Optum

2024 coding guidelines included

Expert

ICD-10-CM Expert for Skilled Nursing Facilities and Inpatient Rehabilitation Facilities

The complete official code set

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

2024

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Contents

How to Use ICD-10-CM Expert for Skilled Nursing Facilities and Inpatient Rehabilitation Facilities 2024

Introduction

ICD-10-CM for Skilled Nursing Facilities and Inpatient Rehabilitation Facilities: The Complete Official Code Set is your definitive coding resource, combining the work of the National Center for Health Statistics (NCHS), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and Optum experts to provide the information you need for coding accuracy.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), is an adaptation of ICD-10, copyrighted by the World Health Organization (WHO). The development and maintenance of this clinical modification (CM) is the responsibility of the NCHS as authorized by WHO. Any new concepts added to ICD-10-CM are based on an established update process through the collaboration of WHO's Update and Revision Committee and the ICD-10-CM Coordination and Maintenance Committee.

In addition to the ICD-10-CM classification, other official government source information has been included in this manual. Depending on the source, updates to information may be annual or quarterly. This manual provides the most current information that was available at the time of publication. For updates to the source documents that may have occurred after this manual was published, please refer to the following:

- **NCHS, International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)**

  https://www.cms.gov/medicare/icd-10/2023-icd-10-cm

- **CMS Integrated Outpatient Code Editor (IOCE), version 23.2**

  https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html

- **CMS Skilled Nursing Facility Quality Reporting Program (SNF QRP)**

  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Overview.html

- **CMS Skilled Nursing Facility Prospective Payment System (SNF PPS)**

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html

- **CMS Inpatient Rehabilitation Facility Prospective Payment Model (IRF PPS)**

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/index.html

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html

- **AHA Coding Clinics**

  https://www.codingclinicadvisor.com/

The official NCHS ICD-10-CM classification includes three main sections: the guidelines, the indexes, and the tabular list, all of which make up the bulk of this coding manual. To complement the classification, Optum's coding experts have incorporated Medicare-related coding edits and proprietary features, such as supplementary notations, coding tools, and appendixes, into a comprehensive and easy-to-use reference. This publication is organized as follows:

What's New for 2023

This section provides a high-level overview of the code changes made for FY 2023. The list of codes provided identifies new, revised, and deleted codes. Asterisked codes identify prior midyear changes that were made to the classification, effective April 1, 2022. All changes are based on an official addendum, provided by the National Center for Health Statistics (NCHS), the agency charged with maintaining and updating ICD-10-CM. NCHS is part of the Centers for Disease Control and Prevention (CDC).

Conversion Table

The conversion table was developed by National Center for Healthcare Statistics (NCHS) to help facilitate data retrieval as new codes are added to the ICD-10-CM classification. This table provides a crosswalk from each FY 2023 new code to the equivalent code(s) assigned, prior to October 1, 2022, for that diagnosis or condition. Asterisked codes identify prior midyear additions, effective April 1, 2022. For the full conversion table, refer to the Conversion Table zip file at https://www.cms.gov/medicare/icd-10/2023-icd-10-cm.

10 Steps to Correct Coding

This step-by-step tutorial walks the coder through the process of finding the correct code — from locating the code in the official indexes to verifying the code in the tabular section — while following applicable conventions, guidelines, and instructional notes. Specific examples are provided with detailed explanations of each coding step along with advice for proper sequencing.

Official ICD-10-CM Guidelines for Coding and Reporting

This section provides the full official conventions and guidelines regulating the appropriate assignment and reporting of ICD-10-CM codes. These conventions and guidelines are published by the U.S. Department of Health and Human Services (DHHS) and approved by the cooperating parties (American Health Information Management Association [AHIMA], National Center for Health Statistics [NCHS], Centers for Disease Control and Prevention [CDC], and the American Hospital Association [AHA]).

Indexes

Index to Diseases and Injuries

The Index to Diseases and Injuries is arranged in alphabetic order by terms specific to a disease, condition, illness, injury, eponym, or abbreviation as well as terms that describe circumstances other than a disease or injury that may require attention from a health care professional.

Neoplasm Table

The Neoplasm Table is arranged in alphabetic order by anatomical site. Codes are then listed in individual columns based upon the histological behavior (malignant, in situ, benign, uncertain, or unspecified) of the neoplasm.

Table of Drugs and Chemicals

The Table of Drugs and Chemicals is arranged in alphabetic order by the specific drug or chemical name. Codes are listed in individual columns based upon the associated intent (poisoning, adverse effect, or underdosing). **Note:** Drugs with an asterisk identify substances added to the table by Optum subject matter experts.

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*** RP
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."

G03.9 **Meningitis, unspecified** CC
Arachnoiditis (spinal) NOS
RIC Excl: 03 Non-traumatic brain injury; 05 Non-traumatic spinal cord injury

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 post-acute 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: Skilled Nursing Facility Prospective Payment System Overview
To better classify residents for payment purposes and to ensure that residents' care needs are addressed, Medicare developed the Patient-Driven Payment Model (PDPM), which replaced the RUG-IV classification system. Payments are predominantly based on clinical characteristics instead of service provision. This resource describes the PDPM and its elements, as well as how this classification system is used within the skilled nursing facility prospective payment system (SNF PPS).

Appendix E: PDPM Comorbid Conditions
This resource provides a comprehensive list of the ICD-10-CM codes that are considered comorbid conditions for the non-therapy ancillary (NTA) and the speech-language pathology (SLP) components of the PDPM.

Appendix F: PDPM Return-to-Provider Code List
This resource provides a comprehensive list of the ICD-10-CM codes that are *not* acceptable as the primary reason for SNF care. When one of these codes is listed as the primary diagnosis code on the minimum data set (MDS), the MDS should be returned to the provider to select an appropriate ICD-10-CM diagnosis code.

Appendix G: Skilled Nursing Facility Active Diagnosis List
This resource includes the minimum data set (MDS) data elements that capture the relevant diagnostic or surgical information needed to calculate one or more of the components in PDPM.

Appendix H: Inpatient Rehabilitation Facility Prospective Payment System (PPS) Overview
The inpatient rehabilitation facility prospective payment system (IRF PPS) provides payment rates for rehabilitation facilities providing post-acute care for patients that require additional services to restore the patient's ability to live and work after a disabling injury or illness. This resource summarizes the revisions to the Quality Reporting Program, changes to the IRF-PAI instrument, IRF requirements, and the proposed changes to the IRF PPS for FY 2023.

Appendix I: Rehabilitation Impairment Categories (RIC)
This resource provides a reference of all rehabilitation impairment categories (RIC) and the ICD-10-CM codes associated with each RIC.

Appendix J: RIC Comorbid Conditions
Certain conditions when listed as a secondary diagnosis during a rehabilitation admission may qualify that stay for payment adjustment. All diagnoses that are considered comorbid conditions are identified in this resource in addition to any rehabilitation categories from which the comorbid condition would be exempt.

Appendix K: Coding Issues for Long-Term Care (LTC)
This resource identifies coding and reporting issues that may be encountered in the long-term (post-acute) care setting. Specific case scenarios along with the applicable ICD-10-CM code(s) and rationales are provided.

Illustrations

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

10 Steps to Correct Coding

Follow the 10 steps below to correctly code encounters for health care services.

Step 1: Identify the reason for the visit or encounter (i.e., a sign, symptom, diagnosis and/or condition).

The medical record documentation should accurately reflect the patient's condition, using terminology that includes specific diagnoses and symptoms or clearly states the reasons for the encounter.

Choosing the main term that best describes the reason chiefly responsible for the service provided is the most important step in coding. If symptoms are present and documented but a definitive diagnosis has not yet been determined, code the symptoms. *For outpatient cases, do not code conditions that are referred to as "rule out," "suspected," "probable," or "questionable."* Diagnoses often are not established at the time of the initial encounter/visit and may require two or more visits to be established. Code only what is documented in the available outpatient records and only to the highest degree of certainty known at the time of the patient's visit. For inpatient medical records, uncertain diagnoses may be reported if documented at the time of discharge.

Step 2: After selecting the reason for the encounter, consult the alphabetic index.

The most critical rule is to begin code selection in the alphabetic index. Never turn first to the tabular list. The index provides cross-references, essential and nonessential modifiers, and other instructional notations that may not be found in the tabular list.

Step 3: Locate the main term entry.

The alphabetic index lists conditions, which may be expressed as nouns or eponyms, with critical use of adjectives. Some conditions known by several names have multiple main entries. Reasons for encounters may be located under general terms such as admission, encounter, and examination. Other general terms such as history, status (post), or presence (of) can be used to locate other factors influencing health.

Step 4: Scan subterm entries.

Scan the subterm entries, as appropriate, being sure to review continued lines and additional subterms that may appear in the next column or on the next page. Shaded vertical guidelines in the index indicate the indentation level for each subterm in relation to the main terms.

Step 5: Pay close attention to index instructions.

- Parentheses ( ) enclose nonessential modifiers, terms that are supplementary words or explanatory information that may or may not appear in the diagnostic statement and do not affect code selection.
- Brackets [ ] enclose manifestation codes that can be used only as secondary codes to the underlying condition code immediately preceding it. If used, manifestation codes must be reported with the appropriate etiology codes.
- Default codes are listed next to the main term and represent the condition most commonly associated with the main term or the unspecified code for the main term.
- "*See*" cross-references, identified by italicized type and "code by" cross-references indicate that another term *must be referenced* to locate the correct code.
- "*See also*" cross-references, identified by italicized type, provide alternative terms that may be useful to look up but *are not mandatory*.
- "Omit code" cross-references identify instances when a code is not applicable depending on the condition being coded.
- "With" subterms are listed out of alphabetic order and identify a presumed causal relationship between the two conditions they link.
- "Due to" subterms identify a relationship between the two conditions they link.
- "NEC," abbreviation for "not elsewhere classified," follows some main terms or subterms and indicates that there is no specific code for the condition even though the medical documentation may be very specific.
- "NOS," abbreviation for "not otherwise specified," follows some main terms or subterms and is the equivalent of unspecified; NOS signifies that the information in the medical record is insufficient for assigning a more specific code.
- *Following* references help coders locate alphanumeric codes that are out of sequence in the tabular section.
- Check-additional-character symbols flag codes that require additional characters to make the code valid; the characters available to complete the code should be verified in the tabular section.

Step 6: Choose a potential code and locate it in the tabular list.

To prevent coding errors, always use both the alphabetic index (to identify a code) and the tabular list (to verify a code), as the index does not include the important instructional notes found in the tabular list. An added benefit of using the tabular list, which groups like things together, is that while looking at one code in the list, a coder might see a more specific one that would have been missed had the coder relied solely on the alphabetic index. Additionally, many of the codes require a fourth, fifth, sixth, or seventh character to be valid, and many of these characters can be found only in the tabular list.

Step 7: Read all instructional material in the tabular section.

The coder must follow any Includes, Excludes 1 and Excludes 2 notes, and other instructional notes, such as "Code first" and "Use additional code," listed in the tabular list for the chapter, category, subcategory, and subclassification levels of code selection that direct the coder to use a different or additional code. Any codes in the tabular range A00.0- through T88.9- may be used to identify the diagnostic reason for the encounter. The tabular list encompasses many codes describing disease and injury classifications (e.g., infectious and parasitic diseases, neoplasms, symptoms, nervous and circulatory system, etc.).

Codes that describe symptoms and signs, as opposed to definitive diagnoses, should be reported when an established diagnosis has not been made (confirmed) by the physician. Chapter 18 of the ICD-10-CM code book, "Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified" (codes R00–R99), contains many, but not all, codes for symptoms.

ICD-10-CM classifies encounters with health care providers for circumstances other than a disease or injury in chapter 21, "Factors Influencing Health Status and Contact with Health Services" (codes Z00–Z99). Circumstances other than a disease or injury often are recorded as chiefly responsible for the encounter.

A code is invalid if it does not include the full number of characters (greatest level of specificity) required. Codes in ICD-10-CM can contain from three to seven alphanumeric characters. A three-character code is to be used only if the category is not further subdivided into four-, five-, six-, or seven-character codes. Placeholder character X is used as part of an alphanumeric code to allow for future expansion and as a placeholder for empty characters in a code that requires a seventh character but has no fourth, fifth, or sixth character. Note that certain categories require seventh characters that apply to all codes in that category. Always check the category level for applicable seventh characters for that category.

Step 8: Consult the official ICD-10-CM conventions and guidelines.

The *ICD-10-CM Official Guidelines for Coding and Reporting* govern the use of certain codes. These guidelines provide both general and chapter-specific coding guidance.

