignant neoplasm of buccal aspect of lip, unspecified
- Malignant neoplasm of frenulum of lip, unspecified
- Malignant neoplasm of mucosa of lip, unspecified
- Malignant neoplasm of oral aspect of lip, unspecified

CØØ.6 Malignant neoplasm of commissure of lip, unspecified

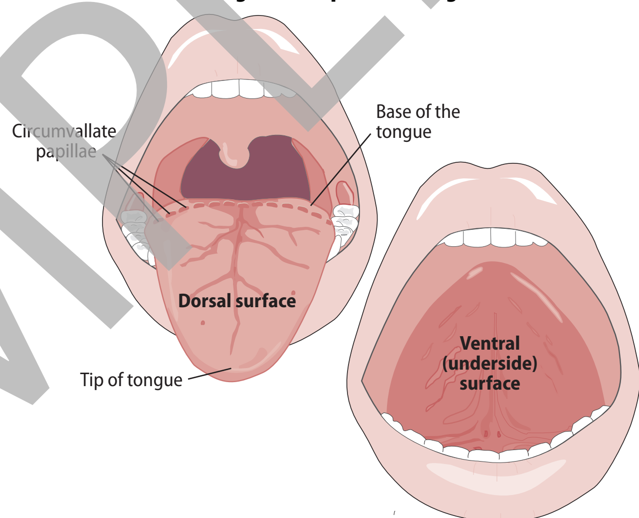
CØØ.8 Malignant neoplasm of overlapping sites of lip

CØØ.9 Malignant neoplasm of lip, unspecified

CØ1 Malignant neoplasm of base of tongue HCC Rx ESR COM
- Malignant neoplasm of dorsal surface of base of tongue
- Malignant neoplasm of fixed part of tongue NOS
- Malignant neoplasm of posterior third of tongue

Use additional code to identify:
- alcohol abuse and dependence (F1Ø.-)
- history of tobacco dependence (Z87.891)
- tobacco dependence (F17.-)
- tobacco use (Z72.Ø)

Malignant Neoplasm of Tongue



✓4th CØ2 Malignant neoplasm of other and unspecified parts of tongue

Use additional code to identify:
- alcohol abuse and dependence (F1Ø.-)
- history of tobacco dependence (Z87.891)
- tobacco dependence (F17.-)
- tobacco use (Z72.Ø)

CØ2.Ø Malignant neoplasm of dorsal surface of tongue HCC Rx ESR COM
- Malignant neoplasm of anterior two-thirds of tongue, dorsal surface

EXCLUDES 2 *malignant neoplasm of dorsal surface of base of tongue (CØ1)*

CØ2.1 Malignant neoplasm of border of tongue HCC Rx ESR COM
- Malignant neoplasm of tip of tongue

CØ2.2 Malignant neoplasm of ventral surface of tongue HCC Rx ESR COM
- Malignant neoplasm of anterior two-thirds of tongue, ventral surface
- Malignant neoplasm of frenulum linguae

CØ2.3 Malignant neoplasm of anterior two-thirds of tongue, part unspecified HCC Rx ESR COM
- Malignant neoplasm of middle third of tongue NOS
- Malignant neoplasm of mobile part of tongue NOS

SAMPLE

Chapter 4. Endocrine, Nutritional, and Metabolic Diseases (EØØ–E89)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

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 EØ8–E13 as needed to identify all of the associated conditions that the patient has.

Patient is seen for uncontrolled diabetes, type 2, with hyperglycemia diabetic nephropathy, and diabetic gastroparesis

E11.65 **Type 2 diabetes mellitus with hyperglycemia**

E11.21 **Type 2 diabetes mellitus with diabetic nephropathy**

E11.43 **Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy**

K31.84 **Gastroparesis**

Explanation: Use as many codes to describe the diabetic complications as needed. Many are combination codes that describe more than one condition. Code first the reason for the encounter. The term "uncontrolled" can refer to either hyperglycemia or hypoglycemia. In this case, "uncontrolled" is described as "with hyperglycemia."

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 45-year-old patient is diagnosed with type 1 diabetes

E1Ø.9 **Type 1 diabetes mellitus without complications**

Explanation: Although most type 1 diabetics are diagnosed in childhood or adolescence, it can also begin in adults.

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.

Office visit lists diabetic retinopathy with macular edema and hypertension on patient problem list

E11.311 **Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema**

I1Ø **Essential (primary) hypertension**

Explanation: Since the type of diabetes was not documented, default to category E11.

