Guidelines Accompany Code Set

- ICD-10-CM Official Guidelines for Coding and Reporting and ICD-10-PCS Official Guidelines for Coding and Reporting accompany and complement code set conventions and instructions

- To ensure accurate coding, providers must use these guidelines in conjunction with the code set

- Adherence to the official coding guidelines in all healthcare settings is required under HIPAA.
Guideline Development

- Guidelines are developed by CMS and the CDC’s National Center for Health Statistics (NCHS)

- Approved by the Cooperating Parties
  - Centers for Medicare & Medicaid Services (CMS)
  - Centers for Disease Control and Prevention, National Center for Health Statistics (NCHS)
  - American Health Information Management Association (AHIMA) and
  - American Hospital Association (AHA)

ICD-10-CM Guideline Changes
Format of ICD-10-CM Guideline Changes

- Narrative changes appear in bold text (e.g. severe sepsis)
- Items underlined have been moved within the guidelines since October 1, 2016 (e.g. severe sepsis)
- Italics are used to indicate revisions to heading changes (e.g. Severe sepsis)
- Deletions are not shown on final document
  - Shown in Coding Clinic Fourth Quarter summary as as strikeouts (e.g. severe sepsis)
- The complete guidelines may be downloaded by visiting http://www.cdc.gov/nchs/icd/icd10cm.htm

Excludes 1 Note Exception

- An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other.
- If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider.
- Replaces interim advice issued October 2015 by the National Center for Health Statistics regarding excludes1 notes and unrelated conditions http://www.cdc.gov/nchs/data/icd/Interim_advice_updated_final.pdf
Etiology/Manifestation Convention

- Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology.
- For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation.

“With”

- The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.
- The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List.
- These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated. For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related. . . .
Diabetes and Associated Conditions
Alphabetic Index Example

- Diabetes, diabetic (mellitus) (sugar) E11.9
  with
  amyotrophy E11.44
  arthropathy NEC E11.618
  autonomic (poly) neuropathy E11.43
  cataract E11.36
  Charcot’s joints E11.610
  chronic kidney disease E11.22

- The physician documentation does not need to provide a link between the diagnoses of diabetes and chronic kidney disease to accurately assign code E11.22, Type 2 diabetes mellitus with diabetic chronic kidney disease. This link can be assumed since the chronic kidney disease is listed under the subterm “with.”

Coding Clinic, Second Quarter 2016, pages 36-37

Caution: Review Index Changes

- ICD-10-CM does not presume a linkage between diabetes and osteomyelitis. The provider will need to document a linkage or relationship between the two conditions before it can be coded as such.

Coding Clinic, Fourth Quarter 2013, page 114

- Effective October 1, 2016, the Alphabetic Index has been revised as follows:
  Diabetes, diabetic (mellitus)(sugar) E11.9
  with
  osteomyelitis E11.69

- These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the osteomyelitis is unrelated and due to some other underlying cause besides diabetes.

Copyright (c) 2016 by American Hospital Association. All rights reserved.
New Guideline: Code Assignment and Clinical Criteria

- The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

Code Assignment and Clinical Criteria Guideline: What Does it Really Mean?

- Reaffirming long standing advice: Coding must be based on provider documentation.
  - Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis, can “diagnose” the patient.
  - Clinical information published in Coding Clinic does not constitute clinical criteria for establishing a diagnosis, substitute for the provider’s clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient’s medical condition.
- Clinical Documentation Improvement (CDI) going away?
  - **NO.**
  - Guideline is addressing coding, not clinical validation. This is a separate function.
Code Assignment and Clinical Criteria
Guideline: What Does it Really Mean? (cont.)

• It is appropriate for facilities to ensure that documentation is complete, accurate, and appropriately reflects the patient’s clinical conditions.
• Clinical validation is a separate function from the coding process and clinical skill.
• CMS’ definition of clinical validation cited in the AHIMA Practice Brief: Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record.
• Coding is based on provider documentation regardless of which clinical definition or set of clinical criteria he/she uses.

Laterality

• When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides), including for the encounter to treat the first side.
• For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters).
• The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously-treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.
Revisions to Guideline for Documentation From Other Clinicians

- Code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient.
  - BMI
  - Depth of non-pressure chronic ulcers
  - Chronic pressure ulcer stage
  - Added: Coma scale
  - Added: National Institute of Health stroke scale (NIHSS)
- The associated diagnosis, such as acute stroke, must be documented by the patient’s provider.
- Coma scale and NIHSS codes should only be reported as secondary diagnoses.
Zika Virus Infections

• Code only confirmed cases
  – Exception to the hospital inpatient guideline Section II, H, Uncertain Diagnosis (“possible,” “probable”)
• If the provider documents “suspected”, “possible” or “probable” Zika, do not assign code A92.5. Assign a code(s) explaining the reason for encounter (such as fever, rash, or joint pain) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.
• “Confirmation” does not require documentation of the type of test performed; the physician’s diagnostic statement that the condition is confirmed is sufficient. This code should be assigned regardless of the stated mode of transmission.

