ICD-10-CM Official Coding Guidelines

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One of the keys to a successful transition to ICD-10-CM/PCS is a thorough understanding of the ICD-10-CM Official Coding Guidelines, which were posted to the National Center for Health Statistics Web site in January 2009. Similar to the ICD-9-CM coding guidelines, the ICD-10-CM guidelines are organized into four sections.

Section I includes the conventions for ICD-10-CM, the general coding guidelines, and chapter-specific coding guidelines. Section II includes guidelines for selecting principal diagnosis for nonoutpatient settings, while section III contains guidelines for reporting additional diagnoses in nonoutpatient settings. Finally, section IV is for outpatient coding and reporting. This article highlights a few of the guidelines found within section I.

ICD-10-CM Conventions

Some of the ICD-10-CM conventions are identical to conventions in ICD-9-CM, such as abbreviations, punctuation marks, and relational terms (e.g., "and," "due to," "with"). However, ICD-10-CM has new conventions such as placeholder characters, seventh characters, and Excludes1 and Excludes2 notes.

Placeholder characters. ICD-10-CM uses a placeholder character of "x." The "x" is used as a fifth character placeholder for certain six-character codes to allow for future expansion. When a placeholder exists, the "x" must be used in order for the code to be considered valid. Additionally, a placeholder "x" must be used to fill in the empty characters as necessary in a code requiring a seventh character.

Seventh characters. Certain ICD-10-CM categories require the use of a seventh character. The seventh character, also referred to as an extension, represents the visit encounter or sequela for injuries and external causes. For obstetrical codes, the seventh character identifies the fetus for which the code applies. The extension character must always be the seventh character in the data field. Placeholder characters should be used as necessary (see above).

Excludes1 and Excludes2 notes. ICD-10-CM features standard definitions for two types of excludes notes. The first, Excludes1 note, is a pure excludes note. It means "not coded here." An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. For example, an Excludes1 note for the congenital form of a condition appears under the code for an acquired form of the same condition.

The second type is an Excludes2 note, which represents "not included here." When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together if the documentation indicates the patient has both conditions.

ICD-10-CM General Coding Guidelines

The ICD-10-CM general coding guidelines are similar to those for ICD-9-CM with the addition of a laterality guideline. For bilateral sites, the final character of the ICD-10-CM code indicates laterality.

An unspecified side code is also provided in instances when the documentation does not identify the laterality. Separate codes for both the left and right side should be assigned in instances where the condition is bilateral and no bilateral code is provided.

ICD-10-CM Chapter-Specific Guidelines

Similarities with ICD-9-CM guidelines also exist with the ICD-10-CM chapter-specific guidelines. However, the ICD-10-CM guidelines include new and revised guidelines.

Chapter 1: Certain Infectious and Parasitic Diseases

HIV infections. The ICD-10-CM guidelines for HIV infections are very similar to the ICD-9-CM HIV guidelines, with the exception of the codes. For example, guideline I.C.1.a.1 states to code only confirmed cases of HIV infection/illness, which is an exception to the hospital inpatient guideline. Guideline I.C.1.a.2.a indicates that if a patient is admitted for an HIV-related condition, the principal diagnosis should be B20, followed by additional diagnosis codes for all reported HIV-related conditions.

The coding guideline for asymptomatic human immunodeficiency virus, I.C.1.a.2.d, specifies that Z21 is to be applied when a patient without any documentation of symptoms is listed as being “HIV positive,” “known HIV,” “HIV test positive,” or similar terminology.

Finally, I.C.1.a.2.f provides guidance for coding patients who have previously been diagnosed with an HIV-related illness. Patients with any known prior diagnosis of an HIV-related illness are to be coded to B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75, Inconclusive laboratory evidence of HIV, or Z21, Asymptomatic HIV status.