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.

Office visit lists chronic diabetes with daily insulin use on patient problem list

E11.9 **Type 2 diabetes mellitus without complications**

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

Explanation: Do not assume that a patient on insulin must have type 1 diabetes. The default for diabetes without further specification defaults to type 2. Add the code for long term use of insulin.

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.

A 24-year-old type 1 diabetic male treated in for hyperglycemia; insulin pump found to be malfunctioning and underdosing

T85.614A **Breakdown (mechanical) of insulin pump, initial encounter**

T38.3X6A **Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, initial encounter**

E1Ø.65 **Type 1 diabetes mellitus with hyperglycemia**

Explanation: The complication code for the mechanical breakdown of the pump is sequenced first, followed by the underdosing code and type of diabetes with complication. Code all other diabetic complication codes necessary to describe the patient's condition.

(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).

A 24-year-old type 1 diabetic male found down with diabetic coma, brought into ED and treated for hypoglycemia; insulin pump found to be malfunctioning and overdosing

T85.614A **Breakdown (mechanical) of insulin pump, initial encounter**

T38.3X1A **Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional), initial encounter**

E1Ø.641 **Type 1 diabetes mellitus with hypoglycemia with coma**

Explanation: The complication code for the mechanical breakdown of the pump is sequenced first, followed by the poisoning code and type of diabetes with complication. All the characters in the combination code must be used to form a valid code and to fully describe the type of diabetes, the hypoglycemia, and the coma.

6) Secondary diabetes mellitus

Codes under categories EØ8, Diabetes mellitus due to underlying condition, EØ9, 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,

SAMPLE

F34.1 Dysthymic disorder Rx Q
- Depressive neurosis
- Depressive personality disorder
- Dysthymia
- Neurotic depression
- Persistent anxiety depression
- Persistent depressive disorder

EXCLUDES 2 *anxiety depression (mild or not persistent) (F41.8)*

DEF: Depression without psychosis. It is a less severe but persistent depression and is considered a mild to moderate chronic form of depression.

✓5th F34.8 Other persistent mood [affective] disorders

AHA: 2016,4Q,14

F34.81 Disruptive mood dysregulation disorder HCC Rx ESR COM Q

F34.89 Other specified persistent mood disorders HCC Rx ESR Q

F34.9 Persistent mood [affective] disorder, unspecified HCC Rx ESR

F39 Unspecified mood [affective] disorder HCC Rx ESR
- Affective psychosis NOS

Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders (F40-F48)

✓4th F40 Phobic anxiety disorders

DEF: Phobia: Broad-range anxiety with abnormally intense dread of certain objects or specific situations that would not normally have that effect.

✓5th F40.0 Agoraphobia

DEF: Profound anxiety or fear of leaving familiar settings like home, or being in unfamiliar locations or with strangers or crowds. Agoraphobia may or may not be preceded by recurrent panic attacks.

F40.00 Agoraphobia, unspecified Rx

F40.01 Agoraphobia with panic disorder Rx
- Panic disorder with agoraphobia

EXCLUDES 1 *panic disorder without agoraphobia (F41.0)*

F40.02 Agoraphobia without panic disorder Rx

✓5th F40.1 Social phobias
- Anthropophobia
- Social anxiety disorder
- Social anxiety disorder of childhood
- Social neurosis

F40.10 Social phobia, unspecified Rx

F40.11 Social phobia, generalized Rx

✓5th F40.2 Specific (isolated) phobias

EXCLUDES 2 *dysmorphophobia (nondelusional) (F45.22)*
nosophobia (F45.22)

✓6th F40.21 Animal type phobia

F40.210 Arachnophobia Rx
- Fear of spiders

F40.218 Other animal type phobia Rx

✓6th F40.22 Natural environment type phobia

F40.220 Fear of thunderstorms Rx

F40.228 Other natural environment type phobia Rx

✓6th F40.23 Blood, injection, injury type phobia

F40.230 Fear of blood Rx

F40.231 Fear of injections and transfusions Rx

F40.232 Fear of other medical care Rx

F40.233 Fear of injury Rx

✓6th F40.24 Situational type phobia

F40.240 Claustrophobia Rx

F40.241 Acrophobia Rx

F40.242 Fear of bridges Rx

F40.243 Fear of flying Rx

F40.248 Other situational type phobia Rx

✓6th F40.29 Other specified phobia

F40.290 Androphobia Rx
- Fear of men

F40.291 Gynephobia Rx
- Fear of women

F40.298 Other specified phobia Rx

F40.8 Other phobic anxiety disorders Rx
- Phobic anxiety disorder of childhood

F40.9 Phobic anxiety disorder, unspecified Rx
- Phobia NOS
- Phobic state NOS

✓4th F41 Other anxiety disorders

EXCLUDES 2 *anxiety in:*
acute stress reaction (F43.0)
neurasthenia (F48.8)
psychophysiologic disorders (F45.-)
transient adjustment reaction (F43.2)
separation anxiety (F93.0)