Diabetes and Oral Hypoglycemics

• New code Z79.84, Long term (current) use of oral hypoglycemic drugs added to guidelines for diabetes mellitus and secondary diabetes mellitus.
Hypertension – “With” Linkage

- The classification presumes a causal relationship between hypertension and heart involvement and between hypertension and kidney involvement, as the two conditions are linked by the term “with” in the Alphabetic Index. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

- For hypertension and conditions not specifically linked by relational terms such as “with,” “associated with” or “due to” in the classification, provider documentation must link the conditions in order to code them as related.

Hypertension with Heart Disease

- Hypertension with heart conditions classified to I50.- or I51.4-I51.9. are assigned to a code from category I11, Hypertensive heart disease
  - There is no longer a need to have a causal relationship stated.

- The same heart conditions (I50.-, I51.4-I51.9) with hypertension, but without a stated causal relationship, are coded separately if the provider has specifically documented a different cause. Sequence according to the circumstances of the admission/encounter.
Hypertensive Chronic Kidney Disease

- Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present.
  - This was true before as well
  - **New:** CKD should not be coded as hypertensive if the physician has specifically documented a different cause.

Hypertensive Heart and Chronic Kidney Disease

- Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated there is hypertension with both heart and kidney involvement.
Hypertensive Crisis

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

Acute Myocardial Infarction

- For encounters occurring while the myocardial infarction is equal to, or less than, four weeks old, including transfers to another acute setting or a postacute setting, and the patient requires continued care for the myocardial infarction meets the definition for “other diagnoses” (see Section III, Reporting Additional Diagnoses), codes from category I21 may continue to be reported.
Pressure Ulcer Stage Codes

- Concept of “combination codes” for category L89, Pressure ulcer is changed to:
  - Codes from category L89, Pressure ulcer, are combination codes that identify the site of the pressure ulcer as well as the stage of the ulcer.
  - Impacts the application of the present on admission (POA) indicator.

Revised: Evolving Pressure Ulcer Stages

- Patient admitted with pressure ulcer evolving into another stage during the admission
  - If a patient is admitted with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned: one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay.
POA Guideline “Combination Codes” to “Codes That Contain Multiple Clinical Concepts”

- Changed concept of “combination codes” to “codes that contain multiple clinical concepts”
- Assign “N” if at least one of the clinical concepts included in the code was not present on admission (e.g., COPD with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission).
- Assign “Y” if all of the clinical concepts included in the code were present on admission (e.g., duodenal ulcer that perforates prior to admission).

Example Evolving Pressure Ulcer Stage

- Patient admitted to the hospital with a stage 2 pressure ulcer of the left heel that worsens during the hospitalization and becomes a stage 3 ulcer.
  - L89.622, Pressure ulcer of left heel, stage 2
    - POA “Y”
  - L89.623, Pressure ulcer of left heel, stage 3
    - POA “N”
Healing/Healed Ulcers

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

7th Characters for Pathologic Fractures and Injuries

• Examples of active treatment for 7th character “initial encounter” and examples of specific subsequent care for 7th character “subsequent encounter” have been removed
  – More complete and extensive examples have been published in Coding Clinic in the past year
  – Guidelines typically have not included specific extensive examples.
• Clarification added that 7th character for “subsequent encounter” is for patients who have completed active care and includes encounters for routine care of fractures during the healing and recovery phase
New Guideline: Supervision of High-Risk Pregnancy

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

Selection of OB Principal or First-listed Diagnosis

- Guideline clarified based on Coding Clinic Editorial Advisory Board (EAB) and published in First Quarter 2016.
- When an obstetric patient is admitted and delivers during that admission, the condition that prompted the admission should be sequenced as the principal diagnosis.
- If multiple conditions prompted the admission, sequence the one most related to the delivery as the principal diagnosis. A code for any complication of the delivery should be assigned as an additional diagnosis.
Pregnancy Long-Term Use of Insulin and Oral Hypoglycemics

- Added new code Z79.84, Long-term (current) use of oral hypoglycemic drugs.
- Established hierarchy:
  - Tx: Both oral medications and insulin, only the code for insulin-controlled should be assigned.
  - Gestational (pregnancy induced) diabetes
    - Tx: Both diet and oral hypoglycemic medications, only the code for "controlled by oral hypoglycemic drugs" is required.
- Code Z79.4, Long-term (current) use of insulin or code Z79.84, Long-term (current) use of oral hypoglycemic drugs, should not be assigned with codes from subcategory O24.4.

