New ICD-10-CM Guidelines: Highlights of the 2010 Changes

By Ann Barta, MSA, RHIA

One of the keys to a successful transition to ICD-10-CM is a thorough understanding of the ICD-10-CM Official Guidelines for Coding and Reporting. Earlier this year, the National Center for Health Statistics published the 2010 guidelines. This article highlights some of the additions and revisions.

ICD-10-CM Conventions

A guideline was added to the ICD-10-CM conventions in section I of the guidelines, I.A.19 Syndromes. The guideline states that coding professionals should "Follow the Alphabetic Index guidance when coding syndromes. In the absence of index guidance, assign codes for the documented manifestations of the syndrome."

ICD-10-CM General Coding Guidelines

A guideline was added to the ICD-10-CM general coding guidelines in section I, I.B.14, Documentation for BMI and Pressure Ulcer Stages. The guideline states:

"For the Body Mass Index (BMI) and pressure ulcer stage codes, 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 (i.e., a dietitian often documents the BMI and nurses often document the pressure ulcer stages). However, the associated diagnosis (such as overweight, obesity, or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification. The BMI codes should only be reported as secondary diagnoses. As with all other secondary diagnosis codes, the BMI codes should only be assigned when they meet the definition of a reportable additional diagnosis."

ICD-10-CM Chapter-Specific Guidelines

Several new and revised guidelines also appear in the chapter-specific guidelines. Following are highlights of some of the additions and revisions.

Chapter 2: Neoplasms

The guidelines feature one revised guideline and one completely new guideline for neoplasm coding. The following instructions have been added to the I.C.2.l.4 guideline, Encounter for complication associated with a neoplasm:

"The exception to this guideline is anemia. When the admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for the anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by code D63.0, Anemia in neoplastic disease."

This addition was added to the 2009 I.C.2.l.4 guideline, which states, "When an encounter is for management of a complication associated with a neoplasm, such as dehydration, and the treatment is only for the complication, the complication is coded first, followed by the appropriate code(s) for the neoplasm."

Guideline I.C.2.r, Malignant neoplasm associated with transplanted organ, was added in 2010 and provides the following instructions: "A malignant neoplasm of a transplanted organ should be coded as a transplant complication. Assign first the appropriate code from category T86.-, Complications of transplanted organ, followed by code C80.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy."

Chapter 4: Endocrine, Nutritional, and Metabolic Diseases

One additional endocrine guideline for secondary diabetes mellitus was added in 2010. Guideline I.C.4.a.6 provides the following directions for coding professionals:

Codes under category E08, Diabetes mellitus due to underlying condition, and E09, Drug or chemical induced diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (i.e., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

> (a) Secondary diabetes mellitus and the use of insulin-For patients who routinely use insulin, code Z79.4, Long-term (current) use of insulin, should also be assigned. Code Z79.4 should not be assigned if insulin is given temporarily to bring a patient's blood sugar under control during an encounter.
> (b) Assigning and sequencing secondary diabetes codes and its causes-The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the tabular instructions for categories E08 and E09. For example, for category E08, code first the underlying condition; for category E09, code first the drug or chemical (T36-T65).
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> > (i) Secondary diabetes mellitus due to pancreatectomy-For postpancreatectomy diabetes mellitus, assign code E89.1, Postsurgical hypoinsulinemia. Assign a code from category E08 and code Z90.4, Other acquired absence of organ, as additional codes.
> > (ii) Secondary diabetes due to drugs-Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or late effect of poisoning.

Chapter 12: Diseases of Skin and Subcutaneous Tissue

There were no chapter-specific guidelines for chapter 12 in the 2009 guidelines. The 2010 guidelines, however, include the following new instruction:

1. 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. The ICD-10-CM classifies ulcer stages based on severity, which is designated by stages 1–4, unspecified stage and unstageable. Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.
2. Unstageable pressure ulcers-Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (i.e., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma. This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage.
3. Documented pressure ulcer stage-Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the terms found in the index. For clinical terms describing the stage that are not found in the index, and there is no documentation of the stage, the provider should be queried.
4. Patient admitted with pressure ulcer documented as healed-No code is assigned if the documentation states that the pressure ulcer is completely healed.
5. Patient admitted with pressure ulcer documented as healing-Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign the appropriate code for unspecified stage. If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.

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, assign the code for the highest stage reported for that site.

Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes

One chapter 19 guideline that underwent revisions in 2010 was guideline I.C.19.e.5.c, Underdosing. The following clarification was added: "Codes for underdosing should never be assigned as principal or first-listed codes. If the patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be coded."

A new guideline for ventilator-associated pneumonia was also added in 2010. Guideline I.C.19.g.6, Ventilator associated pneumonia, provides coding professionals with the following guidance:

> a) Documentation of ventilator associated pneumonia-As with all procedural or postprocedural complications, code assignment is based on the provider's documentation of the relationship between the condition and the procedure. Code J95.851, Ventilator associated pneumonia, should be assigned only when the provider has documented ventilator associated pneumonia (VAP). An additional code to identify the organism (e.g., Pseudomonas aeruginosa, code B96.5) should also be assigned. Do not assign an additional code from categories J12–J18 to identify the type of pneumonia.
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> Code J95.851 should not be assigned for cases where the patient has pneumonia and is on a mechanical ventilator but the provider has not specifically stated that the pneumonia is ventilator-associated pneumonia.
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> If the documentation is unclear as to whether the patient has a pneumonia that is a complication attributable to the mechanical ventilator, query the provider.
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> b) Patient admitted with pneumonia and develops VAP-A patient may be admitted with one type of pneumonia (i.e., code J13, Pneumonia due to Streptococcus pneumonia) and subsequently develop VAP. In this instance, the principal diagnosis would be the appropriate code from categories J12–J18 for the pneumonia diagnosed at the time of admission. Code J95.851, Ventilator associated pneumonia, would be assigned as an additional diagnosis when the provider has also documented the presence of ventilator associated pneumonia.

Reference

National Center for Health Statistics. "ICD-10-CM Official Guidelines for Coding and Reporting, 2010." Available online at www.cdc.gov/nchs/icd/icd10cm.htm.

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Ann Barta (ann.barta@ahima.org) is a professional practice resource specialist at AHIMA.

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