Chapter 1. Certain Infectious and Parasitic Diseases (A00–B99), U07.1, U09.9

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Human immunodeficiency virus (HIV) infections

1) Code only confirmed cases

Code only confirmed cases of HIV infection/illness. This is an exception to the hospital inpatient guideline Section II, H.

In this context, "confirmation" does not require documentation of positive serology or culture for HIV; the provider's diagnostic statement that the patient is HIV positive or has an HIV-related illness is sufficient.

Patient being seen for hypothyroidism with possible HIV infection

E03.9 **Hypothyroidism, unspecified**

Explanation: Only the hypothyroidism is coded in this scenario because it has not been confirmed that an HIV infection is present.

2) Selection and sequencing of HIV codes

(a) Patient admitted for HIV-related condition

If a patient is admitted for an HIV-related condition, the principal diagnosis should be B20, Human immunodeficiency virus [HIV] disease followed by additional diagnosis codes for all reported HIV-related conditions.

An exception to this guideline is if the reason for admission is hemolytic-uremic syndrome associated with HIV disease. Assign code D59.31, Infection-associated hemolytic-uremic syndrome, followed by code B20, Human immunodeficiency virus [HIV] disease.

HIV with CMV

B20 **Human immunodeficiency virus [HIV] disease**

B25.9 **Cytomegaloviral disease, unspecified**

Explanation: Cytomegaloviral infection is an HIV related condition, so the HIV diagnosis code is reported first, followed by the code for the CMV.

(b) Patient with HIV disease admitted for unrelated condition

If a patient with HIV disease is admitted for an unrelated condition (such as a traumatic injury), the code for the unrelated condition (e.g., the nature of injury code) should be the principal diagnosis. Other diagnoses would be B20 followed by additional diagnosis codes for all reported HIV-related conditions.

Sprain of the internal collateral ligament, right ankle; HIV

S93.491A **Sprain of other ligament of right ankle, initial encounter**

B20 **Human immunodeficiency virus [HIV] disease**

Explanation: The ankle sprain is not related to HIV, so it is the first-listed diagnosis code, and HIV is reported secondarily.

(c) Whether the patient is newly diagnosed

Whether the patient is newly diagnosed or has had previous admissions/encounters for HIV conditions is irrelevant to the sequencing decision.

Newly diagnosed multiple cutaneous Kaposi's sarcoma lesions in previously diagnosed HIV disease

B20 **Human immunodeficiency virus [HIV] disease**

C46.0 **Kaposi's sarcoma of skin**

Explanation: Even though the HIV was diagnosed on a previous encounter, it is still sequenced first when coded with an HIV-related condition. Kaposi's sarcoma is an HIV-related condition.

(d) Asymptomatic human immunodeficiency virus

Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive," "known HIV," "HIV test positive," or similar terminology. Do not use this code if the term "AIDS" or "HIV disease" is used or if the patient is treated for any HIV-related illness or is described as having any condition(s) resulting from his/her HIV positive status; use B20 in these cases.

(e) Patients with inconclusive HIV serology

Patients with inconclusive HIV serology, but no definitive diagnosis or manifestations of the illness, may be assigned code R75, Inconclusive laboratory evidence of human immunodeficiency virus [HIV].

(f) Previously diagnosed HIV-related illness

Patients with any known prior diagnosis of an HIV-related illness should be coded to B20. Once a patient has developed an HIV-related illness, the patient should always be assigned code B20 on every subsequent admission/encounter. Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.

(g) HIV infection in pregnancy, childbirth and the puerperium

During pregnancy, childbirth or the puerperium, a patient admitted (or presenting for a health care encounter) because of an HIV-related illness should receive a principal diagnosis code of O98.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by B20 and the code(s) for the HIV-related illness(es). Codes from Chapter 15 always take sequencing priority.

Patients with asymptomatic HIV infection status admitted (or presenting for a health care encounter) during pregnancy, childbirth, or the puerperium should receive codes of O98.7- and Z21.

(h) Encounters for testing for HIV

If a patient is being seen to determine his/her HIV status, use code Z11.4, Encounter for screening for human immunodeficiency virus [HIV]. Use additional codes for any associated high-risk behavior, if applicable.

If a patient with signs or symptoms is being seen for HIV testing, code the signs and symptoms. An additional counseling code Z71.7, Human immunodeficiency virus [HIV] counseling, may be used if counseling is provided during the encounter for the test.

When a patient returns to be informed of his/her HIV test results and the test result is negative, use code Z71.7, Human immunodeficiency virus [HIV] counseling.

If the results are positive, see previous guidelines and assign codes as appropriate.

(i) HIV managed by antiretroviral medication

If a patient with documented HIV disease, HIV-related illness or AIDS is currently managed on antiretroviral medications, assign code B20, Human immunodeficiency virus [HIV] disease. Code Z79.899, Other long term (current) drug therapy, may be assigned as an additional code to identify the long-term (current) use of antiretroviral medications.

(j) Encounter for HIV Prophylaxis Measure

When a patient is seen for administration of pre-exposure prophylaxis medication for HIV, assign code Z29.81, Encounter for HIV pre-exposure prophylaxis. Pre-exposure prophylaxis (PrEP) is intended to prevent infection in people who are at risk for getting HIV through sex or injection drug use. Any risk factors for HIV should also be coded.

b. Infectious agents as the cause of diseases classified to other chapters

Certain infections are classified in chapters other than Chapter 1 and no organism is identified as part of the infection code. In these instances, it is necessary to use an additional code from Chapter 1 to identify the organism. A code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified to other chapters, B96, Other bacterial agents as the cause of diseases classified to other chapters, or B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.

Acute *E. coli* cystitis

N30.00 **Acute cystitis without hematuria**

B96.20 **Unspecified Escherichia coli [E.coli] as the cause of diseases classified elsewhere**

Explanation: An instructional note under the category for the cystitis indicates to code also the specific organism.

c. Infections resistant to antibiotics

Many bacterial infections are resistant to current antibiotics. It is necessary to identify all infections documented as antibiotic resistant. Assign a code from category Z16, Resistance to antimicrobial drugs, following the infection code only if the infection code does not identify drug resistance.

Penicillin-resistant *Streptococcus pneumoniae* pneumonia

J13 Pneumonia due to Streptococcus pneumoniae

Z16.11 Resistance to penicillins

Explanation: Code Z16.11 is assigned as a secondary code to represent the penicillin resistance. This code includes resistance to amoxicillin and ampicillin.

d. Sepsis, severe sepsis, and septic shock infections resistant to antibiotics

1) Coding of Sepsis and Severe Sepsis

(a) Sepsis

For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism.

A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

Gram-negative sepsis

A41.5Ø Gram-negative sepsis, unspecified

Staphylococcal sepsis

A41.2 Sepsis due to unspecified staphylococcus

Explanation: In both examples above the organism causing the sepsis is identified, therefore A41.9 Sepsis, unspecified organism, would not be appropriate as this code would not capture the highest degree of specificity found in the documentation. Do not use an additional code for severe sepsis unless an acute organ dysfunction was also documented as "associated with" or "due to" the sepsis or the sepsis was documented as "severe."

(i) Negative or inconclusive blood cultures and sepsis

Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition; however, the provider should be queried.

(ii) Urosepsis

The term urosepsis is a nonspecific term. It is not to be considered synonymous with sepsis. It has no default code in the Alphabetic Index. Should a provider use this term, he/she must be queried for clarification.

(iii)Sepsis with organ dysfunction

If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction (MOD), follow the instructions for coding severe sepsis.

(iv) Acute organ dysfunction that is not clearly associated with the sepsis

If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign a code from subcategory R65.2, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

Sepsis and acute respiratory failure due to COPD exacerbation

A41.9 Sepsis, unspecified organism

J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation

J96.ØØ Acute respiratory failure, unspecified whether with hypoxia or hypercapnia

Explanation: Although acute organ dysfunction is present in the form of acute respiratory failure, severe sepsis (R65.2) is not coded in this example, as the acute respiratory failure is attributed to the COPD exacerbation rather than the sepsis. Sequencing of these codes would be determined by the reason for the encounter.

(b) Severe sepsis

The coding of severe sepsis requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. If the causal organism is not documented, assign code A41.9, Sepsis, unspecified organism, for the infection. Additional code(s) for the associated acute organ dysfunction are also required.

Due to the complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes.

2) Septic shock

Septic shock generally refers to circulatory failure associated with severe sepsis, and therefore, it represents a type of acute organ dysfunction.

For cases of septic shock, the code for the systemic infection should be sequenced first, followed by code R65.21, Severe sepsis with septic shock or code T81.12, Postprocedural septic shock. Any additional codes for the other acute organ dysfunctions should also be assigned. As noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

Sepsis with septic shock

A41.9 Sepsis, unspecified organism

R65.21 Severe sepsis with septic shock

Explanation: Documentation of septic shock automatically implies severe sepsis as it is a form of acute organ dysfunction. Septic shock is not coded as the first-listed diagnosis; it is always preceded by the code for the systemic infection.

3) Sequencing of severe sepsis

If severe sepsis is present on admission, and meets the definition of principal diagnosis, the underlying systemic infection should be assigned as principal diagnosis followed by the appropriate code from subcategory R65.2 as required by the sequencing rules in the Tabular List. A code from subcategory R65.2 can never be assigned as a principal diagnosis.

When severe sepsis develops during an encounter (it was not present on admission), the underlying systemic infection and the appropriate code from subcategory R65.2 should be assigned as secondary diagnoses.

Severe sepsis may be present on admission, but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether severe sepsis was present on admission, the provider should be queried.

For infection-associated hemolytic-uremic syndrome with severe sepsis, see guideline I.C.1.d.9.

4) Sepsis or severe sepsis with a localized infection

If the reason for admission is sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(s) for the underlying systemic infection should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis. If the patient has severe sepsis, a code from subcategory R65.2 should also be assigned as a secondary diagnosis. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/severe sepsis doesn't develop until after admission, the localized infection should be assigned first, followed by the appropriate sepsis/severe sepsis codes.

For hemolytic-uremic syndrome associated with sepsis, see guideline I. C.1.d.9.

Patient presents with acute renal failure due to severe sepsis from *Pseudomonas pneumonia*

A41.52 Sepsis due to Pseudomonas

J15.1 Pneumonia due to Pseudomonas

R65.2Ø Severe sepsis without septic shock

N17.9 Acute kidney failure, unspecified

Explanation: If all conditions are present, the systemic infection (sepsis) is sequenced first followed by the codes for the localized infection (pneumonia), severe sepsis and any organ dysfunction.

5) Sepsis due to a postprocedural infection

(a) Documentation of causal relationship

As with all postprocedural complications, code assignment is based on the provider's documentation of the relationship between the infection and the procedure.

(b) Sepsis due to a postprocedural infection

For **sepsis** following a **postprocedural wound (surgical site) infection,** a code from T81.4**1** to T81.43, Infection following a procedure, or a code from O86.ØØ to O86.Ø3, Infection of obstetric surgical wound, that identifies the site of the infection should be **sequenced** first, if known. Assign an additional code for sepsis following a procedure (T81.44) or sepsis following an obstetrical

procedure (O86.Ø4). Use an additional code to identify the infectious agent. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

For infections following infusion, transfusion, therapeutic injection, or immunization, a code from subcategory T8Ø.2, Infections following infusion, transfusion, and therapeutic injection, or code T88.Ø-, Infection following immunization, should be coded first, followed by the code for the specific infection. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned, with the additional codes(s) for any acute organ dysfunction.

(c) Postprocedural infection and postprocedural septic shock

If a postprocedural infection has resulted in postprocedural septic shock, assign the codes indicated above for sepsis due to a postprocedural infection, followed by code T81.12-, Postprocedural septic shock. Do not assign code R65.21, Severe sepsis with septic shock. Additional code(s) should be assigned for any acute organ dysfunction.

6) Sepsis and severe sepsis associated with a noninfectious process (condition)

In some cases, a noninfectious process (condition) such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a noninfectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the noninfectious condition should be sequenced first, followed by the code for the resulting infection. If severe sepsis is present, a code from subcategory R65.2 should also be assigned with any associated organ dysfunction(s) codes. It is not necessary to assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin, for these cases.

If the infection meets the definition of principal diagnosis, it should be sequenced before the non-infectious condition. When both the associated non-infectious condition and the infection meet the definition of principal diagnosis, either may be assigned as principal diagnosis.

Only one code from category R65, Symptoms and signs specifically associated with systemic inflammation and infection, should be assigned. Therefore, when a non-infectious condition leads to an infection resulting in severe sepsis, assign the appropriate code from subcategory R65.2, Severe sepsis. Do not additionally assign a code from subcategory R65.1, Systemic inflammatory response syndrome (SIRS) of non-infectious origin.

See Section I.C.18. SIRS due to non-infectious process

7) Sepsis and septic shock complicating abortion, pregnancy, childbirth, and the puerperium

See Section I.C.15. Sepsis and septic shock complicating abortion, pregnancy, childbirth and the puerperium

8) Newborn sepsis

See Section I.C.16. f. Bacterial sepsis of Newborn

9) Hemolytic-uremic syndrome associated with sepsis

If the reason for admission is hemolytic-uremic syndrome that is associated with sepsis, assign code D59.31, Infection-associated hemolytic-uremic syndrome, as the principal diagnosis. Codes for the underlying systemic infection and any other conditions (such as severe sepsis) should be assigned as secondary diagnoses.

e. Methicillin resistant Staphylococcus aureus (MRSA) conditions

1) Selection and sequencing of MRSA codes

(a) Combination codes for MRSA infection

When a patient is diagnosed with an infection that is due to methicillin resistant *Staphylococcus aureus* (MRSA), and that infection has a combination code that includes the causal organism (e.g., sepsis, pneumonia) assign the appropriate combination code for the condition (e.g., code A41.Ø2, Sepsis due to Methicillin resistant Staphylococcus aureus or code J15.212, Pneumonia due to Methicillin resistant Staphylococcus aureus). Do not assign code B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere, as an additional code, because the combination code includes the type of infection and the MRSA organism. Do not assign a code from subcategory Z16.11, Resistance to penicillins, as an additional diagnosis.

See Section C.1. for instructions on coding and sequencing of sepsis and severe sepsis.

(b) Other codes for MRSA infection

When there is documentation of a current infection (e.g., wound infection, stitch abscess, urinary tract infection) due to MRSA, and that infection does not have a combination code that includes the causal organism, assign the appropriate code to identify the condition along with code B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere for the MRSA infection. Do not assign a code from subcategory Z16.11, Resistance to penicillins.

(c) Methicillin susceptible Staphylococcus aureus (MSSA) and MRSA colonization

The condition or state of being colonized or carrying MSSA or MRSA is called colonization or carriage, while an individual person is described as being colonized or being a carrier.

Colonization means that MSSA or MSRA is present on or in the body without necessarily causing illness. A positive MRSA colonization test might be documented by the provider as "MRSA screen positive" or "MRSA nasal swab positive".

Assign code Z22.322, Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus, for patients documented as having MRSA colonization. Assign code Z22.321, Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus, for patients documented as having MSSA colonization. Colonization is not necessarily indicative of a disease process or as the cause of a specific condition the patient may have unless documented as such by the provider.

(d) MRSA colonization and infection

If a patient is documented as having both MRSA colonization and infection during a hospital admission, code Z22.322, Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus, and a code for the MRSA infection may both be assigned.

f. Zika virus infections

1) Code only confirmed cases

Code only a confirmed diagnosis of Zika virus (A92.5, Zika virus disease) as documented by the provider. This is an exception to the hospital inpatient guideline Section II, H. In this context, "confirmation" does not require documentation of the type of test performed; the provider's diagnostic statement that the condition is confirmed is sufficient. This code should be assigned regardless of the stated mode of transmission.