Observation and Evaluation of Newborns for Suspected Conditions not Found – New Code

- Assign a code from category Z05, Observation and evaluation of newborns and infants for suspected conditions ruled out, to identify those instances when a healthy newborn is evaluated for a suspected condition that is determined after study not to be present.
- Do not use a code from category Z05 when the patient has identified signs or symptoms of a suspected problem; in such cases code the sign or symptom.
Observation and Evaluation of Newborns for Suspected Conditions not Found – (cont.)

- A code from category Z05 may also be assigned as a principal or first-listed code for readmissions or encounters when the code from category Z38 code no longer applies.
- Codes from category Z05 are for use only for healthy newborns and infants for which no condition after study is found to be present.
- Birth record
  - A code from category Z05 is to be used as a secondary code after the code from category Z38, Liveborn infants according to place of birth and type of delivery.

Coma Scale

- Added: The coma scale may also be used to assess the status of the central nervous system for other non-trauma conditions, such as monitoring patients in the intensive care unit regardless of medical condition.
NIHSS Stroke Scale

- The NIH stroke scale (NIHSS) codes (R29.7-) can be used in conjunction with acute stroke codes (I63) to identify the patient's neurological status and the severity of the stroke.
- The stroke scale codes should be sequenced after the acute stroke diagnosis code(s).
- At a minimum, report the initial score documented. If desired, a facility may choose to capture multiple stroke scale scores.

Default for 7th Character for Open Fracture Subsequent Encounter

- The open fracture designations in the assignment of the 7th character for fractures of the forearm, femur and lower leg, including ankle are based on the Gustilo open fracture classification.
- When the Gustilo classification type is not specified for an open fracture, the 7th character for open fracture type I or II should be assigned (B, E, H, M, Q).
Poisoning Intent - Default

- If the intent of the poisoning is unknown or unspecified, code the intent as accidental intent.
- The undetermined intent is only for use if the documentation in the record specifies that the intent cannot be determined.

Corrections – Adult and Child Abuse, Neglect and Other Maltreatment

- Updated code range
  - For cases of confirmed abuse or neglect an external cause code from the assault section (X92-Y08 Y09)
- Corrections in code titles
  - Z04.41, Encounter for examination and observation following alleged physical adult abuse, ruled out rape or code Z04.42, Encounter for examination and observation following alleged child rape or sexual abuse, ruled out
Z Code Guidelines – New Codes Added

- **Status**
  - Z19, Hormone sensitivity malignancy status

- **Observation**
  - Z05, Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out
    - Exception to guideline that observation codes are to be used as principal diagnosis only.
    - For birth encounters, category Z05 is sequenced after the Z38 code.

- **Miscellaneous Z codes**
  - Z29, Encounter for other prophylactic measures

New Guideline – Category Z3A

- Category Z3A codes should not be assigned for pregnancies with abortive outcomes (categories O00-O08), elective termination of pregnancy (code Z33.32), nor for postpartum conditions, as category Z3A is not applicable to these conditions.
Other Z Code Guideline Changes

- Z72, Problems related to lifestyle
  - [New:] Note: These codes should be assigned only when the documentation specifies that the patient has an associated problem.
- Z Codes That May Only be Principal/First-Listed Diagnosis
  - Removed code Z31.82, Encounter for Rh incompatibility status

Hospice Services

- Section II Selection of Principal Diagnosis and Section III Reporting Additional Diagnoses
  - Added: The UHDDS definitions also apply to hospice services (all levels of care)
- Guideline regarding “Uncertain Diagnosis” still applies only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.
Section IV Outpatient Guidelines

- Added: Guidelines in Section I, Conventions, general coding guidelines and chapter-specific guidelines, should also be applied for outpatient services and office visits.
- Clarified that the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis does not apply to hospital-based outpatient services and provider-based office visits.

Encounters for General Medical Examinations with Abnormal Findings

- Added: An examination with abnormal findings refers to a condition/diagnosis that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physical examination.
POA Exempt List

- POA exempt list has been deleted from the Official Guidelines for Coding and Reporting and instead moved to the CDC website

ICD-10-PCS Guideline Changes
Format of ICD-10-PCS Guideline Changes

- Deletions, changes are not shown on final document
  - Shown in Coding Clinic Fourth Quarter summary
    - Deletions shown as strikeouts (e.g. coronary artery sites)
    - Narrative changes shown in bold text (e.g. coronary arteries)