F41.0 Panic disorder [episodic paroxysmal anxiety] Rx
- Panic attack
- Panic state

EXCLUDES 1 *panic disorder with agoraphobia (F40.01)*

DEF: Neurotic disorder characterized by recurrent panic or anxiety, apprehension, fear, or terror. Symptoms include shortness of breath, palpitations, dizziness, and shakiness; fear of dying may persist.

F41.1 Generalized anxiety disorder Rx
- Anxiety neurosis
- Anxiety reaction
- Anxiety state
- Overanxious disorder

EXCLUDES 2 *neurasthenia (F48.8)*

F41.3 Other mixed anxiety disorders

F41.8 Other specified anxiety disorders
- Anxiety depression (mild or not persistent)
- Anxiety hysteria
- Mixed anxiety and depressive disorder

AHA: 2021,1Q,10

F41.9 Anxiety disorder, unspecified
- Anxiety NOS

AHA: 2021,1Q,10

✓4th F42 Obsessive-compulsive disorder

EXCLUDES 2 *obsessive-compulsive personality (disorder) (F60.5)*
obsessive-compulsive symptoms occurring in depression (F32-F33)
obsessive-compulsive symptoms occurring in schizophrenia (F20.-)

AHA: 2016,4Q,14-15

F42.2 Mixed obsessional thoughts and acts Rx

F42.3 Hoarding disorder Rx

F42.4 Excoriation (skin-picking) disorder Rx

EXCLUDES 1 *factitial dermatitis (L98.1)*
other specified behavioral and emotional disorders with onset usually occurring in early childhood and adolescence (F98.8)

F42.8 Other obsessive-compulsive disorder Rx
- Anancastic neurosis
- Obsessive-compulsive neurosis

F42.9 Obsessive-compulsive disorder, unspecified Rx

✓4th F43 Reaction to severe stress, and adjustment disorders

F43.0 Acute stress reaction
- Acute crisis reaction
- Acute reaction to stress
- Combat and operational stress reaction
- Combat fatigue
- Crisis state
- Psychic shock

✓5th F43.1 Post-traumatic stress disorder (PTSD)
- Traumatic neurosis

DEF: Preoccupation with traumatic events beyond normal experience (i.e., rape, personal assault, etc.) that may also include recurring flashbacks of the trauma. Symptoms include difficulty remembering, sleeping, or concentrating, and guilt feelings for surviving.

F43.10 Post-traumatic stress disorder, unspecified Rx

F43.11 Post-traumatic stress disorder, acute Rx

F43.12 Post-traumatic stress disorder, chronic Rx

SAMPLE

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

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

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.

Hemiplegia affecting left side of ambidextrous patient

G81.92 Hemiplegia, unspecified affecting left dominant side

Explanation: Documentation states that the left side is affected and dominant is used for ambidextrous persons.

Right spastic hemiplegia, unknown whether patient is right- or left-handed

G81.11 Spastic hemiplegia affecting right dominant side

Explanation: Since it is unknown whether the patient is right- or left-handed, 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.

Elderly patient with back pain is admitted for outpatient kyphoplasty for age-related osteopathic compression fracture at vertebra T3

M8Ø.Ø8XA Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture

Explanation: No code is assigned for the pain as it is inherent in the underlying condition being treated.

(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.

Patient presents for steroid injection in the right elbow due to chronic pain associated with primary degenerative joint disease.

G89.29 Other chronic pain

M19.Ø21 Primary osteoarthritis, right elbow

Explanation: Since the encounter is for control of pain, not treating the underlying condition, the pain code is sequenced first followed by the underlying condition. The M25 pain code is not necessary as the underlying condition code represents the specific site.

- 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.

Patient is seen to evaluate chronic right knee pain

M25.561 Pain in right knee

G89.29 Other chronic pain

Explanation: No underlying condition has been determined yet so the pain would be the reason for the visit. The M25 pain code in this instance does not fully describe the condition as it does not represent that the pain is chronic. The G89 chronic pain code is assigned to provide specificity.

(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).

Management of acute, traumatic left shoulder pain

G89.11 Acute pain due to trauma

M25.512 Pain in left shoulder

Explanation: The reason for the encounter is to manage or control the pain, not to treat or evaluate an underlying condition. The G89 pain code is assigned as the first-listed diagnosis but in this instance does not fully describe the condition as it does not include the site and laterality. The M25 pain code is added to provide this information.

- 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.

SAMPLE

O70 Perineal laceration during delivery

INCLUDES episiotomy extended by laceration

EXCLUDES 1 *obstetric high vaginal laceration alone (O71.4)*

AHA: 2016,2Q,34; 2016,1Q,3-4,5

O70.0 First degree perineal laceration during delivery COM M ♀

Perineal laceration, rupture or tear involving fourchette during delivery

Perineal laceration, rupture or tear involving labia during delivery

Perineal laceration, rupture or tear involving skin during delivery

Perineal laceration, rupture or tear involving vagina during delivery

Perineal laceration, rupture or tear involving vulva during delivery

Slight perineal laceration, rupture or tear during delivery

O70.1 Second degree perineal laceration during delivery COM M ♀

Perineal laceration, rupture or tear during delivery as in O70.0, also involving pelvic floor

Perineal laceration, rupture or tear during delivery as in O70.0, also involving perineal muscles

Perineal laceration, rupture or tear during delivery as in O70.0, also involving vaginal muscles

EXCLUDES 1 *perineal laceration involving anal sphincter (O70.2)*

O70.2 Third degree perineal laceration during delivery

Perineal laceration, rupture or tear during delivery as in O70.1, also involving anal sphincter

Perineal laceration, rupture or tear during delivery as in O70.1, also involving rectovaginal septum

Perineal laceration, rupture or tear during delivery as in O70.1, also involving sphincter NOS

EXCLUDES 1 *anal sphincter tear during delivery without third degree perineal laceration (O70.4)*

perineal laceration involving anal or rectal mucosa (O70.3)

AHA: 2016,4Q,53-54

O70.20 Third degree perineal laceration during delivery, unspecified COM M ♀

O70.21 Third degree perineal laceration during delivery, IIIa COM M ♀

Third degree perineal laceration during delivery with less than 50% of external anal sphincter (EAS) thickness torn

O70.22 Third degree perineal laceration during delivery, IIIb COM M ♀

Third degree perineal laceration during delivery with more than 50% external anal sphincter (EAS) thickness torn

O70.23 Third degree perineal laceration during delivery, IIIc COM M ♀

Third degree perineal laceration during delivery with both external anal sphincter (EAS) and internal anal sphincter (IAS) torn

O70.3 Fourth degree perineal laceration during delivery COM M ♀

Perineal laceration, rupture or tear during delivery as in O70.2, also involving anal mucosa

Perineal laceration, rupture or tear during delivery as in O70.2, also involving rectal mucosa

O70.4 Anal sphincter tear complicating delivery, not associated with third degree laceration COM M ♀

EXCLUDES 1 *anal sphincter tear with third degree perineal laceration (O70.2)*

O70.9 Perineal laceration during delivery, unspecified COM M ♀

O71 Other obstetric trauma

INCLUDES obstetric damage from instruments

O71.0 Rupture of uterus (spontaneous) before onset of labor

EXCLUDES 1 *disruption of (current) cesarean delivery wound (O90.0)*

laceration of uterus, NEC (O71.81)

O71.00 Rupture of uterus before onset of labor, unspecified trimester COM M ♀

O71.02 Rupture of uterus before onset of labor, second trimester COM M ♀

O71.03 Rupture of uterus before onset of labor, third trimester COM M ♀

O71.1 Rupture of uterus during labor COM M ♀

Rupture of uterus not stated as occurring before onset of labor

EXCLUDES 1 *disruption of cesarean delivery wound (O90.0)*

laceration of uterus, NEC (O71.81)

O71.2 Postpartum inversion of uterus COM M ♀

O71.3 Obstetric laceration of cervix COM M ♀

Annular detachment of cervix

O71.4 Obstetric high vaginal laceration alone COM M ♀

Laceration of vaginal wall without perineal laceration

EXCLUDES 1 *obstetric high vaginal laceration with perineal laceration (O70.-)*

AHA: 2016,1Q,5

O71.5 Other obstetric injury to pelvic organs COM M ♀

Obstetric injury to bladder

Obstetric injury to urethra

EXCLUDES 2 *obstetric periurethral trauma (O71.82)*

AHA: 2014,4Q,18

O71.6 Obstetric damage to pelvic joints and ligaments COM M ♀

Obstetric avulsion of inner symphyseal cartilage

Obstetric damage to coccyx

Obstetric traumatic separation of symphysis (pubis)

O71.7 Obstetric hematoma of pelvis COM M ♀

Obstetric hematoma of perineum

Obstetric hematoma of vagina

Obstetric hematoma of vulva

O71.8 Other specified obstetric trauma

O71.81 Laceration of uterus, not elsewhere classified COM M ♀

O71.82 Other specified trauma to perineum and vulva COM M ♀

Obstetric periurethral trauma

AHA: 2016,1Q,4; 2014,4Q,18

O71.89 Other specified obstetric trauma COM M ♀

O71.9 Obstetric trauma, unspecified COM M ♀

O72 Postpartum hemorrhage

INCLUDES hemorrhage after delivery of fetus or infant

O72.0 Third-stage hemorrhage COM M ♀

Hemorrhage associated with retained, trapped or adherent placenta

Retained placenta NOS

Code also type of adherent placenta (O43.2-)

AHA: 2019,3Q,11

O72.1 Other immediate postpartum hemorrhage COM M ♀

Hemorrhage following delivery of placenta

Postpartum hemorrhage (atonic) NOS

Uterine atony with hemorrhage

EXCLUDES 1 *uterine atony NOS (O62.2)*

uterine atony without hemorrhage (O62.2)

postpartum atony of uterus without hemorrhage (O75.89)

AHA: 2016,1Q,4

DEF: Uterine atony: Failure of the uterine muscles to contract after the fetus and placenta are delivered.

O72.2 Delayed and secondary postpartum hemorrhage COM M ♀

Hemorrhage associated with retained portions of placenta or membranes after the first 24 hours following delivery of placenta

Retained products of conception NOS, following delivery

O72.3 Postpartum coagulation defects COM M ♀

Postpartum afibrinogenemia

Postpartum fibrinolysis

O73 Retained placenta and membranes, without hemorrhage

EXCLUDES 1 *placenta accreta (O43.21-)*

placenta increta (O43.22-)

placenta percreta (O43.23-)

DEF: Postpartum condition resulting from failure to expel placental membrane tissues due to failed contractions of the uterine wall.

O73.0 Retained placenta without hemorrhage COM M ♀

Adherent placenta, without hemorrhage

Trapped placenta without hemorrhage

O73.1 Retained portions of placenta and membranes, without hemorrhage COM M ♀

Retained products of conception following delivery, without hemorrhage

SAMPLE

Chapter 21. Factors Influencing Health Status and Contact With Health Services (Z00-Z99)

NOTE Z codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed. Categories Z00-Z99 are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00-Y89 are recorded as "diagnoses" or "problems." This can arise in two main ways:

(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem which is in itself not a disease or injury.

(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury.

AHA: 2018,4Q,60-61

This chapter contains the following blocks:

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

Persons encountering health services for examinations (Z00-Z13)

NOTE Nonspecific abnormal findings disclosed at the time of these examinations are classified to categories R70-R94.

EXCLUDES 1 *examinations related to pregnancy and reproduction (Z30-Z36, Z39.-)*

✓4th **Z00 Encounter for general examination without complaint, suspected or reported diagnosis**

EXCLUDES 1 *encounter for examination for administrative purposes (Z02.-)*

EXCLUDES 2 *encounter for pre-procedural examinations (Z01.81-)*

special screening examinations (Z11-Z13)

AHA: 2017,4Q,95

✓5th **Z00.0 Encounter for general adult medical examination**

Encounter for adult periodic examination (annual) (physical) and any associated laboratory and radiologic examinations

EXCLUDES 1 *encounter for examination of sign or symptom - code to sign or symptom*

general health check-up of infant or child (Z00.12.-)

Z00.00 Encounter for general adult medical examination without abnormal findings PDx A

Encounter for adult health check-up NOS

AHA: 2016,1Q,36

Z00.01 Encounter for general adult medical examination with abnormal findings PDx A

Use additional code to identify abnormal findings

AHA: 2016,1Q,35-36

✓5th **Z00.1 Encounter for newborn, infant and child health examinations**

✓6th **Z00.11 Newborn health examination**

Health check for child under 29 days old

Use additional code to identify any abnormal findings

EXCLUDES 1 *health check for child over 28 days old (Z00.12-)*

Z00.110 Health examination for newborn under 8 days old PDx N

Health check for newborn under 8 days old

Z00.111 Health examination for newborn 8 to 28 days old PDx N

Health check for newborn 8 to 28 days old

Newborn weight check

✓6th **Z00.12 Encounter for routine child health examination**

Health check (routine) for child over 28 days old

Immunizations appropriate for age

Routine developmental screening of infant or child

Routine vison and hearing testing

EXCLUDES 1 *health check for child under 29 days old (Z00.11-)*

health supervision of foundling or other healthy infant or child (Z76.1-Z76.2)

newborn health examination (Z00.11-)

AHA: 2018,4Q,36

Z00.121 Encounter for routine child health examination with abnormal findings PDx P

Use additional code to identify abnormal findings

AHA: 2016,1Q,34-35

Z00.129 Encounter for routine child health examination without abnormal findings PDx P

Encounter for routine child health examination NOS

AHA: 2016,1Q,34

Z00.2 Encounter for examination for period of rapid growth in childhood PDx P

Z00.3 Encounter for examination for adolescent development state PDx P

Encounter for puberty development state

Z00.5 Encounter for examination of potential donor of organ and tissue PDx

Z00.6 Encounter for examination for normal comparison and control in clinical research program

Examination of participant or control in clinical research program

✓5th **Z00.7 Encounter for examination for period of delayed growth in childhood**

Z00.70 Encounter for examination for period of delayed growth in childhood without abnormal findings PDx P

Z00.71 Encounter for examination for period of delayed growth in childhood with abnormal findings PDx P

Use additional code to identify abnormal findings

Z00.8 Encounter for other general examination PDx

Encounter for health examination in population surveys

✓4th **Z01 Encounter for other special examination without complaint, suspected or reported diagnosis**

INCLUDES routine examination of specific system

NOTE Codes from category Z01 represent the reason for the encounter. A separate procedure code is required to identify any examinations or procedures performed

EXCLUDES 1 *encounter for examination for administrative purposes (Z02.-)*

encounter for examination for suspected conditions, proven not to exist (Z03.-)

encounter for laboratory and radiologic examinations as a component of general medical examinations (Z00.0-)

encounter for laboratory, radiologic and imaging examinations for sign(s) and symptom(s) - code to the sign(s) or symptom(s)

EXCLUDES 2 *screening examinations (Z11-Z13)*

✓5th **Z01.0 Encounter for examination of eyes and vision**

EXCLUDES 1 *examination for driving license (Z02.4)*

Z01.00 Encounter for examination of eyes and vision without abnormal findings PDx

Encounter for examination of eyes and vision NOS

Z01.01 Encounter for examination of eyes and vision with abnormal findings PDx

Use additional code to identify abnormal findings

AHA: 2016,4Q,21

SAMPLE

Appendix F: Centers for Medicare & Medicaid Services Quality Payment Program

In 2015, in an effort to repeal the faulty Medicare sustainable growth rate (SGR), focus on quality of patient outcomes, and control Medicare spending, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which included sweeping changes for practitioners who provide services reimbursed under the Medicare physician fee schedule (MPFS). MACRA repealed the Medicare SGR methodology used for updating the MPFS and replaced it with the Quality Payment Program (QPP).

Under the QPP, providers who demonstrate success at controlling costs while providing high-quality care to their patients are eligible to earn increased payments. Clinicians who successfully report on determined criteria receive a larger payment. Those who do not participate at all or do not fulfill the defined requirements receive a negative payment adjustment of 9 percent of Medicare Part B reimbursements based on 2020 performance to be applied in 2022, negative payment adjustment of up to 9 percent of Medicare Part B reimbursements based on 2021 performance to be applied in 2023.

Passage of the Medicare Access and CHIP Reauthorization Act of 2015

The final rule for implementing MACRA was published November 4, 2016. The final rule primarily provided details on how the QPP was to be implemented, including requiring the secretary of Health and Human Services (HHS) to sunset the value-based (VM) modifier incentive program, the Medicare electronic health record (EHR) incentive program, and the Physician Quality Reporting System (PQRS), and incorporated these incentive programs into the QPP.

Replacement of the Sustainable Growth Rate

Under the SGR, if overall physician costs were higher than a targeted Medicare expenditure, payments were reduced across the board. With the SGR method, payments to clinicians would have resulted in substantial cuts.