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 Z2Ø.821, Contact with and (suspected) exposure to Zika virus.

g. Coronavirus infections

1) COVID-19 infection (infection due to SARS-CoV-2)

(a) Code only confirmed cases

Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider, or documentation of a positive COVID-19 test result. For a confirmed diagnosis, assign code UØ7.1, COVID-19. This is an exception to the hospital inpatient guideline Section II, H. In this context, "confirmation" does not require documentation of a positive test result for COVID-19; the provider's documentation that the individual has COVID-19 is sufficient.

Physician documentation states the patient has tested positive for the 2019 novel coronavirus disease.

UØ7.1 COVID-19

Explanation: The type of test is not required; physician documentation that states the patient has COVID-19 or a documented positive COVID-19 test result is sufficient.

If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, do not assign code UØ7.1. Instead, code the signs and symptoms reported. See guideline I.C.1.g.1.g.

Patient presents with cough and a slight fever and fear they were exposed to the coronavirus. The provider documents cough, temperature of 99.4, lungs clear, rule out COVID-19.

R5Ø.9 Fever, unspecified

RØ5.9 Cough, unspecified

Z2Ø.822 Contact with and (suspected) exposure to COVID-19

Explanation: For patients who have been exposed or fear they have been exposed to coronavirus, report codes for signs and symptoms, followed by the Z code. Report UØ7.1 COVID-19, only when the diagnosis is confirmed through provider documentation or a documented positive test result.

(b) Sequencing of codes

When COVID-19 meets the definition of principal diagnosis, code UØ7.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except when

another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications.

For a COVID-19 infection that progresses to sepsis, see Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock

See Section I.C.15.s. for COVID-19 infection in pregnancy, childbirth, and the puerperium

See Section I.C.16.h. for COVID-19 infection in newborn

For a COVID-19 infection in a lung transplant patient, see Section I.C.19.g.3.a. Transplant complications other than kidney.

(c) Acute respiratory manifestations of COVID-19

When the reason for the encounter/admission is a respiratory manifestation of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the respiratory manifestation(s) as additional diagnoses.

The following conditions are examples of common respiratory manifestations of COVID-19.

(i) Pneumonia

For a patient with pneumonia confirmed as due to COVID-19, assign codes U07.1, COVID-19, and J12.82, Pneumonia due to coronavirus disease 2019.

(ii) Acute bronchitis

For a patient with acute bronchitis confirmed as due to COVID-19, assign codes U07.1, and J20.8, Acute bronchitis due to other specified organisms.

Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using code U07.1 and J40, Bronchitis, not specified as acute or chronic.

(iii) Lower respiratory infection

If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22, Unspecified acute lower respiratory infection, should be assigned.

If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J98.8, Other specified respiratory disorders, should be assigned.

(iv) Acute respiratory distress syndrome

For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, Acute respiratory distress syndrome.

(v) Acute respiratory failure

For acute respiratory failure due to COVID-19, assign code U07.1, and code J96.0-, Acute respiratory failure.

(d) Non-respiratory manifestations of COVID-19

When the reason for the encounter/admission is a non-respiratory manifestation (e.g., viral enteritis) of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the manifestation(s) as additional diagnoses.

(e) Exposure to COVID-19

For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.822, Contact with and (suspected) exposure to COVID-19.

For symptomatic individuals with actual or suspected exposure to COVID-19 and the infection has been ruled out, or test results are inconclusive or unknown, assign code Z20.822, Contact with and (suspected) exposure to COVID-19. See guideline I.C.21.c.1, Contact/Exposure, for additional guidance regarding the use of category Z20 codes.

If COVID-19 is confirmed, see guideline I.C.1.g.1.a.

Patient was exposed to COVID-19 by a family member. They are asymptomatic and their test result is negative.

Z20.822 Contact with and (suspected) exposure to COVID-19

Explanation: Report Z20.822 for patients who have a negative test result but have known exposure to someone who has tested positive for COVID-19.

(f) Screening for COVID-19

For screening for COVID-19, including preoperative testing, assign code Z11.52, Encounter for screening for COVID-19.

(g) Signs and symptoms without definitive diagnosis of COVID-19

For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:

- R05.1, Acute cough, or R05.9, Cough, unspecified
- R06.02 Shortness of breath
- R50.9 Fever, unspecified

If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to COVID-19, assign Z20.822, Contact with and (suspected) exposure to COVID19, as an additional code.

(h) Asymptomatic individuals who test positive for COVID-19

For asymptomatic individuals who test positive for COVID-19, see guideline I.C.1.g.1.a. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.

(i) Personal history of COVID-19

For patients with a history of COVID-19, assign code Z86.16, Personal history of COVID-19.

(j) Follow-up visits after COVID-19 infection has resolved

For individuals who previously had COVID-19, without residual symptom(s) or condition(s), and are being seen for follow-up evaluation, and COVID-19 test results are negative, assign codes Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, and Z86.16, Personal history of COVID-19.

For follow-up visits for individuals with symptom(s) or condition(s) related to a previous COVID-19 infection, see guideline I.C.1.g.1.m.

See Section I.C.21.c.8, Factors influencing health states and contact with health services, Follow-up

(k) Encounter for antibody testing

For an encounter for antibody testing that is not being performed to confirm a current COVID-19 infection, nor is a follow-up test after resolution of COVID-19, assign Z01.84, Encounter for antibody response examination.

Follow the applicable guidelines above if the individual is being tested to confirm a current COVID-19 infection.

For follow-up testing after a COVID-19 infection, see guideline I.C.1.g.1.j.

(l) Multisystem inflammatory syndrome

For individuals with multisystem inflammatory syndrome (MIS) and COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code M35.81, Multisystem inflammatory syndrome, as an additional diagnosis.

If an individual with a history of COVID-19 develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and U09.9, Post COVID-19 condition, unspecified.

If an individual with a known or suspected exposure to COVID- 19, and no current COVID-19 infection or history of COVID-19, develops MIS, assign codes M35.81, Multisystem inflammatory syndrome, and Z20.822, Contact with and (suspected) exposure to COVID-19.

Additional codes should be assigned for any associated complications of MIS.

(m)Post COVID-19 condition

For sequela of COVID-19, or associated symptoms or conditions that develop following a previous COVID-19 infection, assign a code(s) for the specific symptom(s) or condition(s) related to the previous COVID-19 infection, if known, and code U09.9, Post COVID-19 condition, unspecified.

Code U09.9 should not be assigned for manifestations of an active (current) COVID-19 infection.

If a patient has a condition(s) associated with a previous COVID-19 infection and develops a new active (current) COVID-19 infection, code U09.9 may be assigned in conjunction with code U07.1, COVID-19, to identify that the patient also has a condition(s) associated with a previous COVID-19 infection. Code(s) for the specific condition(s) associated with the previous COVID-19 infection and code(s) for manifestation(s) of the new active (current) COVID-19 infection should also be assigned.

(n) Underimmunization for COVID-19 Status

Code Z28.310, Unvaccinated for COVID-19, may be assigned when the patient has not received a COVID-19 vaccine of any type. Code Z28.311, Partially vaccinated for COVID-19, may be assigned when the patient has been partially vaccinated for COVID-19 as per the recommendations of the Centers for Disease Control and Prevention (CDC) in place at the time of the encounter. For information, visit the CDC's website https://www.cdc.gov/coronavirus/2019-ncov/vaccines/.

See Section I.B.14. for underimmunization documentation by clinicians other than patient's provider.

Chapter 2. Neoplasms (C00–D49)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

General guidelines

Chapter 2 of the ICD-10-CM contains the codes for most benign and all malignant neoplasms. Certain benign neoplasms, such as prostatic adenomas, may be found in the specific body system chapters. To properly code a neoplasm, it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

Primary malignant neoplasms overlapping site boundaries

A primary malignant neoplasm that overlaps two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 ('overlapping lesion'), unless the combination is specifically indexed elsewhere. For multiple neoplasms of the same site that are not contiguous such as tumors in different quadrants of the same breast, codes for each site should be assigned.

A 62-year-old female with a malignant lesion of the upper lip that extends from the lipstick area to the labial frenulum

C00.8 Malignant neoplasm of overlapping sites of lip

Explanation: Because this is a single lesion that overlaps two contiguous sites, a single code for overlapping sites is assigned.

A 74-year-old male is treated for two distinct malignant lesions, one in the mucosa of the upper lip and a second in the mucosa of the lower lip.

C00.3 Malignant neoplasm of upper lip, inner aspect

C00.4 Malignant neoplasm of lower lip, inner aspect

Explanation: This patient has two distinct malignant lesions of the upper and lower lips. Because the lesions are not contiguous, two codes are reported.

Malignant neoplasm of ectopic tissue

Malignant neoplasms of ectopic tissue are to be coded to the site of origin mentioned, e.g., ectopic pancreatic malignant neoplasms involving the stomach are coded to malignant neoplasm of pancreas, unspecified (C25.9).

The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates "adenoma," refer to the term in the Alphabetic Index to review the entries under this term and the instructional note to "see also neoplasm, by site, benign." The table provides the proper code based on the type of neoplasm and the site. It is important to select the proper column in the table that corresponds to the type of neoplasm. The Tabular List should then be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist.

See Section I.C.21. Factors influencing health status and contact with health services, Status, for information regarding Z15.0, codes for genetic susceptibility to cancer.

a. Admission/Encounter for treatment of primary site

If the malignancy is chiefly responsible for occasioning the patient admission/encounter and treatment is directed at the primary site, designate the primary malignancy as the principal/first-listed diagnosis.

The only exception to this guideline is if the administration of chemotherapy, immunotherapy or external beam radiation therapy is chiefly responsible for occasioning the admission/encounter. In that case, assign the appropriate Z51.-- code as the first-listed or principal diagnosis, and the underlying diagnosis or problem for which the service is being performed as a secondary diagnosis.

b. Admission/Encounter for treatment of secondary site

When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

Patient with primary prostate cancer with metastasis to lungs presents for wedge resection of mass in right lung

C78.01 Secondary malignant neoplasm of right lung

C61 Malignant neoplasm of prostate

Explanation: Since the encounter is for treatment of the lung metastasis, the secondary lung metastasis is sequenced before the primary prostate cancer.

c. Coding and sequencing of complications

Coding and sequencing of complications associated with the malignancies or with the therapy thereof are subject to the following guidelines:

1) Anemia associated with malignancy

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

Patient is seen for treatment of anemia in advanced primary liver cancer

C22.8 Malignant neoplasm of liver, primary, unspecified as to type

D63.0 Anemia in neoplastic disease

Explanation: Even though the admission was solely to treat the anemia, this guideline indicates that the code for the malignancy is sequenced first.

2) Anemia associated with chemotherapy, immunotherapy and radiation therapy

When the admission/encounter is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy and the only treatment is for the anemia, the anemia code is sequenced first followed by the appropriate codes for the neoplasm and the adverse effect (T45.1X5, Adverse effect of antineoplastic and immunosuppressive drugs).

When the admission/encounter is for management of an anemia associated with an adverse effect of radiotherapy, the anemia code should be sequenced first, followed by the appropriate neoplasm code and code Y84.2, Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.

A 55-year-old male with a large malignant rectal tumor has been receiving external radiation therapy to shrink the tumor prior to planned surgery. He is referred today for a blood transfusion to treat anemia related to radiation therapy.

D64.89 Other specified anemias

C20 Malignant neoplasm of rectum

Y84.2 Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure

Explanation: The code for the anemia is sequenced first, followed by the code for the malignancy, and lastly the code for the abnormal reaction due to radiotherapy.

3) Management of dehydration due to the malignancy

When the admission/encounter is for management of dehydration due to the malignancy and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.

4) Treatment of a complication resulting from a surgical procedure

When the admission/encounter is for treatment of a complication resulting from a surgical procedure, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

d. Primary malignancy previously excised

When a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy. Any mention of extension, invasion, or metastasis to another site is coded as a secondary malignant neoplasm to that site. The secondary site may be the principal or first-listed diagnosis with the Z85 code used as a secondary code.

See section I.C.2.t. Secondary malignant neoplasm of lymphoid tissue.

History of lung cancer, left upper lobectomy 18 months ago with no current treatment; MRI of the brain shows metastatic disease in the brain

C79.31 **Secondary malignant neoplasm of brain**

Z85.118 **Personal history of other malignant neoplasm of bronchus and lung**

Explanation: The patient has undergone a diagnostic procedure that revealed metastatic lung cancer in the brain. The code for the secondary (metastatic) site is sequenced first, followed by a personal history code to identify the former site of the primary malignancy.

e. Admissions/encounters involving chemotherapy, immunotherapy and radiation therapy

1) Episode of care involves surgical removal of neoplasm

When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the code for the neoplasm should be assigned as principal or first-listed diagnosis.

2) Patient admission/encounter chiefly for administration of chemotherapy, immunotherapy and radiation therapy

If a patient admission/encounter is **chiefly** for the administration of chemotherapy, immunotherapy or external beam radiation therapy assign code Z51.Ø, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission, more than one of these codes may be assigned, in any sequence.

The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis.

If a patient admission/encounter is for the insertion or implantation of radioactive elements (e.g., brachytherapy) the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis. Code Z51.Ø should not be assigned.

Patient presents for second round of rituximab and fludarabine for his chronic B cell lymphocytic leukemia

Z51.11 **Encounter for antineoplastic chemotherapy**

Z51.12 **Encounter for antineoplastic immunotherapy**

C91.1Ø **Chronic lymphocytic leukemia of B-cell type not having achieved remission**

Explanation: Rituximab is an antineoplastic immunotherapy while fludarabine is an antineoplastic chemotherapy. The two treatments are often used together. The encounter was solely for the purpose of administering this treatment and either can be sequenced first, before the neoplastic condition.

3) Patient admitted for radiation therapy, chemotherapy or immunotherapy and develops complications

When a patient is admitted for the purpose of external beam radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is Z51.Ø, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications.

When a patient is admitted for the purpose of insertion or implantation of radioactive elements (e.g., brachytherapy) and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is the appropriate code for the malignancy followed by any codes for the complications.

f. Admission/encounter to determine extent of malignancy

When the reason for admission/encounter is to determine the extent of the malignancy, or for a procedure such as paracentesis or thoracentesis, the primary malignancy or appropriate metastatic site is designated as the principal or first-listed diagnosis, even though chemotherapy or radiotherapy is administered.

Patient with left lung cancer with malignant pleural effusion being seen for paracentesis and initiation/administration of chemotherapy

C34.92 **Malignant neoplasm of unspecified part of left bronchus or lung**

J91.Ø **Malignant pleural effusion**

Z51.11 **Encounter for antineoplastic chemotherapy**

Explanation: The lung cancer is sequenced before the chemotherapy in this instance because the paracentesis for the malignant effusion is also being performed. An instructional note under the malignant effusion instructs that the lung cancer be sequenced first.

g. Symptoms, signs, and abnormal findings listed in Chapter 18 associated with neoplasms

Symptoms, signs, and ill-defined conditions listed in Chapter 18 characteristic of, or associated with, an existing primary or secondary site malignancy cannot be used to replace the malignancy as principal or first-listed diagnosis, regardless of the number of admissions or encounters for treatment and care of the neoplasm.

See Section I.C.21. Factors influencing health status and contact with health services, Encounter for prophylactic organ removal.

h. Admission/encounter for pain control/management

See Section I.C.6. for information on coding admission/encounter for pain control/management.

i. Malignancy in two or more noncontiguous sites

A patient may have more than one malignant tumor in the same organ. These tumors may represent different primaries or metastatic disease, depending on the site. Should the documentation be unclear, the provider should be queried as to the status of each tumor so that the correct codes can be assigned.

j. Disseminated malignant neoplasm, unspecified

Code C8Ø.Ø, Disseminated malignant neoplasm, unspecified, is for use only in those cases where the patient has advanced metastatic disease and no known primary or secondary sites are specified. It should not be used in place of assigning codes for the primary site and all known secondary sites.

k. Malignant neoplasm without specification of site

Code C8Ø.1, Malignant (primary) neoplasm, unspecified, equates to Cancer, unspecified. This code should only be used when no determination can be made as to the primary site of a malignancy. This code should rarely be used in the inpatient setting.

Evaluation of painful hip leads to diagnosis of a metastatic bone lesion from an unknown primary neoplasm source

C79.51 **Secondary malignant neoplasm of bone**

C8Ø.1 **Malignant (primary) neoplasm, unspecified**

Explanation: If only the secondary site is known, use code C8Ø.1 for the unknown primary site.

l. Sequencing of neoplasm codes

1) Encounter for treatment of primary malignancy

If the reason for the encounter is for treatment of a primary malignancy, assign the malignancy as the principal/first-listed diagnosis. The primary site is to be sequenced first, followed by any metastatic sites.

2) Encounter for treatment of secondary malignancy

When an encounter is for a primary malignancy with metastasis and treatment is directed toward the metastatic (secondary) site(s) only, the metastatic site(s) is designated as the principal/first-listed diagnosis. The primary malignancy is coded as an additional code.

Patient has primary colon cancer with metastasis to rib and is evaluated for possible excision of portion of rib bone

C79.51 Secondary malignant neoplasm of bone

C18.9 Malignant neoplasm of colon, unspecified

Explanation: The treatment for this encounter is focused on the metastasis to the rib bone rather than the primary colon cancer, thus indicating that the bone metastasis is sequenced as the first-listed code.

3) Malignant neoplasm in a pregnant patient

When a pregnant patient has a malignant neoplasm, a code from subcategory O9A.1-, Malignant neoplasm complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate code from Chapter 2 to indicate the type of neoplasm.

A 30-year-old pregnant female in first trimester evaluated for pituitary gland malignancy

O9A.111 Malignant neoplasm complicating pregnancy, first trimester

C75.1 Malignant neoplasm of pituitary gland

Explanation: Codes from chapter 15 describing complications of pregnancy are sequenced as first-listed codes, further specified by codes from other chapters such as neoplastic, unless the pregnancy is documented as incidental to the condition. See also guideline 1.C.15.a.1.

4) Encounter for complication associated with a neoplasm

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.

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 anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by code D63.Ø, Anemia in neoplastic disease.

Patient with pancreatic cancer is seen for initiation of TPN for cancer-related moderate protein-calorie malnutrition

E44.Ø Moderate protein-calorie malnutrition

C25.9 Malignant neoplasm of pancreas, unspecified

Explanation: The encounter is to initiate treatment for malnutrition, a common complication of many types of neoplasms, and is sequenced first.

5) Complication from surgical procedure for treatment of a neoplasm

When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of the neoplasm, designate the complication as the principal/first-listed diagnosis. See the guideline regarding the coding of a current malignancy versus personal history to determine if the code for the neoplasm should also be assigned.

6) Pathologic fracture due to a neoplasm

When an encounter is for a pathological fracture due to a neoplasm, and the focus of treatment is the fracture, a code from subcategory M84.5, Pathological fracture in neoplastic disease, should be sequenced first, followed by the code for the neoplasm.

If the focus of treatment is the neoplasm with an associated pathological fracture, the neoplasm code should be sequenced first, followed by a code from M84.5 for the pathological fracture.

m. Current malignancy versus personal history of malignancy

When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

Female patient with ongoing chemotherapy after right mastectomy for breast cancer

C5Ø.911 Malignant neoplasm of unspecified site of right female breast

Z9Ø.11 Acquired absence of right breast and nipple

Explanation: Even though the breast has been removed, the breast cancer is still being treated with chemotherapy and therefore is still coded as a current condition rather than personal history.

When a primary malignancy has been previously excised or eradicated from its site, there is no further treatment (of the malignancy) directed to that site, and there is no evidence of any existing primary malignancy at that site, a code from category Z85, Personal history of malignant neoplasm, should be used to indicate the former site of the malignancy.

Codes from subcategories Z85.Ø – Z85.85 should only be assigned for the former site of a primary malignancy, not the site of a secondary malignancy. Code Z85.89 may be assigned for the former site(s) of either a primary or secondary malignancy.

See Section I.C.21. Factors influencing health status and contact with health services, History (of)

n. Leukemia, multiple myeloma, and malignant plasma cell neoplasms in remission versus personal history

The categories for leukemia, and category C9Ø, Multiple myeloma and malignant plasma cell neoplasms, have codes indicating whether or not the leukemia has achieved remission. There are also codes Z85.6, Personal history of leukemia, and Z85.79, Personal history of other malignant neoplasms of lymphoid, hematopoietic and related tissues. If the documentation is unclear as to whether the leukemia has achieved remission, the provider should be queried.

See Section I.C.21. Factors influencing health status and contact with health services, History (of)

o. Aftercare following surgery for neoplasm

See Section I.C.21. Factors influencing health status and contact with health services, Aftercare

p. Follow-up care for completed treatment of a malignancy

See Section I.C.21. Factors influencing health status and contact with health services, Follow-up

q. Prophylactic organ removal for prevention of malignancy

See Section I.C. 21, Factors influencing health status and contact with health services, Prophylactic organ removal

r. Malignant neoplasm associated with transplanted organ

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 organs and tissue, followed by code C8Ø.2, Malignant neoplasm associated with transplanted organ. Use an additional code for the specific malignancy.

s. Breast implant associated anaplastic large cell lymphoma

Breast implant associated anaplastic large cell lymphoma (BIA-ALCL) is a type of lymphoma that can develop around breast implants. Assign code C84.7A, Anaplastic large cell lymphoma, ALK-negative, breast, for BIA-ALCL. Do not assign a complication code from chapter 19.

t. Secondary malignant neoplasm of lymphoid tissue

When a malignant neoplasm of lymphoid tissue metastasizes beyond the lymph nodes, a code from categories C81–C85 with a final character "9" should be assigned identifying "extranodal and solid organ sites" rather than a code for the secondary neoplasm of the affected solid organ. For example, for metastasis of **diffuse large** B-cell lymphoma to the lung, brain and left adrenal gland, assign code C83.39, Diffuse large B-cell lymphoma, extranodal and solid organ sites.

Chapter 3. Disease of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism (D5Ø–D89)

Chapter-specific Guidelines with Coding Examples
Reserved for future guideline expansion.

Chapter 4. Endocrine, Nutritional, and Metabolic Diseases (E00–E89)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Diabetes mellitus

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08–E13 as needed to identify all of the associated conditions that the patient has.

Patient is seen for uncontrolled diabetes, type 2, with hyperglycemia diabetic nephropathy, and diabetic gastroparesis

E11.65 **Type 2 diabetes mellitus with hyperglycemia**

E11.21 **Type 2 diabetes mellitus with diabetic nephropathy**

E11.43 **Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy**

K31.84 **Gastroparesis**

Explanation: Use as many codes to describe the diabetic complications as needed. Many are combination codes that describe more than one condition. Code first the reason for the encounter. The term "uncontrolled" can refer to either hyperglycemia or hypoglycemia. In this case, "uncontrolled" is described as "with hyperglycemia."

1) Type of diabetes

The age of a patient is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason, type 1 diabetes mellitus is also referred to as juvenile diabetes.

A 45-year-old patient is diagnosed with type 1 diabetes

E10.9 **Type 1 diabetes mellitus without complications**

Explanation: Although most type 1 diabetics are diagnosed in childhood or adolescence, it can also begin in adults.

2) Type of diabetes mellitus not documented

If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2 diabetes mellitus.

Office visit lists diabetic retinopathy with macular edema and hypertension on patient problem list

E11.311 **Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema**

I10 **Essential (primary) hypertension**

Explanation: Since the type of diabetes was not documented, default to category E11.

3) Diabetes mellitus and the use of insulin, oral hypoglycemics, and injectable non-insulin drugs

If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11-, Type 2 diabetes mellitus, should be assigned. Additional code(s) should be assigned from category Z79 to identify the long-term (current) use of insulin, oral hypoglycemic drugs, or injectable non-insulin antidiabetic, as follows:

If the patient is treated with both oral hypoglycemic drugs and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs, should be assigned.

If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long term (current) use of insulin, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.

If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long term (current) use of oral hypoglycemic drugs, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.

Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

Office visit lists chronic diabetes with daily insulin use on patient problem list

E11.9 **Type 2 diabetes mellitus without complications**

Z79.4 **Long term (current) use of insulin**

Explanation: Do not assume that a patient on insulin must have type 1 diabetes. The default for diabetes without further specification defaults to type 2. Add the code for long term use of insulin.

4) Diabetes mellitus in pregnancy and gestational diabetes

See Section I.C.15. Diabetes mellitus in pregnancy.

See Section I.C.15. Gestational (pregnancy induced) diabetes

5) Complications due to insulin pump malfunction

(a) Underdose of insulin due to insulin pump failure

An underdose of insulin due to an insulin pump failure should be assigned to a code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, that specifies the type of pump malfunction, as the principal or first-listed code, followed by code T38.3X6-, Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs. Additional codes for the type of diabetes mellitus and any associated complications due to the underdosing should also be assigned.

A 24-year-old type 1 diabetic male treated in for hyperglycemia; insulin pump found to be malfunctioning and underdosing

T85.614A **Breakdown (mechanical) of insulin pump, initial encounter**

T38.3X6A **Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, initial encounter**

E10.65 **Type 1 diabetes mellitus with hyperglycemia**

Explanation: The complication code for the mechanical breakdown of the pump is sequenced first, followed by the underdosing code and type of diabetes with complication. Code all other diabetic complication codes necessary to describe the patient's condition.

(b) Overdose of insulin due to insulin pump failure

The principal or first-listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be T85.6-, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, followed by code T38.3X1-, Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional).

A 24-year-old type 1 diabetic male found down with diabetic coma, brought into ED and treated for hypoglycemia; insulin pump found to be malfunctioning and overdosing

T85.614A **Breakdown (mechanical) of insulin pump, initial encounter**

T38.3X1A **Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional), initial encounter**

E10.641 **Type 1 diabetes mellitus with hypoglycemia with coma**

Explanation: The complication code for the mechanical breakdown of the pump is sequenced first, followed by the poisoning code and type of diabetes with complication. All the characters in the combination code must be used to form a valid code and to fully describe the type of diabetes, the hypoglycemia, and the coma.

6) Secondary diabetes mellitus

Codes under categories E08, Diabetes mellitus due to underlying condition, E09, Drug or chemical induced diabetes mellitus, and E13, Other specified diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

(a) Secondary diabetes mellitus and the use of insulin or oral hypoglycemic drugs

For patients with secondary diabetes mellitus who routinely use insulin, oral hypoglycemic drugs, or injectable non-insulin drugs, additional code(s) from category Z79 should be assigned to identify the long-term (current) use of insulin, oral hypoglycemic drugs, or non-injectable non-insulin drugs as follows:

If the patient is treated with both oral hypoglycemic drugs and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs, should be assigned.

If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long-term (current) use of insulin, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.

If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long-term (current) use of oral hypoglycemic drugs, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.

Code Z79.4 should not be assigned if insulin is given temporarily to bring a secondary diabetic patient's blood sugar under control during an encounter.

Type 2 diabetic with no complications, normally only on oral metformin, is given insulin for three days to maintain glucose control while in the hospital recovering from surgery

E11.9 Type 2 diabetes mellitus without complications

Z79.84 Long term (current) use of oral hypoglycemic drugs

Explanation: Although the patient was given insulin for a short time during his hospital stay, the intent was only to maintain the patient's glucose levels while off his regular oral hypoglycemic medication, not for long term use. No code is needed for long term use of insulin, but a Z code for long term use of an oral hypoglycemic should be added to identify the chronic use of this drug.

Type 2 diabetic with diabetic polyneuropathy on insulin

E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy

Z79.4 Long term (current) use of insulin

Explanation: Add a Z code for the long term use of insulin and the long term use of metformin because both are taken chronically.

(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 List instructions for categories E08, E09 and E13.

(i) Secondary diabetes mellitus due to pancreatectomy

For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code E89.1, Postprocedural hypoinsulinemia. Assign a code from category E13 and a code from subcategory Z90.41-, Acquired absence of pancreas, as additional codes.

Patient with newly diagnosed diabetes after surgical removal of part of pancreas

E89.1 Postprocedural hypoinsulinemia

E13.9 Other specified diabetes mellitus without complications

Z90.411 Acquired partial absence of pancreas

Explanation: Sequence the postprocedural complication of the hypoinsulinemia due to the partial removal of the pancreas as the first-listed code, followed by codes for other specified diabetes (NEC) without complications and partial acquired absence of the pancreas.

(ii) Secondary diabetes due to drugs

Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or sequela of poisoning.

See section I.C.19.e. for coding of adverse effects and poisoning, and section I.C.20 for external cause code reporting.

Initial encounter for corticosteroid-induced diabetes mellitus

E09.9 Drug or chemical induced diabetes mellitus without complications

T38.0X5A Adverse effect of glucocorticoids and synthetic analogues, initial encounter

Explanation: If the diabetes is caused by an adverse effect of a drug, the diabetic condition is coded first. If it occurs from a poisoning or overdose, the poisoning code causing the diabetes is sequenced first.

Chapter 5. Mental, Behavioral and Neurodevelopmental Disorders (FØ1–F99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Pain disorders related to psychological factors

Assign code F45.41, for pain that is exclusively related to psychological disorders. As indicated by the Excludes 1 note under category G89, a code from category G89 should not be assigned with code F45.41.

Chest pain determined to be persistent somatoform pain disorder

F45.41 Pain disorder exclusively related to psychological factors

Explanation: This pain was diagnosed as being exclusively psychological; therefore, no code from category G89 is added.

Code F45.42, Pain disorders with related psychological factors, should be used with a code from category G89, Pain, not elsewhere classified, if there is documentation of a psychological component for a patient with acute or chronic pain.

See Section I.C.6. Pain

b. Mental and behavioral disorders due to psychoactive substance use

1) In remission

Selection of codes describing "in remission" for categories F1Ø-F19, Mental and behavioral disorders due to psychoactive substance use (categories F1Ø-F19 with -.11, -.21, -.91) requires the provider's clinical judgment and are assigned only on the basis of provider documentation (as defined in the Official Guidelines for Coding and Reporting), unless otherwise instructed by the classification.

Mild substance use disorders in early or sustained remission are classified to the appropriate codes for substance abuse in remission, and moderate or severe substance use disorders in early or sustained remission are classified to the appropriate codes for substance dependence in remission.

Physician documentation indicates the patient is seen to monitor progress on quitting cigarette smoking. The problem list indicates mild tobacco use disorder that is currently in remission.

F17.211 Nicotine dependence, cigarettes, in remission

Explanation: According to the index, Disorder, tobacco use, cigarettes (mild) (moderate) (severe), in remission (early) (sustained) is categorized to dependence (F17.211). Since the physician clearly documents mild cigarette use "disorder" and that the disorder is in remission, a code for nicotine dependence "in remission" is appropriate.

2) 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.

History and physical notes cannabis dependence and ongoing cannabis abuse

F12.2Ø Cannabis dependence, uncomplicated

Explanation: In the hierarchy, the dependence code is used if both abuse and dependence are documented.

Current problem list indicates daily opioid use with opioid abuse.

