FY 2017 Updates to ICD-10-CM

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The ICD-10 Coordination and Maintenance Committee's code freeze, first implemented after the October 1, 2011 annual update, has finally thawed. For fiscal year (FY) 2017 the ICD-10-CM classification is back on track with annual code and guideline updates. Due to the thousands of new/revised codes, tabular list, and alphabetical index changes as well as the many Official Coding Guideline revisions from the Centers for Medicare and Medicaid Services (CMS), this article will highlight a portion of the updates to the ICD-10-CM classification and the ICD-10-CM Official Guidelines for Coding and Reporting approved for FY 2017. For the complete addenda and guidelines see the resource links at the end of this article.

ICD-10-CM Code Updates for FY 2017

While the number of ICD-10-CM code updates that went into effect October 1, 2016 may have seemed overwhelming, the majority (approximately 61 percent) are new/revised codes updated to specify laterality. The inclusion of laterality affects several areas of the classification system, including diabetic eye complications, cerebral infarction and related arteries, bunions and joints, fractures, nerve disorders, glaucoma, macular degeneration, hearing loss, and testicular, ovarian, and tubal disorders.

As with all code assignments, accurate coding of laterality is dependent upon quality clinical documentation. Documentation should meet the seven criteria for high-quality clinical documentation described in Pamela Hess's book *Clinical Documentation Improvement: Principles and Practice.* It should be legible, reliable, precise, complete, consistent, clear, and timely.

Throughout the ICD-10-CM classification, postprocedural hemorrhage and hematoma were previously combined into one code within each of the applicable chapters. Postprocedural seroma was also included in these codes per the alphabetical index. FY 2017 brought a change in the existing code titles and the addition of new codes for postprocedural hematoma and seroma within each chapter where the postprocedural hemorrhage and hematoma existed. These changes will allow each condition to be identified separately and the data to be more accurate and specific to the actual condition rather than all three conditions combined into the same code. See below for an illustration of this update:

REVISED
D78.21 Postprocedural hemorrhage ~~and hematoma~~ of the spleen following a procedure on the spleen
D78.22 Postprocedural hemorrhage ~~and hematoma~~ of the spleen following other procedure

NEW
D78.31 Postprocedural hematoma of the spleen following a procedure on the spleen
D78.32 Postprocedural hematoma of the spleen following other procedur
D78.33 Postprocedural seroma of the spleen following a procedure on the spleen
D78.34 Postprocedural seroma of the spleen following other procedure

In the tabular list, several Excludes1 notes have been changed to Excludes2 notes. For example, under C78 Secondary malignant neoplasm of respiratory and digestive organs, lymph node metastases (C77.0) is now an Excludes2 notes. In addition, ischemic cardiomyopathy (I25.5) and peripartum cardiomyopathy (O90.3) are both now Excludes2 notes under I42 Cardiomyopathy.

Code A92.5, Zika virus was created in alignment with the World Health Organization (WHO). Guideline I.C.1.f. Zika virus infections was added to clarify that "only a *confirmed* diagnosis of Zika virus as documented by the provider is coded." Chronic viral hepatitis has been reassigned in the alphabetical index from a Z22.5- (Carrier of viral hepatitis) code to B18.1-B18.9 (Chronic viral hepatitis) since the concept of a 'health carrier' is no longer valid. This condition is considered a form of

chronic viral hepatitis and this change brings the code in alignment with the World Health Organization changes that went into effect January 1, 2016.

A new use additional code (UAC) note has been added in the tabular list under E08, E09, E11, and E13—UAC to identify control using:

- Insulin (Z79.4)
- Oral antidiabetic drugs (Z79.84)
- Oral hypoglycemia drugs (Z79.84)

The change was due to the addition of code Z79.84, Long term (current) use of oral hypoglycemic drugs. Official Coding Guideline I.C.4.a.3 has been expanded to include this new code. The index has added the subterm "osteomyelitis" under "Diabetes mellitus, with." This will result in a diabetes combination code when both diabetes mellitus and osteomyelitis are documented by the provider in the medical record (unless the provider stipulates the osteomyelitis or other condition is NOT related to the diabetes). See the update to guideline I.A.15 "With" in the *AHA Coding Clinic,* first and second quarter 2016, for reference.