Chapter 6: Diseases of the Nervous System

Dominant/nondominant side. The ICD-10-CM guidelines include a new guideline, I.C.6.a, for dominant versus nondominant. The guideline indicates that codes from category G81, Hemiplegia and hemiparesis, and subcategories G83.1, Monoplegia of lower limb, G83.2, Monoplegia of upper limb, and G83.3, Monoplegia, unspecified, identify whether the dominant or nondominant side is affected. If this information is not available within the record, the default is the dominant code. For ambidextrous patients, the default remains the dominant code.

Chapter 9: Diseases of the Circulatory System

Hypertension. Two of the ICD-9-CM hypertension guidelines do not appear in the ICD-10-CM guidelines. The first is the hypertension table guideline, which has been removed because ICD-10-CM does not contain a hypertension table. The guideline for hypertension, essential or NOS, was also eliminated from ICD-10-CM.

Hypertension is not further classified as malignant, benign, or unspecified in ICD-10-CM; rather, essential (primary) hypertension, I10, includes arterial, benign, essential, malignant, primary, and systemic hypertension.

Hypertension with heart disease. The hypertension with heart disease guideline is identical to the ICD-9-CM guideline with the exception of the codes. In ICD-10-CM, the guideline specifies that heart conditions classified to I50.- or I51.4–I51.9 are assigned to a code from category I11, Hypertensive heart disease, when a causal relationship is documented (due to hypertension) or implied (hypertensive). An additional code from category I50, Heart failure, is also assigned to identify the type of heart failure if applicable. The same heart conditions with hypertension, but without a documented causal relationship, are coded separately.

Atherosclerotic coronary artery disease and angina. The new guideline I.C.9.b, Atherosclerotic coronary artery disease and angina, results from the ICD-10-CM combination codes for atherosclerotic heart disease with angina. There are two subcategories for these combination codes: I25.11, Atherosclerotic heart disease of native coronary artery with angina pectoris, and I25.7, Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris.

An additional code for angina pectoris is not assigned when using one of these combination codes. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to a condition other than the atherosclerosis.

Acute myocardial infarction (AMI). A comparison of the ICD-9-CM and ICD-10-CM AMI coding guidelines reveals both similarities and differences. An example of a similar guideline is I.C.9.e.1, ST elevation myocardial infarction (STEMI) and non-ST elevation myocardial infarction (NSTEMI), which states the ICD-10-CM codes for AMI identify the site, such as

anterolateral wall or true posterior wall. Subcategories I21.0–I21.2 and code I21.3 are used for ST elevation myocardial infarctions. Code I21.4, Non-ST elevation myocardial infarction, is used for NSTEMI and nontransmural MIs.

ICD-10-CM provides a new guideline, I.C.9.e.4, for the coding of subsequent acute myocardial infarctions. This guideline indicates that a code from category I22, Subsequent STEMI and NSTEMI myocardial infarction, is to be used when a patient who has suffered an AMI has a new AMI within the four-week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21, STEMI and NSTEMI myocardial infarction.

Chapter 15: Pregnancy, Childbirth, and the Puerperium

The ICD-10-CM chapter-specific guidelines for pregnancy, childbirth, and the puerperium reveal many similarities along with some revisions. Two examples of similar guidelines for the obstetrical chapter follow.

Sequencing priority. Guideline I.C.15.a.1 states that obstetric cases require codes from chapter 15, with the chapter 15 codes having sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 15 codes for further specific conditions.

Should the provider document that the pregnancy is incidental to the encounter, then code Z33.1, Pregnant state, incidental, should be used in place of any chapter 15 code. It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.

Outcome of delivery. Guideline I.C.15.b.5 indicates that a code from category Z37, Outcome of delivery, should be included on every maternal record when a delivery has occurred. These codes are not to be used on subsequent records or on newborn records.

References

National Center for Health Statistics. "ICD-9-CM Official Guidelines for Coding and Reporting." Available online at www.cdc.gov/nchs/icd9.htm.

National Center for Health Statistics. "ICD-10-CM Official Guidelines for Coding and Reporting, 2009." Available online at www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm.

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