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	C80.1	C79.9	D09.9	D36.9	D48.9	D49.9
abdomen, abdominal	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
cavity	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
organ	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
viscera	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
wall — *see also* Neoplasm, abdomen, wall, skin	C44.509	C79.2	D04.5	D23.5	D48.5	D49.2
connective tissue	C49.4	C79.8-☑	—	D21.4	D48.1	D49.2
skin	C44.509	—	—	—	—	—
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	D00.08	D10.6	D37.05	D49.0
adipose tissue — *see also* Neoplasm, connective tissue	C49.4	C79.89	—	D21.9	D48.1	D49.2
adnexa (uterine)	C57.4	C79.89	D07.39	D28.7	D39.8	D49.59
adrenal	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
capsule	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
cortex	C74.0-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
gland	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
medulla	C74.1-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
ala nasi (external) — *see also* Neoplasm, skin, nose	C44.301	C79.2	D04.39	D23.39	D48.5	D49.2
alimentary canal or tract NEC	C26.9	C78.80	D01.9	D13.9	D37.9	D49.0
alveolar	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ridge or process	C41.1	C79.51	—	D16.5	D48.0	D49.2
carcinoma	C03.9	C79.8-☑	—	—	—	—
lower	C03.1	C79.8-☑	—	—	—	—
upper	C03.0	C79.8-☑	—	—	—	—
lower	C41.1	C79.51	—	D16.5	D48.0	D49.2
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C41.0	C79.51	—	D16.4	D48.0	D49.2
sulcus	C06.1	C79.89	D00.02	D10.39	D37.09	D49.0
alveolus	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ampulla of Vater	C24.1	C78.89	D01.5	D13.5	D37.6	D49.0
ankle NEC	C76.5-☑	C79.89	D04.7-☑	D36.7	D48.7	D49.89
anorectum, anorectal (junction)	C21.8	C78.5	D01.3	D12.9	D37.8	D49.0
antecubital fossa or space	C76.4-☑	C79.89	D04.6-☑	D36.7	D48.7	D49.89
antrum (Highmore) (maxillary)	C31.0	C78.39	D02.3	D14.0	D38.5	D49.1
pyloric	C16.3	C78.89	D00.2	D13.1	D37.1	D49.0
tympanicum	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
anus, anal	C21.0	C78.5	D01.3	D12.9	D37.8	D49.0
canal	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
cloacogenic zone	C21.2	C78.5	D01.3	D12.9	D37.8	D49.0
margin — *see also* Neoplasm, anus, skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
overlapping lesion with rectosigmoid junction or rectum	C21.8	—	—	—	—	—
skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
basal cell carcinoma	C44.510	—	—	—	—	—
specified type NEC	C44.590	—	—	—	—	—
squamous cell carcinoma	C44.520	—	—	—	—	—
sphincter	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
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	D01.0	D12.1	D37.3	D49.0
arachnoid	C70.9	C79.49	—	D32.9	D42.9	D49.7
cerebral	C70.0	C79.32	—	D32.0	D42.0	D49.7
spinal	C70.1	C79.49	—	D32.1	D42.1	D49.7
areola	C50.0-☑	C79.81	D05-☑	D24-☑	D48.6-☑	D49.3
arm NEC	C76.4-☑	C79.89	D04.6-☑	D36.7	D48.7	D49.89
artery — *see* Neoplasm, connective tissue						
aryepiglottic fold	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
hypopharyngeal aspect	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
laryngeal aspect	C32.1	C78.39	D02.0	D14.1	D38.0	D49.1
marginal zone	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
arytenoid (cartilage)	C32.3	C78.39	D02.0	D14.1	D38.0	D49.1
fold — *see* Neoplasm, aryepiglottic						
associated with transplanted organ	C80.2	—	—	—	—	—
atlas	C41.2	C79.51	—	D16.6	D48.0	D49.2
atrium, cardiac	C38.0	C79.89	—	D15.1	D48.7	D49.89
auditory canal (external) (skin)	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
tube	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
opening	C11.2	C79.89	D00.08	D10.6	D37.05	D49.0
auricle, ear — *see also* Neoplasm, skin, ear	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
auricular canal (external) — *see also* Neoplasm, skin, ear	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.2
autonomic nerve or nervous system NEC (see Neoplasm, nerve, peripheral)						
axilla, axillary	C76.1	C79.89	D09.8	D36.7	D48.7	D49.89
fold — *see also* Neoplasm, skin, trunk	C44.509	C79.2	D04.5	D23.5	D48.5	D49.2
back NEC	C76.8	C79.89	D04.5	D36.7	D48.7	D49.89
Bartholin's gland	C51.0	C79.82	D07.1	D28.0	D39.8	D49.59
basal ganglia	C71.0	C79.31	—	D33.0	D43.0	D49.6
basis pedunculi	C71.7	C79.31	—	D33.1	D43.1	D49.6
bile or biliary (tract)	C24.9	C78.89	D01.5	D13.5	D37.6	D49.0

Chapter 1. Certain Infectious and Parasitic Diseases (A00–B99)

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. Human immunodeficiency virus (HIV) infections

1) Code only confirmed cases

Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.

In this context, "confirmation" does not require documentation of positive serology or culture for HIV; the provider's diagnostic statement that the patient is HIV positive or has an HIV-related illness is sufficient.

Patient admitted with anemia with possible HIV infection

D64.9 Anemia, unspecified

Explanation: Only the anemia is coded in this scenario because it has not been confirmed that an HIV infection is present.

2) Selection and sequencing of HIV codes

(a) Patient admitted for HIV-related condition

If a patient is admitted for an HIV-related condition, the principal diagnosis should be B20, Human immunodeficiency virus [HIV] disease followed by additional diagnosis codes for all reported HIV-related conditions.

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

HIV with PCP

B20 Human immunodeficiency virus [HIV] disease

B59 Pneumocystosis

Explanation: Pneumonia due to *Pneumocystis carinii* is an HIV-related condition, so the HIV diagnosis code is reported first, followed by the code for the pneumonia.

(b) Patient with HIV disease admitted for unrelated condition

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be B20 followed by additional diagnosis codes for all reported HIV-related conditions.

Unstable angina, native coronary artery atherosclerosis, HIV

I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

B20 Human immunodeficiency virus [HIV] disease

Explanation: The arteriosclerotic coronary artery disease and the unstable angina are not related to HIV, so those conditions are reported first using a combination code, and HIV is reported secondarily.

(c) Whether the patient is newly diagnosed

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

Newly diagnosed multiple cutaneous Kaposi's sarcoma lesions in previously diagnosed HIV disease

B20 Human immunodeficiency virus [HIV] disease

C46.0 Kaposi's sarcoma of skin

Explanation: Even though the HIV was diagnosed on a previous encounter, it is still sequenced first when coded with an HIV- related condition. Kaposi's sarcoma is an HIV-related condition.

(d) Asymptomatic human immunodeficiency virus

Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" or "HIV disease" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use B20 in these cases.

(e) Patients with inconclusive HIV serology

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned code R75, Inconclusive laboratory evidence of human immunodeficiency virus [HIV].

(f) Previously diagnosed HIV-related illness

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

(g) HIV infection in pregnancy, childbirth and the puerperium

During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of O98.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by B20 and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth, or the puerperium should receive codes of O98.7- and Z21.

(h) Encounters for testing for HIV

If a patient is being seen to determine his/her HIV status, use code Z11.4, Encounter for screening for human immunodeficiency virus [HIV]. Use additional codes for any associated high-risk behavior, if applicable.

If a patient with signs or symptoms is being seen for HIV testing, code the signs and symptoms. An additional counseling code Z71.7, Human immunodeficiency virus [HIV] counseling, may be used if counseling is provided during the encounter for the test.