General Guidelines B2.1a: General Anatomical Regions

- The procedure codes in the general anatomical regions body systems ...
  - Changed from “should only used ...” to “can be used” when the procedure is performed on an anatomical region rather than a specific body part (e.g., root operations Control and Detachment, Drainage of a body cavity) or on the rare occasion when no information is available to support assignment of a code to a specific body part.
- New examples added: Chest tube drainage of the pleural cavity is coded to the root operation Drainage found in the general anatomical regions body systems. Suture repair of the abdominal wall is coded to the root operation Repair in the general anatomical regions body system.
Multiple Procedure Guideline B3.2

- Multiple procedures are coded if:
  - The same root operation is performed on different body parts as defined by distinct values of the body part character.
    - New example: Excision of lesion in the ascending colon and excision of lesion in the transverse colon are coded separately.
  - The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value.
    - New example: Extraction of multiple toenails are coded separately.

Biopsy Procedures Guideline B3.4a

- Example revised: Fine needle aspiration biopsy of fluid in the lung is coded to the root operation Drainage with the qualifier diagnostic.
Bypass Procedures, Guideline B3.6b

- Changed to align with change in body part values from "coronary artery site" to "coronary artery"
  - Coronary arteries are classified by number of distinct sites treated, rather than number of coronary arteries or anatomic name of a coronary artery (e.g., left anterior descending). Coronary artery bypass procedures are coded differently than other bypass procedures as described in the previous guideline. Rather than identifying the body part bypassed from, the body part specifies the number of coronary artery sites bypassed to, and the qualifier specifies the vessel bypassed from.

Bypass Procedures, Guideline B3.6c

- Changed to align with change in body part values from "coronary artery site" to "coronary artery"
  - If multiple coronary artery sites arteries are bypassed, a separate procedure is coded for each coronary artery site artery that uses a different device and/or qualifier.
Guideline B3.7: Control vs. More Definitive Root Operations

- Guideline revised to align with change in definition for root operation “Control”
  - Added: “or other acute bleeding”
    - The root operation Control is defined as, “Stopping, or attempting to stop, postprocedural or other acute bleeding.” If an attempt to stop postprocedural or other acute bleeding is initially unsuccessful, and to stop the bleeding requires performing any of the definitive root operations Bypass, Detachment, Excision, Extraction, Reposition, Replacement, or Resection, then that root operation is coded instead of Control.
    - Example: Resection of spleen to stop postprocedural bleeding is coded to Resection instead of Control.

Guideline B3.9: Excision for Graft

- If an autograft is obtained from a different body part procedure site in order to complete the objective of the procedure, a separate procedure is coded.
Guideline B4.2: Branches of Body Parts

• **New:** In the cardiovascular body systems, if a general body part is available in the correct root operation table, and coding to a proximal branch would require assigning a code in a different body system, the procedure is coded using the general body part value.

• **New example:** Occlusion of the bronchial artery is coded to the body part value Upper Artery in the body system Upper Arteries, and not to the body part value Thoracic Aorta, Descending in the body system Heart and Great Vessels.

Guideline B4.4: Coronary Arteries

• Changed to align with change in body part values from “coronary artery site” to “coronary artery”
  – The coronary arteries are classified as a single body part that is further specified by number of sites arteries treated, and not by name or number of arteries. Separate body part values are used to specify the number of sites treated. **One procedure code specifying multiple arteries is used** when the same procedure is performed, on multiple sites in the coronary arteries including the same device and qualifier values. Separate codes are used when the same procedure is performed on multiple sites in the coronary arteries.
Addressing Questions to the Central Office

www.CodingClinicAdvisor.com

Please be sure to read the FAQ section to find out what types of questions we can and cannot answer.

Evaluation and Certificate

Please complete evaluation:
https://www.surveymonkey.com/r/octoberondemand

CE certificate may be obtained after completion.
October 2016

Registrant name: __________________________________________

Title: __________________________________________

Organization: __________________________________________

Address: __________________________________________

City, State, ZIP: __________________________________________

This serves as verification for your Continuing Education for the AHA Central Office’s webinar *Update to FY 2017 ICD-10-PCS and ICD-10-CM Guidelines* by Nelly Leon-Chisen, RHIA, Director, Coding & Classification, American Hospital Association. The webinar was held on-demand and was one hour in length.

Retain this verification in your personal file for audit purposes.

Thank you for your interest and participation.

Chabre Ross
Program Chairperson
American Hospital Association
FY 2017 Updates to the ICD-10-CM and ICD-10-PCS Official Guidelines for Coding and Reporting (Live or On-Demand)

Index #AHA0510160527A

This Index # is valid for education purchased prior to 10/31/2017

This program meets AAPC guidelines for 1.0 CEUs. On Demand product requires successful completion of a Post-Test for Core A and all specialties except CIRCC for continuing education units.

*This program has the prior approval of AAPC for continuing education hours. Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor.