Independence

ICD-10 Spotlight: Know the codes

Revised December 1, 2012

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Table of Contents

ICD-10 Spotlight: Know the codes

There are a number of significant changes involved with the transition to ICD-10. In addition to ensuring that systems and processes are updated to be ICD-10-compliant by the mandated implementation date of October 1, 2014, providers and office staff must become familiar with the new ICD-10 codes to ensure accurate clinical documentation.

The thought of transitioning from approximately 24,000 codes to over 140,000 codes might seem daunting. To help educate providers and office staff about what to expect when coding various diagnoses with the new ICD-10 codes, beginning with this month's edition of *Partners in Health Update*, we will include examples of how ICD-9 codes translate to ICD-10 codes in this new section called "ICD-10 Spotlight: Know the codes." We will present coding examples from different specialties and popular disease categories to demonstrate the granularity that the new ICD-10 code set will provide.

CODING CONVENTION/GUIDELINE: CODE FIRST

This example of coding obesity demonstrates how many of the new codes may require documentation using ICD-10 Coding Guidelines such as the "code first" guideline.

ICD-10 has a coding convention that requires the underlying or causal condition be sequenced first followed by the manifested condition, which is referred to as the "code first" guideline.

For example, if a patient is on the antidepressant drug Tryptanol (amitriptyline), and this drug is what caused the patient's weight gain, it is considered an adverse effect and is the underlying or causal condition of the patient's obesity. Therefore, diagnosis code T43.015 (adverse effect of tricyclic antidepressants) must be coded first.

ICD-9 coding table*	ICD-10 coding table*	Clinical documentation of diagnosis: Code first
• 278.01 Morbid obesity • 278.02 Overweight • 278.03 Obesity hypoventilation syndrome	• E66.01 Morbid (severe) obesity due to excess calories • E66.09 Other obesity due to excess calories • E66.1 Drug-induced obesity • E66.2 Morbid (severe) obesity with alveolar hypoventilation • E66.3 Overweight • E66.8 Other obesity • E66.9 Obesity, unspecified	T43.015 Adverse affects of tricyclic antidepressants E66.1 Drug-induced obesity

**Condensed list of codes*

For additional questions related to IBC's transition to ICD-10, please visit *www.ibx.com/icd10*.

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Know the codes

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CODING CONVENTION/GUIDELINE: COMBINATION CODES

This example demonstrates how to code diabetes and pressure ulcers using "combination codes." A combination code is a single code used to clarify one of the following:

- two diagnoses;
- a diagnosis with an associated secondary process (manifestation);
- a diagnosis with an associated complication.

The combination code should be documented only if the code fully identifies the diagnostic conditions involved. All of the diagnostic conditions must be clearly documented.

The tables below show how multiple ICD-9 codes translate to new ICD-10 combination codes.

ICD-10 ***diabetes mellitus*** codes are combination codes that include:

- type of diabetes mellitus;
- body system affected;
- the complication/manifestion affecting the body system.

ICD-9 coding table	ICD-10 coding table
• 250.52 Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled • 362.05 Moderate nonproliferative diabetic retinopathy • 362.07 Diabetic macular edema	• E11.331 Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema

ICD-10 ***pressure ulcer*** codes are combination codes that include:

- the site (lower back) of the pressure ulcer;
- the location (right/left) of the pressure ulcer;
- the stage of the pressure ulcer.

ICD-9 coding table	ICD-10 coding table
• 707.03 Pressure ulcer, lower back • 707.22 Pressure ulcer stage II	• L89.132 Pressure ulcer of right lower back, stage 2 OR • L89.142 Pressure ulcer of left lower back, stage 2 OR • L89.152 Pressure ulcer of sacral region, stage 2*

**The sacral region (coccyx and sacrum) is uniquely identified in ICD-10. In ICD-9, that region is included in the code for the lower back (707.03).*

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Know the codes

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CODING CONVENTION/GUIDELINE: LATERALITY

"Laterality" (side of the body affected) is a new coding convention added to relevant ICD-10 codes to increase specificity. Designated codes for conditions such as fractures, burns, ulcers, and certain neoplasms will require documentation of the side/region of the body where the condition occurs.

In ICD-10, laterality code descriptions include right, left, bilateral, or unspecified designations:

- Right side = character 1;
- Left side = character 2;
- Bilateral = character 3;
- Unspecified side/region = character 0 or 9 (depending on whether it is a 5th or 6th character).

The tables below compare the lack of specificity in ICD-9 to the greater level of specificity in ICD-10 when coding a corneal ulcer and female breast cancer.

Condition: Central Corneal Ulcer

ICD-9 coding table	ICD-10 coding table
• 370.03 Central corneal ulcer	• H16.011 Central corneal ulcer, right eye OR • H16.012 Central corneal ulcer, left eye OR • H16.013 Central corneal ulcer, bilateral OR • H16.019 Central corneal ulcer, unspecified

Condition: Malignant Neoplasm of Lower-Outer Quadrant of Female Breast

ICD-9 coding table	ICD-10 coding table
• 174.5 Malignant neoplasm of lower-outer quadrant of female breast	• C50.511 Malignant neoplasm of lower-outer quadrant of right female breast* AND/OR • C50.512 Malignant neoplasm of lower-outer quadrant of left female breast* OR • C50.519 Malignant neoplasm of lower-outer quadrant of unspecified female breast

**If a bilateral code does not exist and the condition is bilateral, assign separate codes for both the left and right side.*

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CODING CONVENTION: SEVENTH CHARACTER EXTENSION FOR EPISODE OF CARE

One example of how ICD-10 codes differ from ICD-9 codes is the addition of a seventh character extension in the coding structure. The seventh character extension in ICD-10 codes is primarily used to document the episode of care for fractures, injuries, poisonings, other consequences of external causes, and conditions that affect a fetus at multiple gestations. The designation of the seventh character extension in ICD-10 conveys greater specificity and clinical detail.

For injuries, poisonings, and other consequences of external causes, the seventh character designates the episode of care as:

- A = Initial Encounter
- D = Subsequent Encounter
- S = Sequela

Condition	Clinical documentation	ICD-10 code
Injury	Superficial foreign body of unspecified shoulder, initial encounter	S40.259A
Poisoning	Poisoning by penicillins, accidental (unintentional), subsequent encounter	T36.0x1D*
Consequences of external causes	Adverse effect of benzodiazepines, sequela	T42.4x5S*

Note: Fractures are not included in these examples due to the complexity of assigning seventh characters for episode of care.

For conditions that affect a fetus, the seventh character designates certain complications of pregnancy at multiple gestations to denote which fetus is affected:

- 0 = not applicable or unspecified
- 1 = fetus 1
- 2 = fetus 2
- 3 = fetus 3
- 4 = fetus 4
- 5 = fetus 5
- 9 = other fetus

Condition	Clinical documentation	ICD-10 code
Complication of pregnancy affecting fetus	Maternal care for breech presentation, fetus 1	O32.1xx1*
	Maternal care for (suspected) central nervous system malformation in fetus, fetus 2	O35.0xx2*
	Maternal care for anti-D [Rh] antibodies, second trimester, fetus 3	O36.0123
	Polyhydramnios, third trimester, fetus 4	O40.3xx4*
	Infection of amniotic sac and membranes, unspecified, second trimester, fetus 5	O41.1025
	Labor and delivery complicated by cord around neck, with compression, other fetus	O69.1xx9*

**For codes that include only three to five characters, "x" is used to fill in empty character fields.*

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Know the codes

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CODING CONVENTION/GUIDELINE: SEVENTH CHARACTER EXTENSION FOR EPISODE OF CARE FOR FRACTURES

The use of the "seventh character extension" in ICD-10 codes is one example of how the new code set will provide greater specificity and clinical detail.

Similar to injuries, poisonings, other consequences of external causes, and conditions that affect a fetus (see the April edition of *Partners in Health Update* for coding examples), the seventh character is designated to document the episode of care for fractures as well. However, when documenting fractures, the assignment of the seventh character is more complicated because it is designated for additional information about the fracture, including whether the fracture is open or closed and whether healing is routine or has complications (i.e., delayed, nonunion, malunion).

The fracture seventh character extensions are:

- A = Initial encounter for closed fracture
- B = Initial encounter for open fracture
- D = Subsequent encounter for fracture with routine healing
- G = Subsequent encounter for fracture with delayed healing
- K = Subsequent encounter for fracture with nonunion
- P = Subsequent encounter for fracture with malunion
- S = Sequela

CODING EXAMPLE

Condition	Clinical documentation	ICD-10 code
Fracture	Fracture of unspecified part of right clavicle, initial encounter for closed fracture	S42.001A
	Anterior displaced fracture of sternal end of right clavicle, initial encounter for open fracture	S42.011B
	Posterior displaced fracture of sternal end of right clavicle, subsequent encounter for fracture with routine healing	S42.014D
	Nondisplaced fracture of sternal end of right clavicle, subsequent encounter for fracture with delayed healing	S42.017G
	3-part fracture of surgical neck of left humerus, subsequent encounter for fracture with nonunion	S42.232K
	Torus fracture of upper end of left humerus, subsequent encounter for fracture with malunion	S42.272P
	Greenstick fracture of shaft of humerus, unspecified arm, sequela	S42.319S

In addition to the encounters above, there are seventh character extensions for some types of open fractures that are grouped into the "Gustilo Open Fracture Classification."

continued on next page

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Know the codes

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CODING CONVENTION/GUIDELINE: SEVENTH CHARACTER EXTENSION FOR EPISODE OF CARE FOR FRACTURES *(continued)*

Open fractures (where bone pierces the skin) contain a much higher level of specificity in ICD-10. Therefore, further classification is needed for open fractures using the Gustilo Open Fracture Classification system. This classification system groups open fractures into three main categories designated as Type I, Type II, and Type III. Type III injuries are further divided into Type IIIA, Type IIIB, and Type IIIC. The categories are defined by three characteristics: mechanism of injury, extent of soft tissue damage, and degree of bone injury or involvement.

The Gustilo classification groups are:

- Type I – Low energy, wound less than 1 cm
- Type II – Wound greater than 1 cm with moderate soft tissue damage
- Type III – High energy wound greater than 1 cm with extensive soft tissue damage
  - Type IIIA – Adequate soft tissue cover
  - Type IIIB – Inadequate soft tissue cover
  - Type IIIC – Associated with arterial injury

CODING EXAMPLE

Condition	Clinical documentation	ICD-10 code
Open fracture	Galeazzi's fracture of left radius, initial encounter for open fracture Type IIIA, IIIB, or IIIC	S52.372C
	Displaced comminuted fracture of shaft of ulna, left arm, initial encounter for open fracture Type I or II	S52.252B
	Monteggia's fracture of left ulna, subsequent encounter for open fracture Type I or II with routine healing	S52.272E
	Bent bone of right ulna, subsequent encounter for open fracture Type IIIA, IIIB, or IIIC with delayed healing	S52.281J

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Know the codes

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CODING CONVENTION/GUIDELINE: DRUG UNDERDOSING

The coding examples will demonstrate the new clinical concept of drug underdosing conveyed in ICD-10.

Drug underdosing is a new clinical terminology in ICD-10. ICD-10 contains codes for underdosing, whereas ICD-9 does not. This term identifies situations in which a patient has taken less of a medication than prescribed by their physician or less than instructed by the manufacturer, whether inadvertently or deliberately.

For underdosing, assign the code from categories T36 – T50 found in Chapter 19. These codes require a 7th character extension to describe an initial encounter (A), subsequent encounter (D), or sequela encounter (S).

Underdosing codes must be identified in the following order:

1. The medical condition is sequenced first. The first-listed code would be the event that is triggered or prolonged due to this circumstance.
2. The underdosing code is listed as the secondary code assignment. Codes for underdosing should never be assigned as principal or first-listed codes.
3. The additional code explains why the patient is not taking the medication(s). Financial hardships and age-related debilities are some examples of underdosing.

EXAMPLE A

A patient is prescribed the antibiotic tetracycline to treat a UTI (urinary tract infection). The patient did not take the medication as prescribed, which resulted in pyelonephritis (kidney infection).

ICD-10 Code	Narrative	Coding sequence
N10	Acute tubulo-interstitial nephritis	The first-listed code would be the event that is triggered or prolonged due to this circumstance.
T36.4x6A	Underdosing of tetracyclines, initial encounter	The underdosing code would be the secondary code assignment.

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CODING CONVENTION/GUIDELINE: DRUG UNDERDOSING *(continued)*

EXAMPLE B

A patient is prescribed prednisone for rheumatoid arthritis and has been taking it long-term. The patient abruptly stopped taking the medication, which resulted in secondary adrenal insufficiency. The patient is aware of the risk of not being weaned from steroidal drugs but could not afford to pay for the medication.

ICD-10 Code	Narrative	Coding sequence
E27.40	Unspecified adrenocortical insufficiency	The first-listed code would be the event that is triggered or prolonged due to this circumstance.
T38.0x6	Underdosing of glucocorticoids and synthetic analogues	The underdosing code would be the secondary code assignment.
Z91.120	Patient's intentional underdosing of medication regimen due to financial hardship	The additional code explains why the patient is not taking the medication(s).

Note: In this scenario, E27.3 (drug-induced adrenocortical insufficiency) would not be appropriate, as the condition is not drug-induced but is directly attributed to the abrupt discontinuation of the medication.

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CODING CONVENTION/GUIDELINE: CLINICAL TERMINOLOGY CHANGES IN ICD-10

These coding examples will demonstrate the new clinical terminology changes conveyed in ICD-10. These changes reflect standardization of the terms that are used today.

Several terminologies used in ICD-9 have been changed in ICD-10. Some of the names and definitions of disorders have been updated in ICD-10 to reflect more current clinical terminology and standardization of the terms used to diagnose certain conditions and disorders. These changes reflect standardized terminology that clinicians and health care personnel use today for patient care and data reporting.

Although not completely eliminated, commonly used terms such as "senile", are no longer used for certain conditions. Another differentiation involves acute myocardial infarction (AMI). This condition not only includes updated terminology, it also has notable definition changes in ICD-10.

ICD-9	ICD-10
Senile	Age-related
Intermediate coronary syndrome	Unstable angina
Acute myocardial infarction	ST elevation (STEMI) or non-ST elevation (NSTEMI) myocardial infarction

ICD-9: Clinical terminology	ICD-10: Clinical terminology
Senile cataract	**Age-related cataract**
366.10 Unspecified senile cataract	H25.9 Unspecified age-related cataract

Intermediate coronary syndrome	Unstable angina
411.1 Intermediate coronary syndrome	I20.0 Unstable angina

Acute myocardial infarction*	ST elevation (STEMI) or non-ST elevation (NSTEMI) myocardial infarction
410.02 Acute myocardial infarction of anterolateral wall, subsequent episode of care	I21.09 ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall
410.70 Acute myocardial infarction, subendocardial infarction, episode of care unspecified	I21.4 Non-ST elevation (NSTEMI) myocardial infarction

**In ICD-9-CM, the initial time frame for acute myocardial infarction (AMI) treatment is within eight weeks of onset. In ICD-10-CM, the initial time frame for acute treatment is within four weeks of onset.*

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CODING CONVENTION/GUIDELINE: ICD-10 DISTINCTION BETWEEN BURNS AND CORROSIONS

This article will explore the new clinical concept that distinguishes burns and corrosions as conveyed in ICD-10.

In ICD-9, burn codes are reported by body site, depth, extent, and an additional code to identify the external cause when applicable. The same will be reported in ICD-10 but with a few additional concepts. The additional concepts are reporting the agent or cause of the corrosion, laterality, and encounter. ICD-10 also makes a distinction between burns and corrosions. Burn codes apply to thermal burns (except sunburns) that come from a heat source, such as fire, hot appliance, electricity, and radiation. Corrosions are burns due to chemicals.

In ICD-9, burns and corrosions are classified by:

- Body site
- Depth
  - Erythema: First degree
  - Blistering: Second degree
  - Full thickness involvement: Third degree
- Extent
  - Total Body Surface Area (TBSA)
- External cause – to identify the source, place, and intent of the burn/corrosion

In ICD-10, burns and corrosions are classified by:

- Body site
- Depth
  - Erythema: First degree
  - Blistering: Second degree
  - Full thickness involvement: Third degree
- Extent
  - Total Body Surface Area (TBSA)
- External cause/Agent
  - External cause – to identify the source, place, and intent of the burn
  - Agent – to identify the chemical substance of the corrosion
- Laterality
  - Right
  - Left
  - Unspecified
- Encounter – For burns and corrosions, the seventh character designates the episode of care as:
  - Initial encounter = A
  - Subsequent encounter = D
  - Sequela = S

Note: Burns of the eye and internal organs are classified by site, not by degree.

continued on next page

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CODING CONVENTION/GUIDELINE: ICD-10 DISTINCTION BETWEEN BURNS AND CORROSIONS
(continued)

ICD-9: Body site, Depth, Extent, External cause

Same code used for burns and corrosions

	Body site, Depth	Extent (TBSA)	External cause
Burn/Corrosion	945.26 Blisters with epidermal loss due to burn (second degree) of thigh (any part)	948.10 Burn (any degree) involving 10 – 19% of body surface with third degree burn of less than 10% or unspecified amount	E988.1 Injury by burns or fire, undetermined whether accidentally or purposely inflicted