The index contains many new subterms to help classify mental health disorders related to alcohol and drug use. "Use" of alcohol has been reclassified from F10.99, Alcohol use, unspecified with unspecified alcohol-induced disorder, to Z72.89, Other problems related to lifestyle. This change reminds us of the importance of reviewing the index for reclassification of conditions and not just focusing on the new codes.

New code category I16, hypertension, was created, including the codes I16.0, Hypertensive urgency; I16.1, Hypertensive emergency; and I16.9, Hypertensive crisis, unspecified. Codes in category I69.- cognitive deficits that follow cerebral hemorrhage, infarction, other or unspecified cerebrovascular diseases has been expanded to allow specification of the specific cognitive deficit involved (i.e., attention and concentration deficit, memory deficit, etc.) in the sixth character. An index change was made for clot/embolism/ischemia/thrombosis of the heart from I24.0, Acute coronary thrombosis not resulting in MI to I51.3, Complications and ill-defined descriptions of heart disease.

A new code category, M97.01-M97.9, was created for periprosthetic fractures, which includes the seventh characters of "A", "D", and "S" as applicable per the documentation. Prior to October 1, 2016, a periprosthetic fracture was classified as a complication. However, these fractures are not a complication of the prosthetic. A new code of M21.61 was created for bunions. Previously, bunions were not coded separately but were included in the hallux valgus code per the alphabetical index. Atypical femur fractures have a new category, M84.750- through M84.759-. These are pathological fractures in the subtrochanteric region of the hip or the femoral shaft.

Code O34.21 was expanded to specify a previous cesarean delivery scar as low transverse (O34.211) or vertical (O34.212). Category O42, Premature rupture of membranes has had a change in the Includes note under O42.02, O42.12, and O42.92 from "after 37 completed weeks of gestation…" to "at or after 37 completed weeks of gestation…." Code category O70.2, Third degree perineal laceration during delivery has been expanded to allow specification of the laceration as IIIa (O70.21), IIIb (O70.22), or IIIc (O70.23).

The removal of "suspected conditions" from the note at P00-P04 and all code descriptions in this range in the tabular list was the big change for this chapter. Any condition documented as "ruled out" is now assigned to the new code category Z05, Encounter for Observation & Evaluation of NB for Suspected Diseases & Conditions Ruled Out. Be sure to reference Official Coding Guidelines I.C.16.b and I.C.21.c.6, which discuss these changes.

The National Institutes of Health Stroke Scale (NIHSS) score can now be captured with new codes R29.700-R29.742. The NIHSS score is an assessment tool to evaluate and document neurological status and stroke severity. Review the new guideline I.C.18.i for guidance on the assignment of these new codes. The Glasgow coma total score codes (R40.241-R40.244) have been expanded to the seventh character to indicate when the score was obtained:

- 0- unspecified time
- 1- in the field (EMT or ambulance)
- 2- at arrival to emergency department
- 3- at hospital admission

- 4- 24 hours or more after hospital admission

New codes were created to allow coding of physeal and Salter-Harris fractures, S99.001- through S99.299-. The appropriate seventh characters are also applied from the seven options given at each category code. Many code additions and revisions have been made for complications (i.e., mechanical, displaced, leakage, etc.) of specified devices (i.e., indwelling urethral catheter and nervous system prosthetic devices) in categories T83.- and T85.-. A new code, T88.53, has been added to capture unintended awareness under general anesthesia during a procedure.

A much needed update for coding professionals was new category X50 for Overexertion and strenuous or repetitive movements. This category includes code X50.1, Overexertion from prolonged static or awkward postures, which includes "twisting," a code that has been missing in ICD-10-CM.