F11.1Ø Opioid abuse, uncomplicated

Explanation: In the hierarchy, the abuse code is used if both abuse and use are documented.

3) Psychoactive substance use, unspecified

As with all other unspecified diagnoses, the codes for unspecified psychoactive substance use (F1Ø.9-, F11.9-, F12.9-, F13.9-, F14.9-, F15.9-, F16.9-, F18.9-, F19.9-) should only be assigned based on provider documentation and when they meet the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses). These codes are to be used only when the psychoactive substance use is associated with a substance related disorder (chapter 5 disorders such as sexual dysfunction, sleep disorder, or a mental or behavioral disorder) or medical condition, and such a relationship is documented by the provider.

4) Medical conditions due to psychoactive substance use, abuse and dependence

Medical conditions due to substance use, abuse, and dependence are not classified as substance-induced disorders. Assign the diagnosis code for the medical condition as directed by the Alphabetical Index along with the appropriate psychoactive substance use, abuse or dependence code. For example, for alcoholic pancreatitis due to alcohol dependence, assign the appropriate code from subcategory K85.2, Alcohol induced acute pancreatitis, and the appropriate code from subcategory F1Ø.2, such as code F1Ø.20, Alcohol dependence, uncomplicated. It would not be appropriate to assign code F1Ø.288, Alcohol dependence with other alcohol-induced disorder.

5) Blood alcohol level

A code from category Y9Ø, Evidence of alcohol involvement determined by blood alcohol level, may be assigned when this information is documented and the patient's provider has documented a condition classifiable to category F1Ø, Alcohol related disorders. The blood alcohol level does not need to be documented by the patient's provider in order for it to be coded.

See Section I.B.14. for blood alcohol level documentation by clinicians other than patient's provider.

c. Factitious disorder

Factitious disorder imposed on self or Munchausen's syndrome is a disorder in which a person falsely reports or causes his or her own physical or psychological signs or symptoms. For patients with documented factitious disorder on self or Munchausen's syndrome, assign the appropriate code from subcategory F68.1-, Factitious disorder imposed on self.

Munchausen's syndrome by proxy (MSBP) is a disorder in which a caregiver (perpetrator) falsely reports or causes an illness or injury in another person (victim) under his or her care, such as a child, an elderly adult, or a person who has a disability. The condition is also referred to as "factitious disorder imposed on another" or "factitious disorder by proxy." The perpetrator, not the victim, receives this diagnosis. Assign code F68.A, Factitious disorder imposed on another, to the perpetrator's record. For the victim of a patient suffering from MSBP, assign the appropriate code from categories T74, Adult and child abuse, neglect and other maltreatment, confirmed, or T76, Adult and child abuse, neglect and other maltreatment, suspected.

See Section I.C.19.f. Adult and child abuse, neglect and other maltreatment

d. Dementia

The ICD-10-CM classifies dementia (categories FØ1, FØ2, and FØ3) on the basis of the etiology and severity (unspecified, mild, moderate or severe). Selection of the appropriate severity level requires the provider's clinical judgment and codes should be assigned only on the basis of provider documentation (as defined in the Official Guidelines for Coding and Reporting), unless otherwise instructed by the classification. If the documentation does not provide information about the severity of the dementia, assign the appropriate code for unspecified severity.

If a patient is admitted to an inpatient acute care hospital or other inpatient facility setting with dementia at one severity level and it progresses to a higher severity level, assign one code for the highest severity level reported during the stay.

Chapter 6. Diseases of the Nervous System (GØØ–G99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Dominant/nondominant side

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. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

- For ambidextrous patients, the default should be dominant.
- If the left side is affected, the default is non-dominant.
- If the right side is affected, the default is dominant.

Hemiplegia affecting left side of ambidextrous patient

G81.92 Hemiplegia, unspecified affecting left dominant side

Explanation: Documentation states that the left side is affected and dominant is used for ambidextrous persons.

Right spastic hemiplegia, unknown whether patient is right- or left-handed

G81.11 Spastic hemiplegia affecting right dominant side

Explanation: Since it is unknown whether the patient is right- or left-handed, if the right side is affected, the default is dominant.

b. Pain—Category G89

1) General coding information

Codes in category G89, Pain, not elsewhere classified, may be used in conjunction with codes from other categories and chapters to provide more detail about acute or chronic pain and neoplasm-related pain, unless otherwise indicated below.

If the pain is not specified as acute or chronic, post-thoracotomy, postprocedural, or neoplasm-related, do not assign codes from category G89.

A code from category G89 should not be assigned if the underlying (definitive) diagnosis is known, unless the reason for the encounter is pain control/ management and not management of the underlying condition.

When an admission or encounter is for a procedure aimed at treating the underlying condition (e.g., spinal fusion, kyphoplasty), a code for the underlying condition (e.g., vertebral fracture, spinal stenosis) should be assigned as the principal diagnosis. No code from category G89 should be assigned.

Elderly patient with back pain is admitted for outpatient kyphoplasty for age-related osteopathic compression fracture at vertebra T3

M8Ø.Ø8XA Age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter for fracture

Explanation: No code is assigned for the pain as it is inherent in the underlying condition being treated.

(a) Category G89 codes as principal or first-listed diagnosis

Category G89 codes are acceptable as principal diagnosis or the first-listed code:

- When pain control or pain management is the reason for the admission/encounter (e.g., a patient with displaced intervertebral disc, nerve impingement and severe back pain presents for injection of steroid into the spinal canal). The underlying cause of the pain should be reported as an additional diagnosis, if known.

Patient presents for steroid injection in the right elbow due to chronic pain associated with primary degenerative joint disease.

G89.29 Other chronic pain

M19.Ø21 Primary osteoarthritis, right elbow

Explanation: Since the encounter is for control of pain, not treating the underlying condition, the pain code is sequenced first followed by the underlying condition. The M25 pain code is not necessary as the underlying condition code represents the specific site.

- When a patient is admitted for the insertion of a neurostimulator for pain control, assign the appropriate pain code as the principal or first-listed diagnosis. When an admission or encounter is for a procedure aimed at treating the underlying condition and a neurostimulator is inserted for pain control during the same admission/encounter, a code for the underlying condition should be assigned as the principal diagnosis and the appropriate pain code should be assigned as a secondary diagnosis.

(b) Use of category G89 codes in conjunction with site specific pain codes

(i) Assigning category G89 and site-specific pain codes

Codes from category G89 may be used in conjunction with codes that identify the site of pain (including codes from chapter 18) if the category G89 code provides additional information. For example, if the code describes the site of the pain, but does not fully describe whether the pain is acute or chronic, then both codes should be assigned.

Patient is seen to evaluate chronic right knee pain

M25.561 Pain in right knee

G89.29 Other chronic pain

Explanation: No underlying condition has been determined yet so the pain would be the reason for the visit. The M25 pain code in this instance does not fully describe the condition as it does not represent that the pain is chronic. The G89 chronic pain code is assigned to provide specificity.

(ii) Sequencing of category G89 codes with site-specific pain codes

The sequencing of category G89 codes with site-specific pain codes (including chapter 18 codes), is dependent on the circumstances of the encounter/admission as follows:

- If the encounter is for pain control or pain management, assign the code from category G89 followed by the code identifying the specific site of pain (e.g., encounter for pain management for acute neck pain from trauma is assigned code G89.11, Acute pain due to trauma, followed by code M54.2, Cervicalgia, to identify the site of pain).

Management of acute, traumatic left shoulder pain

G89.11 Acute pain due to trauma

M25.512 Pain in left shoulder

Explanation: The reason for the encounter is to manage or control the pain, not to treat or evaluate an underlying condition. The G89 pain code is assigned as the first-listed diagnosis but in this instance does not fully describe the condition as it does not include the site and laterality. The M25 pain code is added to provide this information.

- If the encounter is for any other reason except pain control or pain management, and a related definitive diagnosis has not been established (confirmed) by the provider, assign the code for the specific site of pain first, followed by the appropriate code from category G89.

Tests are performed to investigate the source of the patient's chronic epigastric abdominal pain

R10.13 Epigastric pain

G89.29 Other chronic pain

Explanation: In this instance the patient's epigastric pain is not being treated; rather the source of the pain is being investigated. A code from chapter 18 for epigastric pain is sequenced before the additional specificity of the G89 code for the chronic pain.

2) Pain due to devices, implants and grafts

See Section I.C.19. Pain due to medical devices

3) Postoperative Pain

The provider's documentation should be used to guide the coding of postoperative pain, as well as *Section III. Reporting Additional Diagnoses* and *Section IV. Diagnostic Coding and Reporting in the Outpatient Setting*.

The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form.

Routine or expected postoperative pain immediately after surgery should not be coded.

Pain pump dose is increased for the patient's unexpected, extreme pain post-thoracotomy

G89.12 Acute post-thoracotomy pain

Explanation: When acute or chronic is not documented, default to acute. The use of "unexpected, extreme" and the increase of medication dosage indicate that the pain was more than routine or expected.

(a) Postoperative pain not associated with specific postoperative complication

Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category G89.

(b) Postoperative pain associated with specific postoperative complication

Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. If appropriate, use additional code(s) from category G89 to identify acute or chronic pain (G89.18 or G89.28).

4) Chronic pain

Chronic pain is classified to subcategory G89.2. There is no time frame defining when pain becomes chronic pain. The provider's documentation should be used to guide use of these codes.

5) Neoplasm related pain

Code G89.3 is assigned to pain documented as being related, associated or due to cancer, primary or secondary malignancy, or tumor. This code is assigned regardless of whether the pain is acute or chronic.

This code may be assigned as the principal or first-listed code when the stated reason for the admission/encounter is documented as pain control/pain management. The underlying neoplasm should be reported as an additional diagnosis.

Patient referred today for pain management due to acute pain related to malignancy of the right breast.

G89.3 Neoplasm related pain (acute)(chronic)

C50.911 Malignant neoplasm of unspecified site of right female breast

Explanation: Since the encounter was for pain medication management, the pain, rather than the neoplasm, was the reason for the encounter and is sequenced first. This "neoplasm-related pain" code includes both acute and chronic pain.

When the reason for the admission/encounter is management of the neoplasm and the pain associated with the neoplasm is also documented, code G89.3 may be assigned as an additional diagnosis. It is not necessary to assign an additional code for the site of the pain.

See Section I.C.2. for instructions on the sequencing of neoplasms for all other stated reasons or the admission/encounter (except for pain control/pain management).

Patient with lung cancer presents with acute hip pain and is evaluated and found to have iliac bone metastasis

C79.51 Secondary malignant neoplasm of bone

C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung

G89.3 Neoplasm related pain (acute)(chronic)

Explanation: The reason for the encounter was the evaluation and diagnosis of the bone metastasis, whose code would be assigned as first-listed, followed by codes for the primary neoplasm and the pain due to the iliac bone metastasis.

6) Chronic pain syndrome

Central pain syndrome (G89.0) and chronic pain syndrome (G89.4) are different than the term "chronic pain," and therefore codes should only be used when the provider has specifically documented this condition.

See Section I.C.5. Pain disorders related to psychological factors

Chapter 7. Diseases of the Eye and Adnexa (H00–H59)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Glaucoma

1) Assigning glaucoma codes

Assign as many codes from category H40, Glaucoma, as needed to identify the type of glaucoma, the affected eye, and the glaucoma stage.

2) Bilateral glaucoma with same type and stage

When a patient has bilateral glaucoma and both eyes are documented as being the same type and stage, and there is a code for bilateral glaucoma, report only the code for the type of glaucoma, bilateral, with the seventh character for the stage.

Bilateral mild stage primary open-angle glaucoma

H40.1131 Primary open-angle glaucoma, bilateral, mild stage

Explanation: In this scenario, the patient has the same type and stage of glaucoma in both eyes. As this type of glaucoma has a code for bilateral, assign only the code for the bilateral glaucoma with the seventh character for the stage.

When a patient has bilateral glaucoma and both eyes are documented as being the same type and stage, and the classification does not provide a code for bilateral glaucoma (i.e. subcategories H40.10 and H40.20) report only one code for the type of glaucoma with the appropriate seventh character for the stage.

Bilateral open-angle glaucoma, severe stage; not specified as to type

H40.10X3 Unspecified open-angle glaucoma, severe stage

Explanation: In this scenario, the patient has glaucoma of the same type and stage of both eyes, but there is no code specifically for bilateral glaucoma. Only one code is assigned with the appropriate seventh character for the stage.

3) Bilateral glaucoma stage with different types or stages

When a patient has bilateral glaucoma and each eye is documented as having a different type or stage, and the classification distinguishes laterality, assign the appropriate code for each eye rather than the code for bilateral glaucoma.

Bilateral chronic angle-closure glaucoma; right eye is documented as mild stage and left eye as moderate stage

H40.2211 Chronic angle-closure glaucoma, right eye, mild stage

H40.2222 Chronic angle-closure glaucoma, left eye, moderate stage

Explanation: In this scenario the patient has the same type of glaucoma in both eyes, but each eye is at a different stage. Because the subcategory for this condition identifies laterality, one code is assigned for the right eye and one code is assigned for the left eye, each with the appropriate seventh character for the stage appended.

When a patient has bilateral glaucoma and each eye is documented as having a different type, and the classification does not distinguish laterality (i.e. subcategories H40.10 and H40.20), assign one code for each type of glaucoma with the appropriate seventh character for the stage.

Documentation relates mild, unspecified primary angle-closure glaucoma of the left eye with mild unspecified open-angle glaucoma of the right eye

H40.20X1 Unspecified primary angle-closure glaucoma, mild stage

H40.10X1 Unspecified open-angle glaucoma, mild stage

Explanation: In this scenario the patient has a different type of glaucoma in each eye and the classification does not distinguish laterality. A code for each type of glaucoma is assigned, each with the appropriate seventh character for the stage.

When a patient has bilateral glaucoma and each eye is documented as having the same type, but different stage, and the classification does not distinguish laterality (i.e. subcategories H40.10 and H40.20), assign a code for the type of glaucoma for each eye with the seventh character for the specific glaucoma stage documented for each eye.

Bilateral open-angle glaucoma, not specified as to type; the right eye is documented to be in mild stage and the left eye as being in moderate stage

H40.10X1 Unspecified open-angle glaucoma, mild stage

H40.10X2 Unspecified open-angle glaucoma, moderate stage

Explanation: In this scenario the patient has the same type of glaucoma in each eye but each eye is at a different stage, and the classification does not distinguish laterality at this subcategory level. Two codes are assigned; both codes represent the same type of glaucoma but each has a different seventh character identifying the appropriate stage for each eye.

4) Patient admitted with glaucoma and stage evolves during the admission

If a patient is admitted with glaucoma and the stage progresses during the admission, assign the code for highest stage documented.

5) Indeterminate stage glaucoma

Assignment of the seventh character "4" for "indeterminate stage" should be based on the clinical documentation. The seventh character "4" is used for glaucomas whose stage cannot be clinically determined. This seventh character should not be confused with the seventh character "0", unspecified, which should be assigned when there is no documentation regarding the stage of the glaucoma.

b. Blindness

If "blindness" or "low vision" of both eyes is documented but the visual impairment category is not documented, assign code H54.3, Unqualified visual loss, both eyes. If "blindness" or "low vision" in one eye is documented but the visual impairment category is not documented, assign a code from H54.6-, Unqualified visual loss, one eye. If "blindness" or "visual loss" is documented without any information about whether one or both eyes are affected, assign code H54.7, Unspecified visual loss.

Patient assessment indicates moderately impaired/low vision in the left eye with no visual impairments in the right eye

H54.62 Unqualified visual loss, left eye, normal vision right eye

Report unqualified visual loss when the visual impairment category is not specified. In this case, only the left eye is impacted by visual loss with normal vision of the right eye documented.

Chapter 8. Diseases of the Ear and Mastoid Process (H6Ø–H95)

Chapter-specific Guidelines with Coding Examples
Reserved for future guideline expansion.

Chapter 9. Diseases of the Circulatory System (I00–I99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Hypertension

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.

1) Hypertension with heart disease

Hypertension with heart conditions classified to I50.- or I51.4-I51.7, I51.89, I51.9, are assigned to a code from category I11, Hypertensive heart disease. Use additional code(s) from category I50, Heart failure, to identify the type(s) of heart failure in those patients with heart failure.

The same heart conditions (I50.-, I51.4-I51.7, I51.89, I51.9) with hypertension are coded separately if the provider has documented they are unrelated to the hypertension. Sequence according to the circumstances of the admission/encounter.

2) 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. CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension.

The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease.

See Section I.C.14. Chronic kidney disease.

If a patient has hypertensive chronic kidney disease and acute renal failure, the acute renal failure should also be coded. Sequence according to the circumstances of the admission/encounter.

3) Hypertensive heart and chronic kidney disease

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.

The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.

See Section I.C.14. Chronic kidney disease.

The codes in category I13, Hypertensive heart and chronic kidney disease, are combination codes that include hypertension, heart disease and chronic kidney disease. The Includes note at I13 specifies that the conditions included at I11 and I12 are included together in I13. If a patient has hypertension, heart disease and chronic kidney disease, then a code from I13 should be used, not individual codes for hypertension, heart disease and chronic kidney disease, or codes from I11 or I12.

For patients with both acute renal failure and chronic kidney disease, the acute renal failure should also be coded. Sequence according to the circumstances of the admission/encounter.

Hypertensive heart and kidney disease with congestive heart failure and stage 2 chronic kidney disease

I13.0 **Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease**

I50.9 **Heart failure, unspecified**

N18.2 **Chronic kidney disease, stage 2 (mild)**

Explanation: Combination codes in category I13 are used to report conditions classifiable to *both* categories I11 and I12. Do not report conditions classifiable to I11 and I12 separately. Use additional codes to report type of heart failure and stage of CKD.

4) Hypertensive cerebrovascular disease

For hypertensive cerebrovascular disease, first assign the appropriate code from categories I60-I69, followed by the appropriate hypertension code.

Rupture of cerebral aneurysm caused by malignant hypertension

I60.7 **Nontraumatic subarachnoid hemorrhage from unspecified intracranial artery**

I10 **Essential (primary) hypertension**

Explanation: Hypertensive cerebrovascular disease requires two codes: the appropriate I60–I69 code followed by the appropriate hypertension code.

5) Hypertensive retinopathy

Subcategory H35.0, Background retinopathy and retinal vascular changes, should be used along with a code from categories I10-I15, in the Hypertensive diseases section, to include the systemic hypertension. The sequencing is based on the reason for the encounter.

6) Hypertension, secondary

Secondary hypertension is due to an underlying condition. Two codes are required: one to identify the underlying etiology and one from category I15 to identify the hypertension. Sequencing of codes is determined by the reason for admission/encounter.

Renovascular hypertension due to renal artery atherosclerosis

I15.0 **Renovascular hypertension**

I70.1 **Atherosclerosis of renal artery**

Explanation: Secondary hypertension requires two codes: a code to identify the etiology and the appropriate I15 code.

7) Hypertension, transient

Assign code R03.0, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code O13.-, Gestational [pregnancy-induced] hypertension without significant proteinuria, or O14.-, Pre-eclampsia, for transient hypertension of pregnancy.

8) Hypertension, controlled

This diagnostic statement usually refers to an existing state of hypertension under control by therapy. Assign the appropriate code from categories I10-I15, Hypertensive diseases.

9) Hypertension, uncontrolled

Uncontrolled hypertension may refer to untreated hypertension or hyper- tension not responding to current therapeutic regimen. In either case, assign the appropriate code from categories I10-I15, Hypertensive diseases.

10) Hypertensive crisis

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.

11) Pulmonary hypertension

Pulmonary hypertension is classified to category I27, Other pulmonary heart diseases. For secondary pulmonary hypertension (I27.1, I27.2-), code also any associated conditions or adverse effects of drugs or toxins. The sequencing is based on the reason for the encounter, except for adverse effects of drugs (See Section I.C.19.e.).

12) Hypertension, Resistant

Resistant hypertension refers to blood pressure of a patient with hypertension that remains above goal in spite of the use of antihypertensive medications. Assign code I1A.0, Resistant hypertension, as an additional code when apparent treatment resistant hypertension, treatment resistant hypertension, or true resistant hypertension is documented by the provider. A code for the specific type of existing hypertension is sequenced first, if known.

b. Atherosclerotic coronary artery disease and angina

ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are 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.

When using one of these combination codes it is not necessary to use an additional code for angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis.

If a patient with coronary artery disease is admitted due to an acute myocardial infarction (AMI), the AMI should be sequenced before the coronary artery disease.

See Section I.C.9. Acute myocardial infarction (AMI)

Patient is being seen for spastic angina pectoris. She also has a documented history of progressive coronary artery disease of the native vessels.

I25.111 Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm

Explanation: Report the combination code for atherosclerotic heart disease (coronary artery disease) with angina pectoris. A causal relationship is assumed in a patient with both atherosclerosis and angina pectoris, unless the documentation indicates the angina is due to something other than the atherosclerosis. When using one of these combination codes, it is not necessary to use an additional code for angina pectoris.

c. Intraoperative and postprocedural cerebrovascular accident

Medical record documentation should clearly specify the cause- and- effect relationship between the medical intervention and the cerebrovascular accident in order to assign a code for intraoperative or postprocedural cerebrovascular accident.

Proper code assignment depends on whether it was an infarction or hemorrhage and whether it occurred intraoperatively or postoperatively. If it was a cerebral hemorrhage, code assignment depends on the type of procedure performed.

Embolic cerebral infarction of the right middle cerebral artery that occurred during hip replacement surgery. The surgeon documented as due to the surgery.

I97.811 Intraoperative cerebrovascular infarction during other surgery

I63.411 Cerebral infarction due to embolism of right middle cerebral artery

Explanation: Code assignment for intraoperative or postprocedural cerebrovascular accident is based on the provider's documentation of a cause-and-effect relationship between the condition and the procedure. Proper code assignment also depends on whether the cerebrovascular accident was an infarction or hemorrhage, occurred intraoperatively or postoperatively, and the type of procedure performed.

d. Sequelae of cerebrovascular disease

1) Category I69, Sequelae of cerebrovascular disease

Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (neurologic deficits), themselves classified elsewhere. These "late effects" include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60-I67.

Codes from category I69, Sequelae of cerebrovascular disease, that specify hemiplegia, hemiparesis and monoplegia identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

- For ambidextrous patients, the default should be dominant.
- If the left side is affected, the default is non-dominant.
- If the right side is affected, the default is dominant.

2) Codes from category I69 with codes from I60–I67

Codes from category I69 may be assigned on a health care record with codes from I60-I67, if the patient has a current cerebrovascular disease and deficits from an old cerebrovascular disease.

3) Codes from category I69 and personal history of transient ischemic attack (TIA) and cerebral infarction (Z86.73)

Codes from category I69 should not be assigned if the patient does not have neurologic deficits.

See Section I.C.21. 4. History (of) for use of personal history codes

e. Acute myocardial infarction (AMI)

1) Type 1 ST elevation myocardial infarction (STEMI) and non-ST elevation myocardial infarction (NSTEMI)

The ICD-10-CM codes for type 1 acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories I21.0-I21.2 and code I21.3 are used for type 1 ST elevation myocardial infarction (STEMI). Code I21.4, Non-ST elevation (NSTEMI) myocardial infarction, is used for type 1 non-ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.

If a type 1 NSTEMI evolves to STEMI, assign the STEMI code. If a type 1 STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.

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 myocardial infarction meets the definition for "other diagnoses" (see Section III, Reporting Additional Diagnoses), codes from category I21 may continue to be reported. For encounters after the 4-week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned, rather than a code from category I21. For old or healed myocardial infarctions not requiring further care, code I25.2, Old myocardial infarction, may be assigned.

2) Acute myocardial infarction, unspecified

Code I21.9, Acute myocardial infarction, unspecified, is the default for unspecified acute myocardial infarction or unspecified type. If only type 1 STEMI or transmural MI without the site is documented, assign code I21.3, ST elevation (STEMI) myocardial infarction of unspecified site.

3) AMI documented as nontransmural or subendocardial but site provided

If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI.

See Section I.C.21.3.for information on coding status post administration of tPA in a different facility within the last 24 hours.

Acute inferior subendocardial myocardial infarction (NSTEMI)

I21.4 Non-ST elevation (NSTEMI) myocardial infarction

Explanation: An AMI documented as subendocardial or nontransmural is coded as such (I21.4, I22.2), even if the site of infarction is specified.

4) Subsequent acute myocardial infarction

A code from category I22, Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction, is to be used when a patient who has suffered a type 1 or unspecified AMI has a new AMI within the 4-week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21. The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.

Do not assign code I22 for subsequent myocardial infarctions other than type 1 or unspecified. For subsequent type 2 AMI assign only code I21.A1. For subsequent type 4 or type 5 AMI, assign only code I21.A9.

If a subsequent myocardial infarction of one type occurs within 4 weeks of a myocardial infarction of a different type, assign the appropriate codes from category I21 to identify each type. Do not assign a code from I22. Codes from category I22 should only be assigned if both the initial and subsequent myocardial infarctions are type 1 or unspecified.

Patient suffered an acute NSTEMI 14 days ago and is now seen for an inferior STEMI.

I22.1 Subsequent ST elevation (STEMI) myocardial infarction of inferior wall

I21.4 Non-ST elevation (NSTEMI) myocardial infarction

Explanation: Both MIs were type 1, and the current MI occurred within the four-week time frame; therefore a code for the current/subsequent STEMI (I22.1) is reported as well as a code for the previous NSTEMI (I21.4).

5) Other Types of Myocardial Infarction

The ICD-10-CM provides codes for different types of myocardial infarction. Type 1 myocardial infarctions are assigned to codes I21.0-I21.4.

Type 2 myocardial infarction (myocardial infarction due to demand ischemia or secondary to ischemic imbalance) is assigned to code I21.A1, Myocardial infarction type 2 with the underlying cause coded first. Do not assign code I24.8, Other forms of acute ischemic heart disease, for the demand ischemia. If a type 2 AMI is described as NSTEMI or STEMI, only assign code I21.A1. Codes I21.01-I21.4 should only be assigned for type 1 AMIs.

Acute myocardial infarctions type 3, 4a, 4b, 4c and 5 are assigned to code I21.A9, Other myocardial infarction type.

The "Code also" and "Code first" notes should be followed related to complications, and for coding of postprocedural myocardial infarctions during or following cardiac surgery.

6) Myocardial Infarction with Coronary Microvascular Dysfunction

Coronary microvascular dysfunction (CMD) is a condition that impacts the microvasculature by restricting microvascular flow and increasing microvascular resistance. Code I21.B, Myocardial infarction with coronary microvascular dysfunction, is assigned for myocardial infarction with coronary microvascular disease, myocardial infarction with coronary microvascular dysfunction, and myocardial infarction with non-obstructive coronary arteries (MINOCA) with microvascular disease.

Chapter 10. Diseases of the Respiratory System (J00–J99), U07.0

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Chronic obstructive pulmonary disease [COPD] and asthma

1) Acute exacerbation of chronic obstructive bronchitis and asthma

The codes in categories J44 and J45 distinguish between uncomplicated cases and those in acute exacerbation. An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

Acute streptococcal bronchitis with acute exacerbation of COPD

J20.2 **Acute bronchitis due to streptococcus**

J44.0 **Chronic obstructive pulmonary disease with (acute) lower respiratory infection**

J44.1 **Chronic obstructive pulmonary disease with (acute) exacerbation**

Explanation: ICD-10-CM uses combination codes to create organism-specific classifications for acute bronchitis. Category J44 codes include combination codes with severity components, which differentiate between COPD with acute lower respiratory infection (acute bronchitis), COPD with acute exacerbation, and COPD without mention of a complication (unspecified).

An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection, as in this example.

Exacerbation of moderate persistent asthma with status asthmaticus

J45.42 **Moderate persistent asthma with status asthmaticus**

Explanation: Category J45 Asthma includes severity-specific subcategories and fifth-character codes to distinguish between uncomplicated cases, those in acute exacerbation, and those with status asthmaticus.

b. Acute respiratory failure

1) Acute respiratory failure as principal diagnosis

A code from subcategory J96.0, Acute respiratory failure, or subcategory J96.2, Acute and chronic respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter-specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence.

Acute hypoxic respiratory failure due to exacerbation of chronic obstructive bronchitis

J96.01 **Acute respiratory failure with hypoxia**

J44.1 **Chronic obstructive pulmonary disease with (acute) exacerbation**

Explanation: Category J96 classifies respiratory failure with combination codes that designate the severity and the presence of hypoxia and hypercapnia. Code J96.01 is sequenced as the first-listed diagnosis, as the reason for the encounter. Respiratory failure may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the encounter and the selection is supported by the Alphabetic Index and Tabular List.

2) Acute respiratory failure as secondary diagnosis

Respiratory failure may be listed as a secondary diagnosis if it occurs after admission, or if it is present on admission, but does not meet the definition of principal diagnosis.

Acute respiratory failure due to accidental oxycodone overdose

T40.2X1A **Poisoning by other opioids, accidental (unintentional), initial encounter**

J96.00 **Acute respiratory failure, unspecified whether with hypoxia or hypercapnia**

Explanation: Respiratory failure may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the encounter, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter-specific coding guidelines, such as poisoning, that provide sequencing direction take precedence. When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36–T50. Use additional code(s) for all manifestations of the poisoning. In this instance, the respiratory failure is a manifestation of the poisoning and is sequenced as a secondary diagnosis.

3) Sequencing of acute respiratory failure and another acute condition

When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. Selection of the principal diagnosis will be dependent on the circumstances of admission. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis (*Section II, C.*) may be applied in these situations.

If the documentation is not clear as to whether acute respiratory failure and another condition are equally responsible for occasioning the admission, query the provider for clarification.

Patient presents with acute pneumococcal pneumonia and acute respiratory failure

J96.00 **Acute respiratory failure, unspecified whether with hypoxia or hypercapnia**

J13 **Pneumonia due to Streptococcus pneumoniae**

Explanation: When a patient is seen for respiratory failure and another acute condition, such as a bacterial pneumonia, the principal or first-listed diagnosis is not the same in every situation. This applies whether the other acute condition is a respiratory or nonrespiratory condition. The principal diagnosis depends on the problem chiefly responsible for the encounter.

c. Influenza due to certain identified influenza viruses

Code only confirmed cases of influenza due to certain identified influenza viruses (category J09), and due to other identified influenza virus (category J10). This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).

In this context, "confirmation" does not require documentation of positive laboratory testing specific for avian or other novel influenza A or other identified influenza virus. However, coding should be based on the provider's diagnostic statement that the patient has avian influenza, or other novel influenza A, for category J09, or has another particular identified strain of influenza, such as H1N1 or H3N2, but not identified as novel or variant, for category J10.

If the provider records "suspected" or "possible" or "probable" avian influenza, or novel influenza, or other identified influenza, then the appropriate influenza code from category J11, Influenza due to unidentified influenza virus, should be assigned. A code from category J09, Influenza due to certain identified influenza viruses, should not be assigned nor should a code from category J10, Influenza due to other identified influenza virus.