When a patient returns to be informed of his/her HIV test results and the test result is negative, use code Z71.7, Human immunodeficiency virus [HIV] counseling.

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

(i) HIV managed by antiretroviral medication

If a patient with documented HIV disease, **HIV-related illness or AIDS** is currently managed on antiretroviral medications, assign code B20, Human immunodeficiency virus [HIV] disease. Code Z79.899, Other long term (current) drug therapy, may be assigned as an additional code to identify the long-term (current) use of antiretroviral medications.

b. Infectious agents as the cause of diseases classified to other chapters

Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism. A code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.

c. Infections resistant to antibiotics

Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign a code from category Z16, Resistance to antimicrobial drugs, following the infection code only if the infection code does not identify drug resistance.

E05.31 Thyrotoxicosis from ectopic thyroid tissue with thyrotoxic crisis or storm

✓5th **E05.4 Thyrotoxicosis factitia**

E05.40 Thyrotoxicosis factitia without thyrotoxic crisis or storm

E05.41 Thyrotoxicosis factitia with thyrotoxic crisis or storm

✓5th **E05.8 Other thyrotoxicosis**

Overproduction of thyroid-stimulating hormone

E05.80 Other thyrotoxicosis without thyrotoxic crisis or storm

E05.81 Other thyrotoxicosis with thyrotoxic crisis or storm

✓5th **E05.9 Thyrotoxicosis, unspecified**

Hyperthyroidism NOS

E05.90 Thyrotoxicosis, unspecified without thyrotoxic crisis or storm

E05.91 Thyrotoxicosis, unspecified with thyrotoxic crisis or storm

✓4th **E06 Thyroiditis**

EXCLUDES 1 *postpartum thyroiditis (O90.5)*

DEF: Inflammation of the thyroid gland.

E06.0 Acute thyroiditis

Abscess of thyroid
Pyogenic thyroiditis
Suppurative thyroiditis
Use additional code (B95-B97) to identify infectious agent

E06.1 Subacute thyroiditis

de Quervain thyroiditis
Giant-cell thyroiditis
Granulomatous thyroiditis
Nonsuppurative thyroiditis
Viral thyroiditis

EXCLUDES 1 *autoimmune thyroiditis (E06.3)*

E06.2 Chronic thyroiditis with transient thyrotoxicosis

EXCLUDES 1 *autoimmune thyroiditis (E06.3)*

E06.3 Autoimmune thyroiditis

Hashimoto's thyroiditis
Hashitoxicosis (transient)
Lymphadenoid goiter
Lymphocytic thyroiditis
Struma lymphomatosa

E06.4 Drug-induced thyroiditis

Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)

E06.5 Other chronic thyroiditis

Chronic fibrous thyroiditis
Chronic thyroiditis NOS
Ligneous thyroiditis
Riedel thyroiditis

E06.9 Thyroiditis, unspecified

✓4th **E07 Other disorders of thyroid**

E07.0 Hypersecretion of calcitonin

C-cell hyperplasia of thyroid
Hypersecretion of thyrocalcitonin

E07.1 Dyshormogenetic goiter

Familial dyshormogenetic goiter
Pendred's syndrome

EXCLUDES 1 *transitory congenital goiter with normal function (P72.0)*

✓5th **E07.8 Other specified disorders of thyroid**

E07.81 Sick-euthyroid syndrome

Euthyroid sick-syndrome
DEF: Thyroid dysfunction caused by abnormal levels of thyroid hormones T3 and/or T4. This syndrome is often associated with starvation or critical illness.

E07.89 Other specified disorders of thyroid

Abnormality of thyroid-binding globulin
Hemorrhage of thyroid
Infarction of thyroid

E07.9 Disorder of thyroid, unspecified

Diabetes mellitus (E08-E13)

AHA: 2020,1Q,12; 2018,2Q,6; 2017,4Q,100-101; 2016,2Q,36; 2016,1Q,11-13; 2013,4Q,114; 2013,3Q,20

TIP: There is no default code for diabetes mellitus documented only as uncontrolled. The provider must indicate whether the diabetic patient is hypoglycemic or hyperglycemic to determine the appropriate code.

✓4th **E08 Diabetes mellitus due to underlying condition**

Code first the underlying condition, such as:
congenital rubella (P35.0)
Cushing's syndrome (E24.-)
cystic fibrosis (E84.-)
malignant neoplasm (C00-C96)
malnutrition (E40-E46)
pancreatitis and other diseases of the pancreas (K85-K86.-)

Use additional code to identify control using:
insulin (Z79.4)
oral antidiabetic drugs (Z79.84)
oral hypoglycemic drugs (Z79.84)

EXCLUDES 1 *drug or chemical induced diabetes mellitus (E09.-)*
gestational diabetes (O24.4-)
neonatal diabetes mellitus (P70.2)
postpancreatectomy diabetes mellitus (E13.-)
postprocedural diabetes mellitus (E13.-)
secondary diabetes mellitus NEC (E13.-)
type 1 diabetes mellitus (E10.-)
type 2 diabetes mellitus (E11.-)

✓5th **E08.0 Diabetes mellitus due to underlying condition with hyperosmolarity**

DEF: Diabetic hyperosmolarity: Extremely high levels of glucose in the blood without ketones.

E08.00 Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC) RP

E08.01 Diabetes mellitus due to underlying condition with hyperosmolarity with coma RP

✓5th **E08.1 Diabetes mellitus due to underlying condition with ketoacidosis**

DEF: Diabetic ketoacidosis: Potentially life-threatening complication due to a shortage of insulin in which the body switches to burning fatty acids and producing acidic ketone bodies.

E08.10 Diabetes mellitus due to underlying condition with ketoacidosis without coma RP

E08.11 Diabetes mellitus due to underlying condition with ketoacidosis with coma RP

✓5th **E08.2 Diabetes mellitus due to underlying condition with kidney complications**

AHA: 2019,3Q,3; 2018,4Q,88

E08.21 Diabetes mellitus due to underlying condition with diabetic nephropathy RP CC

Diabetes mellitus due to underlying condition with intercapillary glomerulosclerosis
Diabetes mellitus due to underlying condition with intracapillary glomerulonephrosis
Diabetes mellitus due to underlying condition with Kimmelstiel-Wilson disease

E08.22 Diabetes mellitus due to underlying condition with diabetic chronic kidney disease RP CC

Use additional code to identify stage of chronic kidney disease (N18.1-N18.6)

E08.29 Diabetes mellitus due to underlying condition with other diabetic kidney complication RP CC

Renal tubular degeneration in diabetes mellitus due to underlying condition

K83 Other diseases of biliary tract
EXCLUDES 1 *postcholecystectomy syndrome (K91.5)*
EXCLUDES 2 *conditions involving the gallbladder (K81-K82)*
conditions involving the cystic duct (K81-K82)

K83.0 Cholangitis
EXCLUDES 1 *cholangitic liver abscess (K75.0)*
cholangitis with choledocholithiasis (K80.3-, K80.4-)
EXCLUDES 2 *chronic nonsuppurative destructive cholangitis (K74.3)*
primary biliary cholangitis (K74.3)
primary biliary cirrhosis (K74.3)
AHA: 2018,4Q,20
K83.01 Primary sclerosing cholangitis
K83.09 Other cholangitis
Ascending cholangitis
Cholangitis NOS
Primary cholangitis
Recurrent cholangitis
Sclerosing cholangitis
Secondary cholangitis
Stenosing cholangitis
Suppurative cholangitis

K83.1 Obstruction of bile duct
Occlusion of bile duct without cholelithiasis
Stenosis of bile duct without cholelithiasis
Stricture of bile duct without cholelithiasis
EXCLUDES 1 *congenital obstruction of bile duct (Q44.3)*
obstruction of bile duct with cholelithiasis (K80.-)
AHA: 2016,1Q,18

K83.2 Perforation of bile duct CC
Rupture of bile duct

K83.3 Fistula of bile duct
Choledochoduodenal fistula
AHA: 2019,1Q,17

K83.4 Spasm of sphincter of Oddi

K83.5 Biliary cyst

K83.8 Other specified diseases of biliary tract
Adhesions of biliary tract
Atrophy of biliary tract
Hypertrophy of biliary tract
Ulcer of biliary tract

K83.9 Disease of biliary tract, unspecified

K85 Acute pancreatitis
INCLUDES acute (recurrent) pancreatitis
subacute pancreatitis
AHA: 2016,4Q,34

K85.0 Idiopathic acute pancreatitis
K85.00 Idiopathic acute pancreatitis without necrosis or infection
K85.01 Idiopathic acute pancreatitis with uninfected necrosis
K85.02 Idiopathic acute pancreatitis with infected necrosis

K85.1 Biliary acute pancreatitis
Gallstone pancreatitis
K85.10 Biliary acute pancreatitis without necrosis or infection
K85.11 Biliary acute pancreatitis with uninfected necrosis
K85.12 Biliary acute pancreatitis with infected necrosis

K85.2 Alcohol induced acute pancreatitis
EXCLUDES 2 *alcohol induced chronic pancreatitis (K86.0)*
K85.20 Alcohol induced acute pancreatitis without necrosis or infection
AHA: 2020,1Q,9
K85.21 Alcohol induced acute pancreatitis with uninfected necrosis
K85.22 Alcohol induced acute pancreatitis with infected necrosis

K85.3 Drug induced acute pancreatitis
Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)
Use additional code to identify drug abuse and dependence (F11.- F17.-)
K85.30 Drug induced acute pancreatitis without necrosis or infection
K85.31 Drug induced acute pancreatitis with uninfected necrosis
K85.32 Drug induced acute pancreatitis with infected necrosis

K85.8 Other acute pancreatitis
K85.80 Other acute pancreatitis without necrosis or infection
K85.81 Other acute pancreatitis with uninfected necrosis
K85.82 Other acute pancreatitis with infected necrosis

K85.9 Acute pancreatitis, unspecified
Pancreatitis NOS
K85.90 Acute pancreatitis without necrosis or infection, unspecified
K85.91 Acute pancreatitis with uninfected necrosis, unspecified
K85.92 Acute pancreatitis with infected necrosis, unspecified

K86 Other diseases of pancreas
EXCLUDES 2 *fibrocystic disease of pancreas (E84.-)*
islet cell tumor (of pancreas) (D13.7)
pancreatic steatorrhea (K90.3)

K86.0 Alcohol-induced chronic pancreatitis NA
Use additional code to identify:
alcohol abuse and dependence (F10.-)
Code also exocrine pancreatic insufficiency (K86.81)
EXCLUDES 2 *alcohol induced acute pancreatitis (K85.2-)*

K86.1 Other chronic pancreatitis NA
Chronic pancreatitis NOS
Infectious chronic pancreatitis
Recurrent chronic pancreatitis
Relapsing chronic pancreatitis
Code also exocrine pancreatic insufficiency (K86.81)

K86.2 Cyst of pancreas CC

K86.3 Pseudocyst of pancreas CC

K86.8 Other specified diseases of pancreas
AHA: 2016,4Q,34-35
K86.81 Exocrine pancreatic insufficiency
K86.89 Other specified diseases of pancreas
Aseptic pancreatic necrosis, unrelated to acute pancreatitis
Atrophy of pancreas
Calculus of pancreas
Cirrhosis of pancreas
Fibrosis of pancreas
Pancreatic fat necrosis, unrelated to acute pancreatitis
Pancreatic infantilism
Pancreatic necrosis NOS, unrelated to acute pancreatitis

K86.9 Disease of pancreas, unspecified RP

K87 Disorders of gallbladder, biliary tract and pancreas in diseases classified elsewhere RP
Code first underlying disease
EXCLUDES 1 *cytomegaloviral pancreatitis (B25.2)*
mumps pancreatitis (B26.3)
syphilitic gallbladder (A52.74)
syphilitic pancreas (A52.74)
tuberculosis of gallbladder (A18.83)
tuberculosis of pancreas (A18.83)

Other diseases of the digestive system (K90-K95)

K90 Intestinal malabsorption
EXCLUDES 1 *intestinal malabsorption following gastrointestinal surgery (K91.2)*
AHA: 2017,4Q,108

K90.0 Celiac disease
Celiac disease with steatorrhea
Celiac gluten-sensitive enteropathy
Nontropical sprue
Use additional code for associated disorders including:
dermatitis herpetiformis (L13.0)
gluten ataxia (G32.81)
Code also exocrine pancreatic insufficiency (K86.81)
DEF: Malabsorption syndrome due to gluten consumption. Symptoms include fetid, bulky, frothy, oily stools; a distended abdomen; gas; asthenia; electrolyte depletion; and vitamin B, D, and K deficiency.

Muscle/Tendon Table

ICD-10-CM categorizes certain muscles and tendons in the upper and lower extremities by their action (e.g., extension, flexion), their anatomical location (e.g., posterior, anterior), and/or whether they are intrinsic or extrinsic to a certain anatomical area. The Muscle/Tendon Table is provided at the beginning of chapters 13 and 19 as a resource to help users when code selection depends on one or more of these characteristics. Please note that this table is not all-inclusive, and proper code assignment should be based on the provider's documentation.