ICD-10: Body site, Depth, Encounter, Laterality, Extent, External cause/Agent

Distinct codes used for burns and corrosions

	Body site, Depth, Encounter, Laterality	Extent (TBSA)	External cause/Agent
Burn	T24.211A Burn of second degree of right thigh, initial encounter	T31.10 Burns involving 10 – 19% of body surface with 0 – 9% third degree burns	X00.3XXA Fall from burning building or structure in uncontrolled fire, initial encounter
Corrosion	T24.611A Corrosion of second degree of right thigh, initial encounter	T32.10 Corrosions involving 10-19% of body surface with 0 – 9% third degree corrosions	T52.0X1A Toxic effect of petroleum products, accidental (unintentional), initial encounter

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CODING CONVENTION: ICD-10 CODING BURNS AND CORROSIONS *(continued from last month)*

This article will convey the coding conventions used in assigning the appropriate codes for burns and corrosions.

ICD-10 makes a distinction between burns and corrosions. In addition to the distinction, there are coding conventions that are essential in attaining the correct code assignment. These conventions include:

Sequencing

- When more than one burn/corrosion is present, sequence the code that reflects the highest degree first.
- When the reason for the admission or encounter is for treatment of external burns/corrosions, sequence the code that reflects the highest degree first.
- When a patient has both internal and external burns/corrosions, the circumstances of admission govern the selection of the principal diagnosis (i.e., first-listed diagnosis).
- When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal diagnosis.

Burns/corrosions of the same local site

Classify burns of the same local site, but of different degrees, to the subcategory identifying the highest degree recorded in the diagnosis.

Non-healing and infected burns/corrosions

Non-healing and necrosis (death) of burned skin should be coded as acute burns. For any infected burn site, use an additional code for the infection.

Assign separate codes for each burn site

When coding burns, assign separate codes for each burn site. Category T30, “Burn and corrosion, body region unspecified,” is extremely vague and should rarely be used.

Extent of body surface involved (categories T31, T32)

Burns and corrosions classified according to extent of body surface involved should be assigned when the site of the burn is not specified or when there is a need for additional data such as evaluating burn mortality (usually needed by burn units), and when there is mention of a third-degree burn involving 20 percent or more of the body surface.

Categories T31 and T32 are based on the classic “Rule of Nines” in estimating body surface area that has been burned. The Rule of Nines is a system that is based on the rough approximation that each arm has 9 percent of the body’s total skin, the head and neck have 9 percent, each leg 18 percent (two 9s), the front of the torso 18 percent, the back of the torso 18 percent, and the genitalia 1 percent.*

*Providers may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults, and patients who have large buttocks, thighs, or abdomen that involve burns.

continued on next page

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CODING CONVENTION: ICD-10 CODING BURNS AND CORROSIONS *(continued)*

Encounter for treatment of sequela of burns/corrosions
Encounters for the treatment of late effects of burns/corrosions (i.e., scars or joint contractures) should be coded with a burn or corrosion code with the 7th character "S" for sequela.

Sequela and current burn
Burns and corrosions do not heal at the same rate. A current healing wound may still exist with sequela of a healed burn or corrosion. Therefore, when both a current burn and sequela of an old burn exist, both a code for a current burn or corrosion with the 7th character "A" or "D" *and* a burn or corrosion code with "S" may be assigned on the same record.

Use of external cause code with burns and corrosions
An external cause code should be used with burns and corrosions to identify the source and intent of the burn, as well as the place where it occurred.

Example: Burns of the same local site

Same local site	Trunk	Degree	Sequencing
Subcategory	Chest Wall	1st degree	Secondary diagnosis code
Subcategory	Abdominal Wall	2nd degree	Principal diagnosis code

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ICD-10 Spotlight:
Know the codes

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CODING CONVENTION/GUIDELINE: EXCLUDES1 AND EXCLUDES2, AND BORDERLINE DIAGNOSIS CODES

Similar to ICD-9, there are coding conventions, general guidelines, and chapter-specific guidelines in ICD-10. These conventions and guidelines are rules and instructions that must be followed to classify and assign the most appropriate code. As with ICD-9, adherence to these guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA). Many of the conventions and guidelines in ICD-9 are the same in ICD-10. This article will focus on a new Coding Convention: Excludes1 and Excludes2, and a new General Coding Guideline: Borderline Diagnosis Codes.

Excludes1 and Excludes2

As in ICD-9, a variety of notes appear in both the Alphabetic Index and Tabular List of ICD-10. These types of notes consist of inclusion notes, excludes notes, code first notes, use additional code notes, and cross reference notes. ICD-10 incorporates two types of excludes notes: Excludes1 and Excludes2. Each type of note has a different definition for use but are similar in that they indicate codes excluded from each other are independent of each other.

EXCLUDES1

A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" It corresponds with what the current ICD-9 Excludes note indicates. An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 note is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

K51.4	**Inflammatory polyps of colon**
EXCLUDES1	adenomatous polyp of colon (D12.6) polyposis of colon (D12.6) polyps of colon NOS (K63.5)

EXCLUDES2

A type 2 Excludes note represents "Not included here." An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

J37.1	**Chronic laryngotracheitis**
EXCLUDES2	acute laryngotracheitis (J04.2) acute tracheitis (J04.1)

continued on next page

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CODING CONVENTION/GUIDELINE: EXCLUDES1 AND EXCLUDES2, AND BORDERLINE DIAGNOSIS CODES (*continued)*

*Borderline Diagnosis**

If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry. If a borderline condition has a specific index entry in ICD-10, it should be coded as such. Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient).

Examples of Specific Borderline Entries:

F60.3	Borderline personality disorder
R41.83	Borderline intellectual functioning
H40.021	Open angle with borderline findings, high-risk, right eye

**Whenever the documentation is unclear regarding a borderline condition, coders are encouraged to query for clarification.*

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Know the codes

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CODING CONVENTION/GUIDELINE: MENTAL AND BEHAVIORAL DISORDERS

As in ICD-9, the codes for mental and behavioral disorders are located in Chapter 5 of ICD-10. However, in ICD-10, the clinical terminology and classification of many conditions are different. There are also more subchapters, categories, subcategories, and codes that provide greater clinical detail. This includes some changes in names and definitions of disorders to reflect more current clinical terminology and standardization of the terms used to diagnosis mental, behavioral, and substance use disorders.

One difference involves the classification of substance use, abuse, and dependence. In ICD-10, the terms are not interchangeable as they are in ICD-9; they are separate conditions in ICD-10.

Condition: Alcohol-induced psychotic disorder with delusions

Substance	ICD-9		ICD-10	
Use	291.5	Alcohol-induced psychotic disorder with delusions	F10.950	Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions
Abuse	291.5	Alcohol-induced psychotic disorder with delusions	F10.150	Alcohol abuse with alcohol-induced psychotic disorder with delusions
Dependence	291.5	Alcohol-induced psychotic disorder with delusions	F10.250	Alcohol dependence with alcohol-induced psychotic disorder with delusions

Alcohol dependence, drug dependence, and non-dependent abuse of drugs are classified into three different categories. The ICD-10 codes identify the aspects of use (e.g., withdrawal state), the effects (e.g., dependence), and the manifestations (e.g., with delirium).

Condition: Opioid use, abuse, and dependence

Categories	ICD-10	
Aspects of use	F11.23	Opioid dependence with withdrawal
Effects	F11.10	Opioid abuse, uncomplicated
	F11.20	Opioid dependence, uncomplicated
Manifestations	F11.151	Opioid abuse with opioid-induced psychotic disorder with hallucinations
	F11.282	Opioid dependence with opioid-induced sleep disorder
	F11.921	Opioid use, unspecified with intoxication delirium

In addition to the clinical terminology and classification changes, unlike ICD-9, there are chapter-specific guidelines for mental and behavioral disorders in ICD-10. These consist of pain disorders related to psychological factors and disorders due to psychoactive substance use (i.e., in remission, psychoactive substance use, abuse, and dependence).

continued on next page

CODING CONVENTION/GUIDELINE: MENTAL AND BEHAVIORAL DISORDERS (*continued)*

Pain disorders related to psychological factors

There is a distinctive code assignment when the pain is exclusively related or indirectly related to psychological factors.

ICD-10
F45.41 Pain disorder exclusively related to psychological factors
F45.42 Pain disorder with related psychological factors

Mental and behavioral disorders due to psychoactive substance use

In remission: The appropriate code assignments for "in remission" are assigned only on the basis of provider documentation.

Psychoactive substance use, abuse, and dependence: When the provider documentation refers to use, abuse, and dependence of the same substance (e.g., alcohol, opioid, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

- If both use and abuse are documented, assign only the code for abuse.
- If both abuse and dependence are documented, assign only the code for dependence.
- If use, abuse, and dependence are all documented, assign only the code for dependence.
- If both use and dependence are documented, assign only the code for dependence.

For additional information related to the IBC transition to ICD-10, please visit *www.ibx.com/icd10*. On this site you will also find other examples of how ICD-9 codes will translate to ICD-10 codes in the *ICD-10 Spotlight: Know the codes* booklet.