Some of the chapters did not have a large amount of updates to highlight. A new code was created for periorbital cellulitis, L03.213. This will replace previous *AHA Coding Clinic* advice to assign L03.211. Excessive and redundant skin and subcutaneous tissue now has a unique code of L98.7. A new code was created for bacilluria/bacteriuria of R82.71, which was previously indexed to N39.0 (UTI). New codes have been added related to Surrogacy: Z31.7 and Z33.3. Z53.31-Z53.39 is a new category of codes for "Procedure converted to open procedure" that could not be captured previously in ICD-10-CM.

ICD-10-CM Official Guidelines for Coding and Reporting FY 2017

FY 2017 has brought several changes and additions to the guidelines. Please refer to the complete FY 2017 Official Guidelines for Coding and Reporting on the Centers for Disease Control and Prevention (CDC) website, available at www.cdc.gov/nchs/data/icd/10cmguidelines_2017_final.pdf. Pay particular attention to the following:

- Bold text, which represents narrative changes
- Underlined items, which represents items that have been moved within the guidelines since the FY 2016 version
- Italics, which represents revisions to heading changes

I.A.15. "With"

This guideline was clarified and expanded to indicate that 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. Official Coding Guideline I.C.9.a. Hypertension was updated to clarify that "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."

I.A.19 Code assignment and clinical criteria

This is a new guideline that indicates a diagnosis code is based on the provider's diagnostic statement that the condition exists and this is sufficient. Code assignment is not based on clinical criteria used by the provider. The actual condition must be documented by the provider.

I.B.14. Documentation for BMI, Depth of Non-pressure Ulcers, Pressure Ulcer Stages, Coma Scale, and NIH Stroke Scale

I.B.14. was expanded to clarify coma scale and NIH stroke scale codes documented by non-provider clinicians that may be used in ICD-10-CM code assignment. Additional guideline changes are described below.

I.C.12.a.5) Patients admitted with pressure ulcers documented as healing

This guideline was revised to include the following. 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. This addition will assist in ensuring more consistency in the pressure ulcers assigned.

I.C.12.a.6) 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, then 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. This is a new directive and will result in two separate pressure ulcer codes being assigned for one actual ulcer. This change will impact data analysis because two pressure ulcer codes on the same admission may only be for one actual ulcer.

Additional Guideline Changes

Some additional verbiage was added to Section III: Reporting Additional Diagnoses, and Section IV: Diagnostic Coding and Reporting Guidelines for Outpatient Services, to clarify that "The UHDDS definitions also apply to hospice services (all levels of care)," and that the guidelines "….should also be applied for outpatient services and office visits." It also states that the "UHDDS definition of principal diagnosis does not apply to hospital-based outpatient services and provider-based office visits."

The exempt present on admission (POA) indicator list has been removed from Appendix I of the POA guidelines. The ICD-10-CM diagnosis codes that do not require the use of a POA indicator can be found on the CDC website.

This article has only touched upon some of the many ICD-10-CM addenda and *ICD-10-CM Official Guidelines for Coding and Reporting* additions and revisions. All coding and clinical documentation improvement professionals should review the complete ICD-10-CM addenda, as well as the new FY 2017 *ICD-10-CM Official Guidelines for Coding and Reporting*. This will ensure all diagnosis codes assigned for visits and discharges after October 1 are specific and accurate to produce quality data and compliant reimbursement.

Additional Resources to Review

- FY 2017 ICD-10-CM Addenda on the CMS website: www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-CM-and-GEMs.html
- FY 2017 ICD-10-CM Official Guidelines for Coding and Reporting: www.cdc.gov/nchs/icd/icd10cm.htm
- ICD-10 Coordination and Maintenance Committee meeting notes, proposals, and other information: www.cdc.gov/nchs/icd/icd10cm_maintenance.htm

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