Influenza due to avian influenza virus with pneumonia

J09.X1 Influenza due to identified novel influenza A virus with pneumonia

Explanation: Codes in category J09 Influenza due to certain identified influenza viruses should be assigned only for confirmed cases. "Confirmation" does not require positive laboratory testing of a specific influenza virus but does need to be based on the provider's diagnostic statement, which should not include terms such as "possible," "probable," or "suspected."

d. Ventilator associated pneumonia

1) 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.

Code J95.851 should not be assigned for cases where the patient has pneumonia and is on a mechanical ventilator and the provider has not specifically stated that the pneumonia is ventilator-associated pneumonia. 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.

2) Ventilator associated pneumonia develops after admission

A patient may be admitted with one type of pneumonia (e.g., 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.

e. Vaping-related disorders

For patients presenting with condition(s) related to vaping, assign code U07.0, Vaping-related disorder, as the principal diagnosis. For lung injury due to vaping, assign only code U07.0. Assign additional codes for other manifestations, such as acute respiratory failure (subcategory J96.0-) or pneumonitis (code J68.0).

Associated respiratory signs and symptoms due to vaping, such as cough, shortness of breath, etc., are not coded separately, when a definitive diagnosis has been established. However, it would be appropriate to code separately any gastrointestinal symptoms, such as diarrhea and abdominal pain.

See Section I.C.1.g.1.c.i. for Pneumonia confirmed as due to COVID-19

Chapter 11. Diseases of the Digestive System (KØØ–K95)

Chapter-specific Guidelines with Coding Examples
Reserved for future guideline expansion.

Chapter 12. Diseases of the Skin and Subcutaneous Tissue (L00–L99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Pressure ulcer stage codes

1) Pressure ulcer stages

Codes in category L89, Pressure ulcer, identify the site and stage of the pressure ulcer.

The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, deep tissue pressure injury, unspecified stage, and unstageable.

Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.

See Section I.B.14. for pressure ulcer stage documentation by clinicians other than patient's provider.

Stage 3 pressure ulcer left ankle, 6 x 7 cm that invades the fascia; stage 2 pressure ulcer of left hip

L89.523 Pressure ulcer of left ankle, stage 3

L89.222 Pressure ulcer of left hip, stage 2

Explanation: Patient has a left ankle pressure ulcer documented as stage 3 and a left hip pressure ulcer documented as stage 2. Combination codes from category L89 Pressure ulcer, identify the site of the pressure ulcer as well as the stage. Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has.

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 (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft). 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 (L89.--9).

Pressure ulcer of the right lower back documented as unstageable due to the presence of thick eschar covering the ulcer

L89.130 Pressure ulcer of right lower back, unstageable

Explanation: Codes for unstageable pressure ulcers are assigned when the stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft).

If during an encounter, the stage of an unstageable pressure ulcer is revealed after debridement, assign only the code for the stage revealed following debridement.

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 Alphabetic Index. For clinical terms describing the stage that are not found in the Alphabetic Index, and there is no documentation of the stage, the provider should be queried.

Left heel pressure ulcer with partial thickness skin loss involving the dermis

L89.622 Pressure ulcer of left heel, stage 2

Explanation: Code assignment for the pressure ulcer stage should be guided by either the clinical documentation of the stage or the documentation of terms found in the Alphabetic Index. The clinical documentation describing the left heel pressure ulcer "partial thickness skin loss involving the dermis" matches the ICD-10-CM index parenthetical description for stage 2 "(abrasion, blister, partial thickness skin loss involving epidermis and/or dermis)."

4) Patients admitted with pressure ulcers documented as healed

No code is assigned if the documentation states that the pressure ulcer is completely healed at the time of admission.

Patient receiving follow-up examination of a completely healed pressure ulcer of the foot

Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Z87.2 Personal history of diseases of the skin and subcutaneous tissue

Explanation: Assign only codes for the reason for the encounter and the personal history of the pressure ulcer. Personal history code Z87.2 includes conditions classifiable to L00–L99 such as pressure ulcer. No code is assigned for a pressure ulcer documented as completely healed.

5) Pressure ulcers 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.

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.

6) Patient admitted with pressure ulcer evolving into another stage during the admission

If a patient is admitted to an inpatient hospital 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.

7) Pressure-induced deep tissue damage

For pressure-induced deep tissue damage or deep tissue pressure injury, assign only the appropriate code for pressure-induced deep tissue damage (L89.--6).

b. Non-pressure chronic ulcers

1) Patients admitted with non-pressure ulcers documented as healed

No code is assigned if the documentation states that the non-pressure ulcer is completely healed at the time of admission.

2) Non-pressure ulcers documented as healing

Non-pressure ulcers described as healing should be assigned the appropriate non-pressure ulcer code based on the documentation in the medical record. If the documentation does not provide information about the severity of the healing non-pressure ulcer, assign the appropriate code for unspecified severity.

If the documentation is unclear as to whether the patient has a current (new) non-pressure ulcer or if the patient is being treated for a healing non-pressure ulcer, query the provider.

For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and severity of the non-pressure ulcer at the time of admission.

3) Patient admitted with non-pressure ulcer that progresses to another severity level during the admission

If a patient is admitted to an inpatient hospital with a non-pressure ulcer at one severity level and it progresses to a higher severity level, two separate codes should be assigned: one code for the site and severity level of the ulcer on admission and a second code for the same ulcer site and the highest severity level reported during the stay.

See Section I.B.14. for pressure ulcer stage documentation by clinicians other than patient's provider.

Chapter 13. Diseases of the Musculoskeletal System and Connective Tissue (MØØ–M99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Site and laterality

Most of the codes within Chapter 13 have site and laterality designations. The site represents the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a "multiple sites" code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

Rheumatoid arthritis of multiple sites without rheumatoid factor

MØ6.Ø9 Rheumatoid arthritis without rheumatoid factor, multiple sites

Explanation: For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a "multiple sites" code available.

Adolescent scoliosis in the upper thoracic region and the lumbar vertebrae

M41.124 Adolescent idiopathic scoliosis, thoracic region

M41.126 Adolescent idiopathic scoliosis, lumbar region

Explanation: For categories without a multiple site code and more than one bone, joint, or muscle is involved, multiple codes should be used to indicate the different sites involved.

1) Bone versus joint

For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M8Ø, M81). Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.

Idiopathic avascular necrosis of the femoral head of the left hip joint

M87.Ø52 Idiopathic aseptic necrosis of left femur

Explanation: For certain conditions such as avascular necrosis, the bone may be affected at the joint, but the site designation is the bone, not the joint.

b. Acute traumatic versus chronic or recurrent musculoskeletal conditions

Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions. Bone, joint or muscle conditions that are the result of a healed injury are usually found in chapter 13. Recurrent bone, joint or muscle conditions are also usually found in chapter 13. Any current, acute injury should be coded to the appropriate injury code from chapter 19. Chronic or recurrent conditions should generally be coded with a code from chapter 13. If it is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.

Acute traumatic bucket handle tear of right medial meniscus

S83.211A Bucket-handle tear of medial meniscus, current injury, right knee, initial encounter

Explanation: Any current, acute injury is not coded in chapter 13. It should instead be coded to the appropriate injury code from chapter 19.

Old bucket handle tear of right medial meniscus

M23.2Ø3 Derangement of unspecified medial meniscus due to old tear or injury, right knee

Explanation: Chronic or recurrent conditions should generally be coded with a code from chapter 13.

c. Coding of Pathologic Fractures

7th character A is for use as long as the patient is receiving active treatment for the fracture. Examples of active treatment are: surgical treatment, emergency department encounter, evaluation and continuing treatment by the same or a different physician. While the patient may be seen by a new or different provider over the course of treatment for a pathological fracture, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

Pathologic fracture of left foot, unknown cause, currently under active treatment by a follow-up provider

M84.475A Pathological fracture, left foot, initial encounter for fracture

Explanation: Seventh character A is for use as long as the patient is receiving active treatment for a pathologic fracture. Examples of active treatment are surgical treatment, emergency department encounter, evaluation, and continuing treatment by the same or a different physician.

The seventh character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

7th character D is to be used for encounters after the patient has completed active treatment for the fracture and is receiving routine care for the fracture during the healing or recovery phase. The other 7th characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for treatment of problems associated with the healing, such as malunions, nonunions, and sequelae.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

See Section I.C.19. Coding of traumatic fractures.

d. Osteoporosis

Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. Therefore, site is not a component of the codes under category M81, Osteoporosis without current pathological fracture. The site codes under category M8Ø, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis.

1) Osteoporosis without pathological fracture

Category M81, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. For patients with a history of osteoporosis fractures, status code Z87.31Ø, Personal history of (healed) osteoporosis fracture, should follow the code from M81.

Age-related osteoporosis with healed osteoporotic fracture of the lumbar vertebra

M81.Ø Age-related osteoporosis without current pathological fracture

Z87.31Ø Personal history of (healed) osteoporosis fracture

Explanation: Category M81 is used for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis. To report a previous (healed) fracture, status code Z87.31Ø Personal history of (healed) osteoporosis fracture, should follow the code from M81.

2) Osteoporosis with current pathological fracture

Category M8Ø, Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter. The codes under M8Ø identify the site of the fracture. A code from category M8Ø, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

Disuse osteoporosis with current fracture of right shoulder sustained lifting a grocery bag, initial encounter

M8Ø.811A Other osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture

Explanation: A code from category M8Ø, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

e. Multisystem inflammatory syndrome

See Section I.C.1.g.1.l. for Multisystem Inflammatory Syndrome

Chapter 14. Diseases of Genitourinary System (NØØ–N99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Chronic kidney disease

1) Stages of chronic kidney disease (CKD)

The ICD-10-CM classifies CKD based on severity. The severity of CKD is designated by stages 1-5. Stage 2, code N18.2, equates to mild CKD; stage 3, codes N18.3Ø-N18.32, equate to moderate CKD; and stage 4, code N18.4, equates to severe CKD. Code N18.6, End stage renal disease (ESRD), is assigned when the provider has documented end-stage renal disease (ESRD).

If both a stage of CKD and ESRD are documented, assign code N18.6 only.

Stage 5 chronic kidney disease with ESRD requiring chronic dialysis

N18.6 **End stage renal disease**

Z99.2 **Dependence on renal dialysis**

Explanation: The diagnostic statement indicates the patient has chronic kidney disease, documented both as stage 5 and as ESRD requiring chronic dialysis. Code N18.6 End stage renal disease (ESRD), is assigned when the provider has documented end-stage-renal disease (ESRD). If both a stage of CKD and ESRD are documented, assign code N18.6 only.

2) Chronic kidney disease and kidney transplant status

Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function. Therefore, the presence of CKD alone does not constitute a transplant complication. Assign the appropriate N18 code for the patient's stage of CKD and code Z94.Ø, Kidney transplant status. If a transplant complication such as failure or rejection or other transplant complication is documented, see section I.C.19.g for information on coding complications of a kidney transplant. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

Patient with residual chronic kidney disease stage 1 after kidney transplant

N18.1 **Chronic kidney disease, stage 1**

Z94.Ø **Kidney transplant status**

Explanation: Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function. The presence of CKD alone does not constitute a transplant complication. Assign the appropriate N18 code for the patient's stage of CKD and code Z94.Ø Kidney transplant status.

3) Chronic kidney disease with other conditions

Patients with CKD may also suffer from other serious conditions, most commonly diabetes mellitus and hypertension. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the Tabular List.

See I.C.9. Hypertensive chronic kidney disease.

See I.C.19. Chronic kidney disease and kidney transplant complications.

Type 1 diabetic chronic kidney disease, stage 2

E1Ø.22 **Type 1 diabetes mellitus with diabetic chronic kidney disease**

N18.2 **Chronic kidney disease, stage 2 (mild)**

Explanation: Patients with CKD may also suffer from other serious conditions such as diabetes mellitus. The sequencing of the CKD code in relationship to codes for other contributing conditions is based on the conventions in the Tabular List. Diabetic CKD code E1Ø.22 includes an instructional note to "Use additional code to identify stage of chronic kidney disease (N18.1–N18.6)," thus providing sequencing direction.

Chapter 15. Pregnancy, Childbirth, and the Puerperium (O00–O9A)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. General rules for obstetric cases

1) Codes from Chapter 15 and sequencing priority

Obstetric cases require codes from chapter 15, codes in the range O00-O9A, Pregnancy, Childbirth, and the Puerperium. Chapter 15 codes have sequencing priority over codes from other chapters. Additional codes from other chapters may be used in conjunction with chapter 15 codes to further specify 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 codes. It is the provider's responsibility to state that the condition being treated is not affecting the pregnancy.

Bladder abscess in pregnant patient at 25 weeks' gestation

O23.12 Infections of bladder in pregnancy, second trimester

N30.80 Other cystitis without hematuria

Z3A.25 25 weeks gestation of pregnancy

Explanation: The documentation does not indicate that the pregnancy is incidental or in any way unaffected by the bladder abscess; therefore, an obstetrics code should be sequenced first. An additional code was provided to identify the specific bladder condition as this information is not called out specifically in the obstetrics code.

2) Chapter 15 codes used only on the maternal record

Chapter 15 codes are to be used only on the maternal record, never on the record of the newborn.

3) Final character for trimester

The majority of codes in Chapter 15 have a final character indicating the trimester of pregnancy. The timeframes for the trimesters are indicated at the beginning of the chapter. If trimester is not a component of a code, it is because the condition always occurs in a specific trimester, or the concept of trimester of pregnancy is not applicable. Certain codes have characters for only certain trimesters because the condition does not occur in all trimesters, but it may occur in more than just one. Assignment of the final character for trimester should be based on the provider's documentation of the trimester (or number of weeks) for the current admission/encounter. This applies to the assignment of trimester for pre-existing conditions as well as those that develop during or are due to the pregnancy. The provider's documentation of the number of weeks may be used to assign the appropriate code identifying the trimester.

Pregnant patient at 21 weeks' gestation admitted with excessive vomiting

O21.2 Late vomiting of pregnancy

Z3A.21 21 weeks gestation of pregnancy

Explanation: Category O21 classifies vomiting in pregnancy. Although code selection is based on whether the vomiting is before or after 20 completed weeks, these codes are not further classified by trimester. If vomiting only in the second trimester was documented, the provider should be queried for the specific week of gestation, as this will affect code selection.

Whenever delivery occurs during the current admission, and there is an "in childbirth" option for the obstetric complication being coded, the "in childbirth" code should be assigned. When the classification does not provide an obstetric code with an "in childbirth" option, it is appropriate to assign a code describing the current trimester.

4) Selection of trimester for inpatient admissions that encompass more than one trimester

In instances when a patient is admitted to a hospital for complications of pregnancy during one trimester and remains in the hospital into a subsequent trimester, the trimester character for the antepartum complication code should be assigned on the basis of the trimester when the complication developed, not the trimester of the discharge. If the condition developed prior to the current admission/encounter or represents a pre-existing condition, the trimester character for the trimester at the time of the admission/encounter should be assigned.

5) Unspecified trimester

Each category that includes codes for trimester has a code for "unspecified trimester." The "unspecified trimester" code should rarely be used, such as when the documentation in the record is insufficient to determine the trimester and it is not possible to obtain clarification.

6) 7th character for fetus identification

Where applicable, a 7th character is to be assigned for certain categories (O31, O32, O33.3 - O33.6, O35, O36, O40, O41, O60.1, O60.2, O64, and O69) to identify the fetus for which the complication code applies.

Assign 7th character "0":

- For single gestations.
- When the documentation in the record is insufficient to determine the fetus affected and it is not possible to obtain clarification.
- When it is not possible to clinically determine which fetus is affected.

Maternal patient with twin gestations is seen after ultrasound identifies fetus B to be in breech presentation

O32.1XX2 Maternal care for breech presentation, fetus 2

Explanation: The documentation indicates that although there are two fetuses, only one fetus is determined to be in breech presentation. Whether fetus 2 or fetus B is used, the coder can assign the seventh character of 2 to identify the second fetus as the one in breech.

7) Completed weeks of gestation

In ICD-10-CM, "completed" weeks of gestation refers to full weeks. For example, if the provider documents gestation at 39 weeks and 6 days, the code for 39 weeks of gestation should be assigned, as the patient has not yet reached 40 completed weeks.

b. Selection of OB principal or first-listed diagnosis

1) Routine outpatient prenatal visits

For routine outpatient prenatal visits when no complications are present, a code from category Z34, Encounter for supervision of normal pregnancy, should be used as the first-listed diagnosis. These codes should not be used in conjunction with chapter 15 codes.

2) 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.

For routine prenatal outpatient visits for patients with high-risk pregnancies, a code from category O09, Supervision of high-risk pregnancy, should be used as the first-listed diagnosis. Secondary chapter 15 codes may be used in conjunction with these codes if appropriate.

36-year-old seen in labor with second child at 39 weeks' gestation, delivered a healthy baby, delivery complicated by tear of fourchette that was repaired

O70.0 First degree perineal laceration during delivery

Z3A.39 39 weeks gestation of pregnancy

Z37.0 Single live birth

Explanation: Although this patient is over 35 and having her second child (elderly multigravida), do not append a code from subcategory O09.52-. A code describing the tear of the fourchette, which complicated the delivery, should be used in addition to the applicable Z codes.

3) Episodes when no delivery occurs

In episodes when no delivery occurs, the principal diagnosis should correspond to the principal complication of the pregnancy which necessitated the encounter. Should more than one complication exist, all of which are treated or monitored, any of the complication codes may be sequenced first.

4) When a delivery occurs

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. In cases of cesarean delivery, if the patient was admitted with a condition that resulted in the performance of a cesarean procedure, that condition should be selected as the principal diagnosis. If the reason for the admission was unrelated to the condition resulting in the cesarean delivery, the condition related to the reason for the admission should be selected as the principal diagnosis.

Maternal patient with diet-controlled gestational diabetes was seen at 38 weeks' gestation in obstructed labor due to footling presentation; cesarean performed for the malpresentation

O64.8XX0 **Obstructed labor due to other malposition and malpresentation, not applicable or unspecified**

O24.420 **Gestational diabetes mellitus in childbirth, diet controlled**

Z3A.38 **38 weeks gestation of pregnancy**

Z37.0 **Single live birth**

Explanation: The obstructed labor necessitated the cesarean procedure.

5) Outcome of delivery

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 the newborn record.

c. Pre-existing conditions versus conditions due to the pregnancy

Certain categories in Chapter 15 distinguish between conditions of the mother that existed prior to pregnancy (pre-existing) and those that are a direct result of pregnancy. When assigning codes from Chapter 15, it is important to assess if a condition was pre-existing prior to pregnancy or developed during or due to the pregnancy in order to assign the correct code.

Categories that do not distinguish between pre-existing and pregnancy-related conditions may be used for either. It is acceptable to use codes specifically for the puerperium with codes complicating pregnancy and childbirth if a condition arises postpartum during the delivery encounter.

Type 2 diabetic patient presents at 19 weeks gestation for glucose check. Patient has been taking oral metformin for several years and currently is experiencing no diabetic complications.

O24.112 **Pre-existing type 2 diabetes mellitus, in pregnancy, second trimester**

E11.9 **Type 2 diabetes mellitus without complications**

Z79.84 **Long term (current) use of oral hypoglycemic drugs**

Explanation: The documentation states that the patient has been on a diabetic medication (oral metformin) for several years, indicating the patient was diabetic prior to becoming pregnant. Reporting pre-existing Type 2 diabetes in a pregnant patient requires two codes to capture the condition, a code from category O24 and a code from category E11. A note at E11 indicates that the code for long-term use of oral hypoglycemic drugs should also be reported.

d. Pre-existing hypertension in pregnancy

Category O10, Pre-existing hypertension complicating pregnancy, childbirth and the puerperium, includes codes for hypertensive heart and hypertensive chronic kidney disease. When assigning one of the O10 codes that includes hypertensive heart disease or hypertensive chronic kidney disease, it is necessary to add a secondary code from the appropriate hypertension category to specify the type of heart failure or chronic kidney disease.

See Section I.C.9. Hypertension.

e. Fetal conditions affecting the management of the mother

1) Codes from categories O35 and O36

Codes from categories O35, Maternal care for known or suspected fetal abnormality and damage, and O36, Maternal care for other fetal problems, are assigned only when the fetal condition is actually responsible for modifying the management of the mother, i.e., by requiring diagnostic studies, additional observation, special care, or termination of pregnancy. The fact that the fetal condition exists does not justify assigning a code from this series to the mother's record.

A patient with twin gestation is seen for spotting 15 weeks into her pregnancy; the doctors also suspect fetal hydrocephalus. Patient is instructed to return in one week for additional diagnostic testing, sooner if the problem worsens.

O35.00X0 **Maternal care for (suspected) central nervous system malformation or damage in fetus, unspecified, not applicable or unspecified**

O26.852 **Spotting complicating pregnancy, second trimester**

Z3A.15 **15 weeks gestation of pregnancy**

Explanation: Whether the fetal hydrocephalus was suspected or confirmed, an additional code is warranted for this condition since documentation indicates the patient is to return sooner than her routine visit for further testing.

2) In utero surgery

In cases when surgery is performed on the fetus, a diagnosis code from category O35, Maternal care for known or suspected fetal abnormality and damage, should be assigned identifying the fetal condition. Assign the appropriate procedure code for the procedure performed.

No code from Chapter 16, the perinatal codes, should be used on the mother's record to identify fetal conditions. Surgery performed in utero on a fetus is still to be coded as an obstetric encounter.

f. HIV infection in pregnancy, childbirth and the puerperium

During pregnancy, childbirth or the puerperium, a patient admitted because of an HIV-related illness should receive a principal diagnosis from subcategory O98.7-, Human immunodeficiency [HIV] disease complicating pregnancy, childbirth and the puerperium, followed by the code(s) for the HIV-related illness(es).

Patients with asymptomatic HIV infection status admitted during pregnancy, childbirth, or the puerperium should receive codes of O98.7- and Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.

A previously asymptomatic HIV patient who is 13 weeks pregnant is evaluated for HIV-related candidal bronchitis

O98.711 **Human immunodeficiency virus [HIV] disease complicating pregnancy, first trimester**

B20 **Human immunodeficiency virus [HIV] disease**

B37.1 **Pulmonary candidiasis**

Z3A.13 **13 weeks gestation of pregnancy**

Explanation: Because candidal bronchitis is an AIDS-related condition, this patient is now considered to have HIV disease. An obstetrics code indicating that HIV is complicating the pregnancy is coded first, followed by B20 for HIV disease as well as a code for the candidal bronchitis.

g. Diabetes mellitus in pregnancy

Diabetes mellitus is a significant complicating factor in pregnancy. Pregnant patients who are diabetic should be assigned a code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, first, followed by the appropriate diabetes code(s) (E08-E13) from Chapter 4.

h. Long term use of insulin and oral hypoglycemics

See section I.C.4.a.3 for information on the long term-use of insulin and oral hypoglycemics.

i. Gestational (pregnancy induced) diabetes

Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in patients who were not diabetic prior to pregnancy. Gestational diabetes can cause complications in the pregnancy similar to those of pre-existing diabetes mellitus. It also puts the patient at greater risk of developing diabetes after the pregnancy.

Codes for gestational diabetes are in subcategory O24.4, Gestational diabetes mellitus. No other code from category O24, Diabetes mellitus in pregnancy, childbirth, and the puerperium, should be used with a code from O24.4.

The codes under subcategory O24.4 include diet controlled, insulin controlled, and controlled by oral hypoglycemic drugs. If a patient with gestational diabetes is treated with both diet and insulin, only the code for insulin-controlled is required. If a patient with gestational diabetes is treated with both diet and oral hypoglycemic medications, only the code for "controlled by oral hypoglycemic drugs" is required. Codes Z79.4, Long-term (current) use of insulin, Z79.84, Long-term (current) use of oral hypoglycemic drugs, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs, should not be assigned with codes from subcategory O24.4.

An abnormal glucose tolerance in pregnancy is assigned a code from subcategory O99.81, Abnormal glucose complicating pregnancy, childbirth, and the puerperium.

j. Sepsis and septic shock complicating abortion, pregnancy, childbirth and the puerperium

When assigning a chapter 15 code for sepsis complicating abortion, pregnancy, childbirth, and the puerperium, a code for the specific type of infection should be assigned as an additional diagnosis. If severe sepsis is present, a code from subcategory R65.2, Severe sepsis, and code(s) for associated organ dysfunction(s) should also be assigned as additional diagnoses.

Patient is seen several days after a miscarriage with sepsis; cultures return MSSA

O03.87 Sepsis following complete or unspecified spontaneous abortion

B95.61 Methicillin susceptible Staphylococcus aureus infection as the cause of diseases classified elsewhere

Explanation: The type of infection that caused this patient to become septic was methicillin susceptible *Staphylococcus aureus* (MSSA), which as a secondary code helps capture all aspects related to this patient's septic condition.

k. Puerperal sepsis

Code O85, Puerperal sepsis, should be assigned with a secondary code to identify the causal organism (e.g., for a bacterial infection, assign a code from category B95-B96, Bacterial infections in conditions classified elsewhere). A code from category A40, Streptococcal sepsis, or A41, Other sepsis, should not be used for puerperal sepsis. If applicable, use additional codes to identify severe sepsis (R65.2-) and any associated acute organ dysfunction.

Code O85 should not be assigned for sepsis following an obstetrical procedure (See Section I.C.1.d.5.b., Sepsis due to a postprocedural infection).

l. Alcohol, tobacco and drug use during pregnancy, childbirth and the puerperium

1) Alcohol use during pregnancy, childbirth and the puerperium

Codes under subcategory O99.31, Alcohol use complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a patient uses alcohol during the pregnancy or postpartum. A secondary code from category F10, Alcohol related disorders, should also be assigned to identify manifestations of the alcohol use.

2) Tobacco use during pregnancy, childbirth and the puerperium

Codes under subcategory O99.33, Smoking (tobacco) complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a patient uses any type of tobacco product during the pregnancy or postpartum.

A secondary code from category F17, Nicotine dependence, should also be assigned to identify the type of nicotine dependence.

3) Drug use during pregnancy, childbirth and the puerperium

Codes under subcategory O99.32, Drug use complicating pregnancy, childbirth, and the puerperium, should be assigned for any pregnancy case when a patient uses drugs during the pregnancy or postpartum. This can involve illegal drugs, or inappropriate use or abuse of prescription drugs. Secondary code(s) from categories F11-F16 and F18-F19 should also be assigned to identify manifestations of the drug use.

m. Poisoning, toxic effects, adverse effects and underdosing in a pregnant patient

A code from subcategory O9A.2, Injury, poisoning and certain other consequences of external causes complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate injury, poisoning, toxic effect, adverse effect or underdosing code, and then the additional code(s) that specifies the condition caused by the poisoning, toxic effect, adverse effect or underdosing.

See Section I.C.19. Adverse effects, poisoning, underdosing and toxic effects.

Patient treated for accidental carbon monoxide poisoning from a gas heating implement; the patient is 18 weeks' pregnant

O9A.212 Injury, poisoning and certain other consequences of external causes complicating pregnancy, second trimester

T58.11XA Toxic effect of carbon monoxide from utility gas, accidental (unintentional), initial encounter

Z3A.18 18 weeks gestation of pregnancy

Explanation: Although the carbon monoxide poisoning is the reason for the encounter, a code from the obstetrics chapter must be sequenced first. Chapter 15 codes have sequencing priority over codes from other chapters.

n. Normal delivery, code O80

1) Encounter for full term uncomplicated delivery

Code O80 should be assigned when a patient is admitted for a full-term normal delivery and delivers a single, healthy infant without any complications antepartum, during the delivery, or postpartum during the delivery episode. Code O80 is always a principal diagnosis. It is not to be used if any other code from chapter 15 is needed to describe a current complication of the antenatal, delivery, or postnatal period. Additional codes from other chapters may be used with code O80 if they are not related to or are in any way complicating the pregnancy.

2) Uncomplicated delivery with resolved antepartum complication

Code O80 may be used if the patient had a complication at some point during the pregnancy, but the complication is not present at the time of the admission for delivery.

Patient presents in labor at 39 weeks' gestation and delivers a healthy newborn; patient had abnormal glucose levels in her first trimester, which have since resolved

O80 Encounter for full-term uncomplicated delivery

Z37.0 Single live birth

Explanation: The abnormal glucose levels during the first trimester cannot be coded if they are not affecting the patient's current trimester. Without additional complications associated with the pregnancy, fetus, or mother, code O80 is appropriate.

3) Outcome of delivery for O80

Z37.0, Single live birth, is the only outcome of delivery code appropriate for use with O80.

o. The peripartum and postpartum periods

1) Peripartum and postpartum periods

The postpartum period begins immediately after delivery and continues for six weeks following delivery. The peripartum period is defined as the last month of pregnancy to five months postpartum.

2) Peripartum and postpartum complication

A postpartum complication is any complication occurring within the six-week period.

3) Pregnancy-related complications after 6-week period

Chapter 15 codes may also be used to describe pregnancy-related complications after the peripartum or postpartum period if the provider documents that a condition is pregnancy related.

Patient referred for varicose veins. She had a baby boy three months ago; the varicose veins started to appear one month ago. The doctor attributes the patient's pregnancy as the cause of the varicose veins, which continue to be painful and bother the patient. She is seeking surgical relief.

O87.4 Varicose veins of the lower extremity in the puerperium

Explanation: Although the varicose veins occurred several months after the delivery of the newborn, the doctor attributed the varicose veins to pregnancy and therefore a code from chapter 15 is appropriate.

4) Admission for routine postpartum care following delivery outside hospital

When the mother delivers outside the hospital prior to admission and is admitted for routine postpartum care and no complications are noted, code Z39.0, Encounter for care and examination of mother immediately after delivery, should be assigned as the principal diagnosis.

5) Pregnancy associated cardiomyopathy

Pregnancy associated cardiomyopathy, code O90.3, is unique in that it may be diagnosed in the third trimester of pregnancy but may continue to progress months after delivery. For this reason, it is referred to as peripartum cardiomyopathy. Code O90.3 is only for use when the cardiomyopathy develops as a result of pregnancy in a patient who did not have pre-existing heart disease.

p. Code O94, Sequelae of complication of pregnancy, childbirth, and the puerperium

1) Code O94

Code O94, Sequelae of complication of pregnancy, childbirth, and the puerperium, is for use in those cases when an initial complication of a pregnancy develops a sequela or sequelae requiring care or treatment at a future date.

2) After the initial postpartum period

This code may be used at any time after the initial postpartum period.

3) Sequencing of code O94

This code, like all sequela codes, is to be sequenced following the code describing the sequelae of the complication.

q. Termination of pregnancy and spontaneous abortions

1) Abortion with Liveborn Fetus

When an attempted termination of pregnancy results in a liveborn fetus, assign code Z33.2, Encounter for elective termination of pregnancy and a code from category Z37, Outcome of Delivery.

2) Retained Products of Conception following an abortion

Subsequent encounters for retained products of conception following a spontaneous abortion or elective termination of pregnancy, without complications are assigned O03.4, Incomplete spontaneous abortion without complication, or code O07.4, Failed attempted termination of pregnancy without complication. This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion. If the patient has a specific complication associated with the spontaneous abortion or elective termination of pregnancy in addition to retained products of conception, assign the appropriate complication code (e.g., O03.-, O04.-, O07.-) instead of code O03.4 or O07.4.