Body Region	Muscle	Extensor Tendon	Flexor Tendon	Other Tendon
Shoulder				
	Deltoid	Posterior deltoid	Anterior deltoid	
	Rotator cuff			
	Infraspinatus			Infraspinatus
	Subscapularis			Subscapularis
	Supraspinatus			Supraspinatus
	Teres minor			Teres minor
	Teres major	Teres major		
Upper arm				
	Anterior muscles			
	Biceps brachii — long head		Biceps brachii — long head	
	Biceps brachii — short head		Biceps brachii — short head	
	Brachialis		Brachialis	
	Coracobrachialis		Coracobrachialis	
	Posterior muscles			
	Triceps brachii	Triceps brachii		
Forearm				
	Anterior muscles			
	Flexors			
	Deep			
	Flexor digitorum profundus		Flexor digitorum profundus	
	Flexor pollicis longus		Flexor pollicis longus	
	Intermediate			
	Flexor digitorum superficialis		Flexor digitorum superficialis	
	Superficial			
	Flexor carpi radialis		Flexor carpi radialis	
	Flexor carpi ulnaris		Flexor carpi ulnaris	
	Palmaris longus		Palmaris longus	
	Pronators			
	Pronator quadratus			Pronator quadratus
	Pronator teres			Pronator teres
	Posterior muscles			
	Extensors			
	Deep			
	Abductor pollicis longus			Abductor pollicis longus
	Extensor indicis	Extensor indicis		
	Extensor pollicis brevis	Extensor pollicis brevis		
	Extensor pollicis longus	Extensor pollicis longus		
	Superficial			
	Brachioradialis			Brachioradialis
	Extensor carpi radialis brevis	Extensor carpi radialis brevis		
	Extensor carpi radialis longus	Extensor carpi radialis longus		
	Extensor carpi ulnaris	Extensor carpi ulnaris		
	Extensor digiti minimi	Extensor digiti minimi		
	Extensor digitorum	Extensor digitorum		
	Anconeus	Anconeus		
	Supinator			Supinator

Injuries to the neck (S10-S19)

INCLUDES injuries of nape
injuries of supraclavicular region
injuries of throat

EXCLUDES 2 *burns and corrosions (T20-T32)*
effects of foreign body in esophagus (T18.1)
effects of foreign body in larynx (T17.3)
effects of foreign body in pharynx (T17.2)
effects of foreign body in trachea (T17.4)
frostbite (T33-T34)
insect bite or sting, venomous (T63.4)

S10 Superficial injury of neck

The appropriate 7th character is to be added to each code from category S10.
A initial encounter
D subsequent encounter
S sequela

S10.0 Contusion of throat
Contusion of cervical esophagus
Contusion of larynx
Contusion of pharynx
Contusion of trachea

S10.1 Other and unspecified superficial injuries of throat
- **S10.10 Unspecified superficial injuries of throat** RP
- **S10.11 Abrasion of throat** RP
- **S10.12 Blister (nonthermal) of throat** RP
- **S10.14 External constriction of part of throat** RP
- **S10.15 Superficial foreign body of throat** RP
  Splinter in the throat
- **S10.16 Insect bite (nonvenomous) of throat** RP
- **S10.17 Other superficial bite of throat** RP
  EXCLUDES 1 *open bite of throat (S11.85)*

S10.8 Superficial injury of other specified parts of neck
- **S10.80 Unspecified superficial injury of other specified part of neck** RP
- **S10.81 Abrasion of other specified part of neck** RP
- **S10.82 Blister (nonthermal) of other specified part of neck** RP
- **S10.83 Contusion of other specified part of neck** RP
- **S10.84 External constriction of other specified part of neck** RP
- **S10.85 Superficial foreign body of other specified part of neck** RP
  Splinter in other specified part of neck
- **S10.86 Insect bite of other specified part of neck** RP
- **S10.87 Other superficial bite of other specified part of neck** RP
  EXCLUDES 1 *open bite of other specified parts of neck (S11.85)*

S10.9 Superficial injury of unspecified part of neck
- **S10.90 Unspecified superficial injury of unspecified part of neck** RP
- **S10.91 Abrasion of unspecified part of neck** RP
- **S10.92 Blister (nonthermal) of unspecified part of neck** RP
- **S10.93 Contusion of unspecified part of neck** RP
- **S10.94 External constriction of unspecified part of neck** RP
- **S10.95 Superficial foreign body of unspecified part of neck** RP
- **S10.96 Insect bite of unspecified part of neck** RP
- **S10.97 Other superficial bite of unspecified part of neck** RP

S11 Open wound of neck

Code also any associated:
spinal cord injury (S14.0, S14.1-)
wound infection

EXCLUDES 2 *open fracture of vertebra (S12.- with 7th character B)*

The appropriate 7th character is to be added to each code from category S11.
A initial encounter
D subsequent encounter
S sequela

S11.0 Open wound of larynx and trachea

S11.01 Open wound of larynx
EXCLUDES 2 *open wound of vocal cord (S11.03)*
- **S11.011 Laceration without foreign body of larynx** RIC
- **S11.012 Laceration with foreign body of larynx** RIC
- **S11.013 Puncture wound without foreign body of larynx** RIC
- **S11.014 Puncture wound with foreign body of larynx** RIC
- **S11.015 Open bite of larynx** RIC
  Bite of larynx NOS
- **S11.019 Unspecified open wound of larynx** RIC

S11.02 Open wound of trachea
Open wound of cervical trachea
Open wound of trachea NOS
EXCLUDES 2 *open wound of thoracic trachea (S27.5-)*
- **S11.021 Laceration without foreign body of trachea** RIC
- **S11.022 Laceration with foreign body of trachea** RIC
- **S11.023 Puncture wound without foreign body of trachea** RIC
- **S11.024 Puncture wound with foreign body of trachea** RIC
- **S11.025 Open bite of trachea** RIC
  Bite of trachea NOS
- **S11.029 Unspecified open wound of trachea** RIC

S11.03 Open wound of vocal cord
- **S11.031 Laceration without foreign body of vocal cord** RIC
- **S11.032 Laceration with foreign body of vocal cord** RIC
- **S11.033 Puncture wound without foreign body of vocal cord** RIC
- **S11.034 Puncture wound with foreign body of vocal cord** RIC
- **S11.035 Open bite of vocal cord** RIC
  Bite of vocal cord NOS
- **S11.039 Unspecified open wound of vocal cord** RIC

S11.1 Open wound of thyroid gland
- **S11.10 Unspecified open wound of thyroid gland** RIC
- **S11.11 Laceration without foreign body of thyroid gland** RIC
- **S11.12 Laceration with foreign body of thyroid gland** RIC
- **S11.13 Puncture wound without foreign body of thyroid gland** RIC
- **S11.14 Puncture wound with foreign body of thyroid gland** RIC
- **S11.15 Open bite of thyroid gland** RIC
  Bite of thyroid gland NOS

S11.2 Open wound of pharynx and cervical esophagus
EXCLUDES 1 *open wound of esophagus NOS (S27.8-)*
- **S11.20 Unspecified open wound of pharynx and cervical esophagus** RIC
- **S11.21 Laceration without foreign body of pharynx and cervical esophagus** RIC
- **S11.22 Laceration with foreign body of pharynx and cervical esophagus** RIC
- **S11.23 Puncture wound without foreign body of pharynx and cervical esophagus** RIC

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

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.