Because the QPP replaces the SGR methodology, the following revisions were detailed in MACRA:

- Established conversion factor updates:
  - a Medicare physician fee schedule conversion factor adjustment of 0.5 percent in 2016–2019 and a conversion factor adjustment of 0.00 percent for 2020–2025
  - the qualifying participant (QP) alternative payment models (APM) conversion factor of 0.75 percent and a nonqualifying provider APM conversion factor of 0.25 percent for 2026 and each subsequent year

Under the QPP, the Centers for Medicare and Medicaid Services (CMS) aims to:

- Support quality of patient care improvement by focusing on better outcomes for patients, decreasing provider burden, and preserving the independent clinical practice
- Promote the adoption of APMs, which align incentives across healthcare stakeholders
- Advance existing efforts of delivery system reform, including ensuring a smooth transition to a new system that promotes high-quality, efficient care through unification of CMS legacy programs such as the EHR incentive program

Quality Payment Program Established

The MACRA final rule established the Quality Payment Program (QPP) effective January 1, 2017. Within the QPP there are two interrelated pathways: Advanced Alternative Payment Models (APM) and the Merit-based Incentive Payment System (MIPS).

Eligible clinicians (EC) select the track/pathway—MIPS or advanced APMs—they wish to participate in based on the practice size, specialty, location, and patient population. Unlike previous quality initiatives, a provider does not have to enroll in the QPP. However, groups wishing to participate in the MIPS program via the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS survey measures or CMS Web Interface (WI) must register by June 30 each year. Note that beginning with the 2022 performance period, the CMS WI will no longer be available as a submission or collection type. The CAHPS for MIPS survey is an optional quality measure that groups participating in MIPS can elect to administer.

In the 2020 Physician Fee Schedule Final Rule, CMS finalized a new participation framework to begin in 2021 known as MIPS Value Pathways (MVPs). The MVPs allow for a more cohesive participation experience by connecting activities and measures that are relevant to a specialty, medical condition, or a particular population. Due to the 2019 Coronavirus public health emergency (PHE), CMS postponed the implementation of MVPs as a reporting option for MIPS measures and activities through at least 2021. CMS finalized proposed updates for the criteria, process and MVP implementation, and anticipate the first MVP candidates to be proposed in the CY2022 notice of proposed rule making (NPRM). For additional and updated information on MVPs, see https://qpp.cms.gov/mips/mips-value-pathways.

Merit-based Incentive Payment System

MIPS is the track for clinicians who opt to participate in traditional Medicare as opposed to participating through an advanced APM. In doing so, clinicians may earn a payment adjustment related to evidence-based and practice-specific quality data. As a result, depending on the degree and success of performance in all four categories for CY 2021, clinicians receive one of the following:

- Positive payment adjustment in which additional compensation is received; bonuses are also available for meeting the exceptional performance threshold
- Neutral payment adjustment that neither increases nor reduces Medicare payments
- Negative payment adjustment of up to 9 percent of Medicare payment furnished in calendar year (CY) 2023

Participation in the MIPS track is determined based on the amount billed to Medicare and the number of beneficiaries seen per year. The following provider types are eligible for participation if they meet or exceed at least one of the following criteria:

- Medicare billings are greater than $90,000
- Care is provided for more than 200 covered services
- Care is provided to 200 or more Medicare patients each year

For 2021, the following clinician types are considered ECs:

- Physicians (MD, DO, DDS, DMD, DPM, OD)
- Physician assistants (PA)
- Nurse practitioners (NP)
- Clinical nurse specialists (CNS)
- Certified registered nurse anesthetists (CRNA)
- Physical therapists (PT)
- Occupational therapists (OT)
- Qualified speech-language pathologists
- Qualified audiologists
- Clinical psychologists
- Osteopathic practitioners
- Chiropractor
- Registered dieticians or nutrition professionals
- Any clinician group that includes one of the professionals listed above

Anatomy of MIPS

A measurement-based regime creates a single reporting framework for physicians that comprise four performance categories:

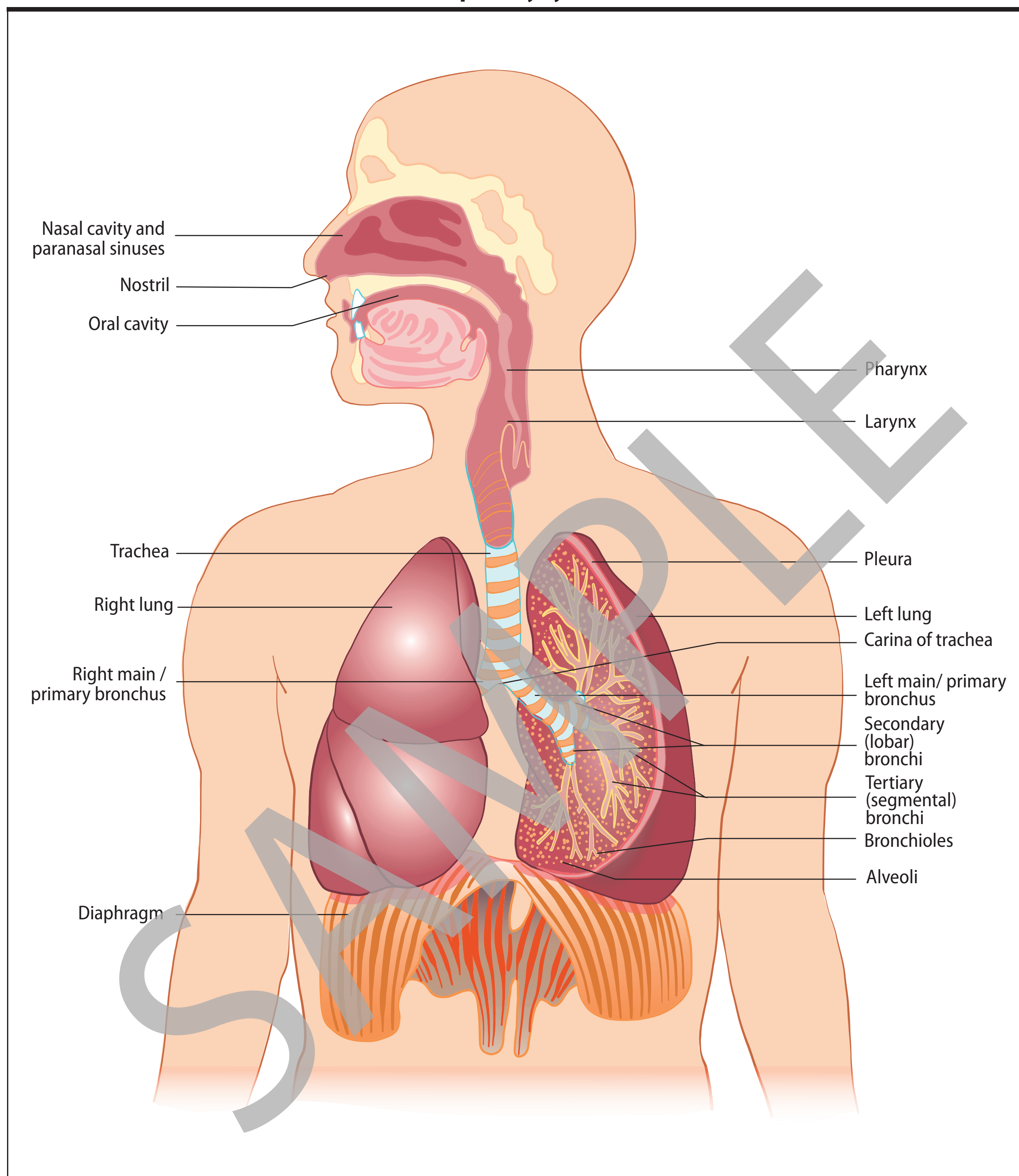
- Quality
- Improvement Activities (IA)—implemented in 2017
- Promoting Interoperability
- Cost

MIPS eligible clinicians may participate in the program as an individual clinician, group, virtual group, or APM entity (applicable for 2021). Each of the four performance categories has been weighted, with greatest emphasis placed on the Quality category. Performance category weights for individuals, groups, and virtual groups placed the Quality category at 40 percent, Promoting Interoperability is second at 25 percent, IA at 15 percent, and Cost at 20 percent. Performance category weights for APM entities reporting traditional MIPS for the 2021 performance period are weighted differently than these participation levels. The emphasis is still on the Quality category at 50 percent, Promoting Interoperability is second at 30 percent, Improvement Activities is third at 20 percent, and Cost is at 0 percent. Beginning with the 2022 performance period regardless of participation level (e.g., individual, group, etc.) the quality and cost performance categories will be equally weighted at 30%.

SAMPLE

Chapter 10. Diseases of the Respiratory System (JØØ–J99)

Respiratory System



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