The external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis.

External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred, the activity of the patient at the time of the event, and the person's status (e.g., civilian, military).

There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

a. General external cause coding guidelines

1) Used with any code in the range of A00.0–T88.9, Z00–Z99

An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that represents a health condition due to an external cause. Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

Patient has bilateral sensorineural hearing loss due to history of exposure to loud noise over 100 dB for a period of greater than 10 years as a sound technician for a band.

H90.3 **Sensorineural hearing loss, bilateral**

W42.9XXS **Exposure to other noise, sequela**

Explanation: The hearing loss is due to noise exposure. An external cause code identifies the noise as the cause. The seventh character S is used in this case as the hearing loss is a residual effect of the exposure.

2) External cause code used for length of treatment

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

Most categories in chapter 20 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values: A, initial encounter, D, subsequent encounter and S, sequela. While the patient may be seen by a new or different provider over the course of treatment for an injury or condition, assignment of the 7th character for external cause should match the 7th character of the code assigned for the associated injury or condition for the encounter.

3) Use the full range of external cause codes

Use the full range of external cause codes to completely describe the cause, the intent, the place of occurrence, and if applicable, the activity of the patient at the time of the event, and the patient's status, for all injuries, and other health conditions due to an external cause.

4) Assign as many external cause codes as necessary

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.

5) The selection of the appropriate external cause code

The selection of the appropriate external cause code is guided by the Alphabetic Index of External Causes and by Inclusion and Exclusion notes in the Tabular List.

6) External cause code can never be a principal diagnosis

An external cause code can never be a principal (first-listed) diagnosis.

7) Combination external cause codes

Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

8) No external cause code needed in certain circumstances

No external cause code from Chapter 20 is needed if the external cause and intent are included in a code from another chapter (e.g., T36.0X1-, Poisoning by penicillins, accidental (unintentional)).

b. Place of occurrence guideline

Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use after other external cause codes to identify the location of the patient at the time of injury or other condition.

Generally, a place of occurrence code is assigned only once, at the initial encounter for treatment. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned. No 7th characters are used for Y92.

Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

c. Activity code

Assign a code from category Y93, Activity code, to describe the activity of the patient at the time the injury or other health condition occurred.

An activity code is used only once, at the initial encounter for treatment. Only one code from Y93 should be recorded on a medical record.

The activity codes are not applicable to poisonings, adverse effects, misadventures or sequela.

Do not assign Y93.9, Unspecified activity, if the activity is not stated.

A code from category Y93 is appropriate for use with external cause and intent codes if identifying the activity provides additional information about the event.

d. Place of occurrence, activity, and status codes used with other external cause code

When applicable, place of occurrence, activity, and external cause status codes are sequenced after the main external cause code(s). Regardless of the number of external cause codes assigned, there should be only one place of occurrence code, one activity code, and one external cause status code assigned to an encounter.

e. If the reporting format limits the number of external cause codes

If the reporting format limits the number of external cause codes that can be used in reporting clinical data, report the code for the cause/intent most related to the principal diagnosis. If the format permits, capture of additional external cause codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity, or external status.

f. Multiple external cause coding guidelines

More than one external cause code is required to fully describe the external cause of an illness or injury. The assignment of external cause codes should be sequenced in the following priority:

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

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

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

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

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

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

Activity and external cause status codes are assigned following all causal (intent) external cause codes.

The first-listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above.

Appendix K: Coding Issues for Long-Term Care (LTC)

The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis, "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care," is applied across all nonoutpatient settings, including long-term care.

In a long-term care setting, the principal diagnosis is regarded as the "first-listed diagnosis" and is the diagnosis that is chiefly responsible for the admission to the facility, or the diagnosis that is chiefly responsible for continued residence in the facility and should be sequenced first. In addition, chronic conditions that affect a resident's care are also coded. The diagnoses present and the sequencing of these diagnoses depend on the point in time the coding is done as ICD-10-CM codes can be assigned upon admission; concurrently as diagnoses arise; or at the time of discharge, transfer, or death of the resident.

The following guidelines and examples have been developed and approved by the Cooperating Parties in conjunction with the Editorial Advisory Board of *Coding Clinic*, to standardize the process of data collection for LTC and to assist the coder in coding and reporting these cases using ICD-10-CM. This guidance appeared in *Coding Clinic for ICD-10-CM*, published by the American Hospital Association, 4Q, '12, 90-98; 4Q,'13, 129; 1Q, '14, 23; 3Q,'16, 16-17; 3Q, '17, 4, 3Q, '20, 9; 4Q, '21, 101.

Example 1:

The patient is discharged from the acute care hospital and admitted to the LTC facility with a diagnosis of acute cerebrovascular accident (CVA) with left-sided hemiparesis and dysphasia.

First listed diagnosis:
I69.354, Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side

Additional diagnosis:
I69.321, Dysphasia following cerebral infarction

The hemiparesis and dysphasia are considered sequelae of the acute CVA for this LTC admission. Coding guidelines state that these "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. Codes from I60-I67 are reserved for the initial (first) episode of care for the acute cerebrovascular disease. Coding guidelines also provide guidance as to the use of dominant/nondominant side for codes from category I69.

There is no time limit on when a late effect code may be used since the neurologic deficit caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to I60-I67. When the patient is admitted to LTC following treatment of an acute CVA, a code from subcategory I69.3, Sequelae of cerebral infarction, is assigned for the LTC admission.

Example 2:

A patient with progressive senile dementia, coronary artery disease, and congestive heart failure is admitted to an LTC facility after suffering a CVA and receiving treatment elsewhere. The patient has made a complete recovery from the CVA prior to admission to the LTC facility. She is admitted for long-term care because of her chronic illnesses and her deteriorating mental status.

First listed diagnosis:
F03.90, Unspecified dementia without behavioral disturbance

Additional diagnoses:
I50.9, Heart failure, unspecified
I25.10, Atherosclerotic heart disease of native coronary artery without angina pectoris
Z86.73, Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits

Any of the patient's chronic diseases can be listed first, since each one could be considered chiefly responsible for LTC facility admission. Since this patient has no residuals from the CVA, a code from category I69, Sequelae of cerebrovascular disease, is inappropriate. Instead, code Z86.73, Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits, may be assigned to identify the history of CVA without residual deficits.

Example 3:

A patient is admitted to the LTC facility for physical therapy from an acute care setting after treatment for acute pelvic and clavicular fractures.

First listed diagnosis:
S32.9XXD, Fracture of unspecified parts of lumbosacral spine and pelvis, subsequent encounter for fracture with routine healing

Additional diagnoses:
S42.009D, Fracture of unspecified part of unspecified clavicle, subsequent encounter for fracture with routine healing

The first-listed diagnosis for a patient admitted to LTC specifically for physical therapy following an injury should be the acute injury code with the appropriate 7th character for subsequent encounter. Assigning a Z code for any aftercare provided for traumatic fractures is inappropriate in ICD-10-CM. For further guidance on the application of the 7th characters for Chapter 19, refer to Section I.C.19.c., of the Official Guidelines for Coding and Reporting.

Either of these fractures could be the reason for the LTC admission and therefore either one could be assigned as the "first-listed" diagnosis. The appropriate procedure code(s) should also be assigned to show that physical therapy was provided.

Example 4:

A patient is admitted to LTC following hospital treatment of a traumatic fracture of the right femur in order to heal the fracture and regain strength.

First listed diagnosis:
S72.90XD, Unspecified fracture of right femur, subsequent encounter for closed fracture with routine healing

Additional diagnoses:
Code any other existing conditions that require treatment.

The patient is no longer receiving active treatment for the fracture and instead is receiving routine care while the fracture heals. The acute injury is still coded but with a 7th character of "D" signifying a subsequent encounter for fracture with routine healing. Do not assign an aftercare Z code.

Example 5:

An LTC patient develops a urinary tract infection during the LTC stay that was subsequently treated and resolved.

First listed diagnosis:
N39.0, Urinary tract infection, site not specified

Additional diagnoses:
Code any other existing conditions that require treatment.

The urinary tract infection would remain on the active problem list until resolution of the infection, after which it would no longer be correct to code or report it.

Example 6:

A patient returns to the LTC facility after hospitalization for pneumonia. The admission orders request "IV antibiotic continuation for three days, and then repeat x-ray to determine pneumonia status."

First listed diagnosis:
J18.9, Pneumonia, unspecified organism

Additional diagnoses:
Code any other existing conditions that require treatment.

Code the pneumonia until it is resolved, after which it should no longer be coded and reported.

Example 7:

After hospitalization for pneumonia, a nursing home resident is readmitted with orders for continued antibiotic regimen for pneumonia. Other specified residuals from a CVA several years ago are the chief reason for her original admission and continued residence in the LTC facility.

First listed diagnosis:
I69.30, Unspecified sequelae of cerebral infarction

Additional diagnoses:
J18.9, Pneumonia, unspecified organism

Assign the appropriate code from subcategory I69.3, Sequelae of cerebral infarction, as the first-listed diagnosis to identify the residual neurologic deficits from the acute CVA. It is also appropriate to assign the code for the pneumonia as an additional diagnosis for as long as the patient receives treatment for the condition.

Example 8:

After surgical treatment in the acute care setting for a left wrist fracture sustained while a resident in a nursing home, the patient returns to the nursing home. The patient was admitted several years ago and has received continued care for Alzheimer's disease. Occupational therapy is ordered for the wrist, but the therapy is not the primary reason for the patient's admission.

First listed diagnosis:
G30.9, Alzheimer's disease, unspecified

Additional diagnoses:
S62.102D, Fracture of unspecified carpal bone, left wrist, subsequent encounter for fracture with routine healing
W19.XXXD, Unspecified fall, subsequent encounter

Although the patient is receiving therapy for the wrist fracture, it is the Alzheimer's disease that is the reason the patient is continuing care in the nursing home and should be reported as the first-listed diagnosis, over the wrist fracture. However, the appropriate ICD-10-PCS procedure code should still be assigned to show that the patient received occupational therapy.

Example 9:

A patient is admitted to the LTC facility for convalescence following an acute illness or injury.

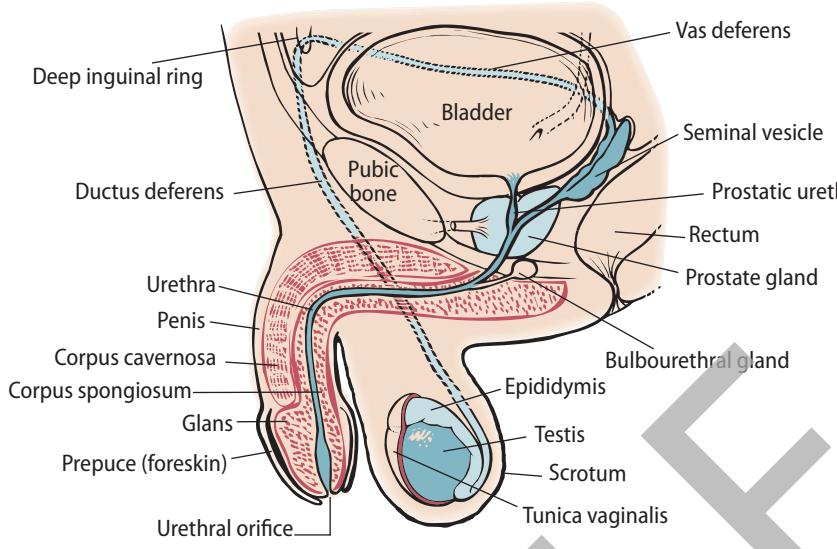
First listed diagnosis:
Z51.89, Encounter for other specified aftercare

Additional diagnoses:
Code any other existing conditions that require treatment.

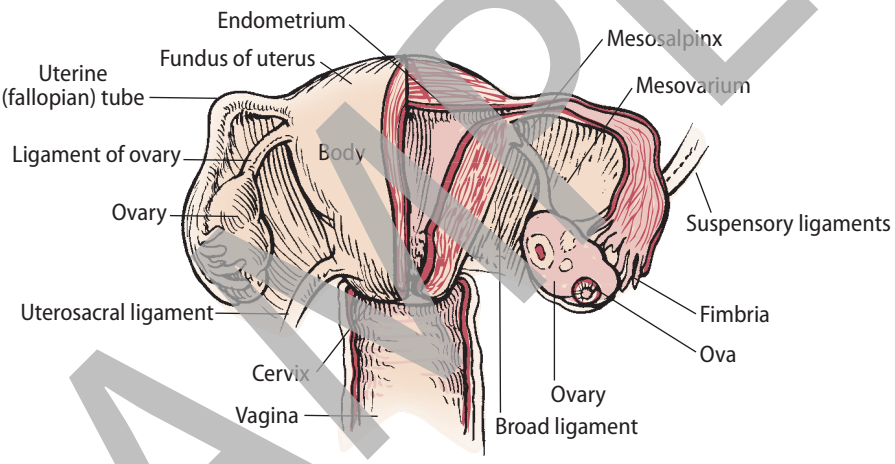
Use only if the patient is admitted solely for convalescence and there is no information in the medical record identifying a more definitive diagnosis.

Selection of codes in all cases is based on documentation in the medical record of conditions treated. Codes for any late effects, signs, and symptoms present are assigned if documented.

Male Genitourinary System



Female Internal Genitalia



Female Genitourinary Tract Lateral View