Patient was seen two days ago for complete spontaneous abortion but returns today for urinary tract infection (UTI) with ultrasound showing retained products of conception

O03.38 Urinary tract infection following incomplete spontaneous abortion

Explanation: Although the diagnosis from the patient's previous stay indicated that the patient had a complete abortion, it is now determined that there were actually retained products of conception (POC). An abortion with retained POC is considered incomplete and in this case resulted in the patient developing a UTI.

3) Complications leading to abortion

Codes from Chapter 15 may be used as additional codes to identify any documented complications of the pregnancy in conjunction with codes in categories in O04, O07 and O08.

4) Hemorrhage following elective abortion

For hemorrhage post elective abortion, assign code O04.6, Delayed or excessive hemorrhage following (induced) termination of pregnancy. Do not assign code O72.1, Other immediate postpartum hemorrhage, as this code should not be assigned for post abortion conditions.

r. Abuse in a pregnant patient

For suspected or confirmed cases of abuse of a pregnant patient, a code(s) from subcategories O9A.3, Physical abuse complicating pregnancy, childbirth, and the puerperium, O9A.4, Sexual abuse complicating pregnancy, childbirth, and the puerperium, and O9A.5, Psychological abuse complicating pregnancy, childbirth, and the puerperium, should be sequenced first, followed by the appropriate codes (if applicable) to identify any associated current injury due to physical abuse, sexual abuse, and the perpetrator of abuse.

See Section I.C.19. Adult and child abuse, neglect and other maltreatment.

s. COVID-19 infection in pregnancy, childbirth, and the puerperium

During pregnancy, childbirth or the puerperium, when COVID-19 is the reason for admission/encounter, code O98.5-, Other viral diseases complicating pregnancy, childbirth and the puerperium, should be sequenced as the principal/first-listed diagnosis, and code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) should be assigned as additional diagnoses. Codes from Chapter 15 always take sequencing priority.

If the reason for admission/encounter is unrelated to COVID-19 but the patient tests positive for COVID-19 during the admission/encounter, the appropriate code for the reason for admission/encounter should be sequenced as the principal/first-listed diagnosis, and codes O98.5-and U07.1, as well as the appropriate codes for associated COVID-19 manifestations, should be assigned as additional diagnoses.

Chapter 16. Certain Conditions Originating in the Perinatal Period (P00–P96)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

For coding and reporting purposes the perinatal period is defined as before birth through the 28th day following birth. The following guidelines are provided for reporting purposes

a. General perinatal rules

1) Use of Chapter 16 codes

Codes in this chapter are never for use on the maternal record. Codes from Chapter 15, the obstetric chapter, are never permitted on the newborn record. Chapter 16 codes may be used throughout the life of the patient if the condition is still present.

2) Principal diagnosis for birth record

When coding the birth episode in a newborn record, assign a code from category Z38, Liveborn infants according to place of birth and type of delivery, as the principal diagnosis. A code from category Z38 is assigned only once, to a newborn at the time of birth. If a newborn is transferred to another institution, a code from category Z38 should not be used at the receiving hospital.

A code from category Z38 is used only on the newborn record, not on the mother's record.

3) Use of codes from other chapters with codes from Chapter 16

Codes from other chapters may be used with codes from chapter 16 if the codes from the other chapters provide more specific detail. Codes for signs and symptoms may be assigned when a definitive diagnosis has not been established. If the reason for the encounter is a perinatal condition, the code from chapter 16 should be sequenced first.

4) Use of Chapter 16 codes after the perinatal period

Should a condition originate in the perinatal period, and continue throughout the life of the patient, the perinatal code should continue to be used regardless of the patient's age.

A 7-year-old patient with history of birth injury that resulted in Erb's palsy is seen for subscapularis release

P14.0 Erb's paralysis due to birth injury

Explanation: Although in this instance Erb's palsy is specifically related to a birth injury, it has not resolved and continues to be a health concern. A perinatal code is appropriate even though this patient is beyond the perinatal period.

5) Birth process or community acquired conditions

If a newborn has a condition that may be either due to the birth process or community acquired and the documentation does not indicate which it is, the default is due to the birth process and the code from Chapter 16 should be used. If the condition is community-acquired, a code from Chapter 16 should not be assigned.

For COVID-19 infection in a newborn, see guideline I.C.16.h.

6) Code all clinically significant conditions

All clinically significant conditions noted on routine newborn examination should be coded. A condition is clinically significant if it requires:

clinical evaluation; or

therapeutic treatment; or

diagnostic procedures; or

extended length of hospital stay; or

increased nursing care and/or monitoring; or

has implications for future health care needs

Note: The perinatal guidelines listed above are the same as the general coding guidelines for "additional diagnoses", except for the final point regarding implications for future health care needs. Codes should be assigned for conditions that have been specified by the provider as having implications for future health care needs.

b. Observation and evaluation of newborns for suspected conditions not found

1) Use of Z05 codes

Assign a code from category Z05, Observation and evaluation of newborn for suspected diseases and conditions ruled out, to identify those instances when a healthy newborn is evaluated for a suspected condition/disease that is determined after study not to be present. Do not use a code from category Z05 when the patient is documented to have signs or symptoms of a suspected problem; in such cases code the sign or symptom.

2) Z05 on other than the birth record

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.

3) Z05 on a 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.

Newborn delivered via vaginal delivery; previous ultrasounds showed what appeared to be an abnormality of the right kidney. Kidney function tests were performed and ultrasounds taken and any genitourinary conditions ruled out.

Z38.00 Single liveborn infant, delivered vaginally

Z05.6 Observation and evaluation of newborn for suspected genitourinary condition ruled out

Explanation: The newborn had no signs or symptoms of kidney or other genitourinary condition but was evaluated after delivery due to the abnormal prenatal ultrasound findings. A Z code describing the type and place of birth should be coded first, followed by a Z05 category code for the work performed to rule out a suspected genitourinary condition.

c. Coding additional perinatal diagnoses

1) Assigning codes for conditions that require treatment

Assign codes for conditions that require treatment or further investigation, prolong the length of stay, or require resource utilization.

2) Codes for conditions specified as having implications for future health care needs

Assign codes for conditions that have been specified by the provider as having implications for future health care needs.

Note: This guideline should not be used for adult patients.

An abnormal noise was heard in the left hip of a post-term newborn during a physical examination. The pediatrician would like to follow the patient after discharge as a hip click can be an early sign of hip dysplasia. The newborn was delivered via cesarean at 41 weeks.

Z38.01 Single liveborn infant, delivered by cesarean

P08.21 Post-term newborn

R29.4 Clicking hip

Explanation: The abnormal hip noise or click is appended as a secondary diagnosis not only because it is an abnormal finding upon examination, but also due to its potential to be part of a bigger health issue. The hip dysplasia has not yet been diagnosed and does not warrant a code at this time.

d. Prematurity and fetal growth retardation

Providers utilize different criteria in determining prematurity. A code for prematurity should not be assigned unless it is documented. Assignment of codes in categories P05, Disorders of newborn related to slow fetal growth and fetal malnutrition, and P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified, should be based on the recorded birth weight and estimated gestational age.

When both birth weight and gestational age are available, two codes from category P07 should be assigned, with the code for birth weight sequenced before the code for gestational age.

e. Low birth weight and immaturity status

Codes from category P07, Disorders of newborn related to short gestation and low birth weight, not elsewhere classified, are for use for a child or adult who was premature or had a low birth weight as a newborn and this is affecting the patient's current health status.

See Section I.C.21. Factors influencing health status and contact with health services, Status.

A 35-year-old patient, who weighed 659 grams at birth, is seen for heart disease documented as being a consequence of the low birth weight

I51.9 Heart disease, unspecified

P07.02 Extremely low birth weight newborn, 500–749 grams

Explanation: A code from subcategories P07.0- and P07.1- is appropriate, regardless of the age of the patient, as long as the documentation provides a clear link between the patient's current illness and the low birth weight.

f. Bacterial sepsis of newborn

Category P36, Bacterial sepsis of newborn, includes congenital sepsis. If a perinate is documented as having sepsis without documentation of congenital or community acquired, the default is congenital and a code from category P36 should be assigned. If the P36 code includes the causal organism, an additional code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, should not be assigned. If the P36 code does not include the causal organism, assign an additional code from category B96. If applicable, use additional codes to identify severe sepsis (R65.2-) and any associated acute organ dysfunction.

A full-term infant develops severe sepsis 24 hours after discharge from the hospital and is readmitted; cultures identified *E. coli* as the infective agent

P36.4 Sepsis of newborn due to Escherichia coli

R65.20 Severe sepsis without septic shock

Explanation: Even though this newborn was discharged and could have acquired *E. coli* from his/her external environment, due to the lack of documentation specifying specifically how this pathogen was acquired, the default is to code the *E. coli* sepsis as congenital. A code from chapter 1, "Certain Infectious and Parasitic Diseases," is not required because the perinatal sepsis code identifies both the sepsis and the bacteria causing the sepsis.

g. Stillbirth

Code P95, Stillbirth, is only for use in institutions that maintain separate records for stillbirths. No other code should be used with P95. Code P95 should not be used on the mother's record.

h. COVID-19 infection in newborn

For a newborn that tests positive for COVID-19, assign code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) in neonates/newborns in the absence of documentation indicating a specific type of transmission. For a newborn that tests positive for COVID-19 and the provider documents the condition was contracted in utero or during the birth process, assign codes P35.8, Other congenital viral diseases, and U07.1, COVID-19. When coding the birth episode in a newborn record, the appropriate code from category Z38, Liveborn infants according to place of birth and type of delivery, should be assigned as the principal diagnosis.

Chapter 17. Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00–Q99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

Assign an appropriate code(s) from categories Q00-Q99, Congenital malformations, deformations, and chromosomal abnormalities when a malformation/deformation or chromosomal abnormality is documented. A malformation/deformation/or chromosomal abnormality may be the principal/first-listed diagnosis on a record or a secondary diagnosis.

When a malformation/deformation/or chromosomal abnormality does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.

When the code assignment specifically identifies the malformation/deformation/or chromosomal abnormality, manifestations that are an inherent component of the anomaly should not be coded separately. Additional codes should be assigned for manifestations that are not an inherent component.

8-day-old infant with tetralogy of Fallot and pulmonary stenosis

Q21.3 Tetralogy of Fallot

Explanation: Pulmonary stenosis is inherent in the disease process of tetralogy of Fallot. When the code assignment specifically identifies the malformation/deformation/or chromosomal abnormality, manifestations that are inherent components of the anomaly should not be coded separately.

7-month-old infant with Down syndrome and common atrioventricular canal

Q90.9 Down syndrome, unspecified

Q21.23 Complete atrioventricular septal defect

Explanation: While a common atrioventricular canal is often associated with patients with Down syndrome, this manifestation is not an inherent component and may be reported separately. When the code assignment specifically identifies the anomaly, manifestations that are inherent components of the condition should not be coded separately. Additional codes should be assigned for manifestations that are not inherent components.

Codes from Chapter 17 may be used throughout the life of the patient. If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity. Although present at birth, a malformation/deformation/or chromosomal abnormality may not be identified until later in life. Whenever the condition is diagnosed by the provider, it is appropriate to assign a code from codes Q00-Q99. For the birth admission, the appropriate code from category Z38, Liveborn infants, according to place of birth and type of delivery, should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, Q00-Q99.

Three-year-old with history of corrected ventricular septal defect

Z87.74 Personal history of (corrected) congenital malformations of heart and circulatory system

Explanation: If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity.

Forty-year-old man with headaches diagnosed with congenital arteriovenous malformation of cerebral vessels by brain scan

Q28.2 Arteriovenous malformation of cerebral vessels

Explanation: Although present at birth, malformations may not be identified until later in life. Whenever a congenital condition is diagnosed by the physician, it is appropriate to assign a code from the range Q00–Q99.

Chapter 18. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (RØØ–R99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

Chapter 18 includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded. Signs and symptoms that point to a specific diagnosis have been assigned to a category in other chapters of the classification.

a. Use of symptom codes

Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

Tenderness and localized pain in the right upper quadrant; based on presentation, probable gallstones

R1Ø.11 Right upper quadrant pain

R1Ø.811 Right upper quadrant abdominal tenderness

Explanation: Codes that describe symptoms such as abdominal pain are acceptable for reporting purposes when the provider has not established (confirmed) a definitive diagnosis.

b. Use of a symptom code with a definitive diagnosis code

Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes. The definitive diagnosis code should be sequenced before the symptom code.

Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

Pneumonia with hemoptysis

J18.9 Pneumonia, unspecified organism

RØ4.2 Hemoptysis

Explanation: Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis.

Abdominal pain due to acute appendicitis

K35.8Ø Unspecified acute appendicitis

Explanation: Codes for signs or symptoms routinely associated with a disease process should not be assigned unless the classification instructs otherwise.

c. Combination codes that include symptoms

ICD-10-CM contains a number of combination codes that identify both the definitive diagnosis and common symptoms of that diagnosis. When using one of these combination codes, an additional code should not be assigned for the symptom.

IBS with diarrhea

K58.Ø Irritable bowel syndrome with diarrhea

Explanation: When a combination code identifies both the definitive diagnosis and the symptom, an additional code should not be assigned for the symptom.

d. Repeated falls

Code R29.6, Repeated falls, is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated.

Code Z91.81, History of falling, is for use when a patient has fallen in the past and is at risk for future falls. When appropriate, both codes R29.6 and Z91.81 may be assigned together.

e. Coma

Code R4Ø.2Ø, Unspecified coma, **should** be assigned **when the underlying cause of the coma is not known, or the cause is a traumatic brain injury and the coma scale is not documented in the medical record**.

Do not report codes for unspecified coma, individual or total Glasgow coma scale scores for a patient with a medically induced coma or a sedated patient.

1) Coma scale

The coma scale codes (R4Ø.21- to R4Ø.24-) can be used in conjunction with traumatic brain injury codes. These codes **cannot be used with R4Ø.2A, Nontraumatic coma due to underlying condition. They** are primarily for use by trauma registries, but they may be used in any setting where this information is collected. The coma scale codes should be sequenced after the diagnosis code(s).

These codes, one from each subcategory, are needed to complete the scale. The 7th character indicates when the scale was recorded. The 7th character should match for all three codes.

At a minimum, report the initial score documented on presentation at your facility. This may be a score from the emergency medicine technician (EMT) or in the emergency department. If desired, a facility may choose to capture multiple coma scale scores.

Assign code R4Ø.24-, Glasgow coma scale, total score, when only the total score is documented in the medical record and not the individual score(s).

If multiple coma scores are captured within the first 24 hours after hospital admission, assign only the code for the score at the time of admission. ICD-1Ø-CM does not classify coma scores that are reported after admission but less than 24 hours later.

See Section I.B.14. for coma scale documentation by clinicians other than patient's provider

36-year-old man found down after unknown injury with skull fracture and with concussion and loss of consciousness of unknown duration. Upon hospital admission, the patient was evaluated with the following Glasgow coma scores:

Eye-opening response—3: eyes open to speech

Verbal response—3: random speech with no conversational exchange

Motor response—4: pulls limb away from painful stimulus

SØ2.ØXXA Fracture of vault of skull, initial encounter for closed fracture

SØ6.ØX9A Concussion with loss of consciousness of unspecified duration, initial encounter

R4Ø.2133 Coma scale, eyes open, to sound, at hospital admission

R4Ø.2233 Coma scale, best verbal response, inappropriate words, at hospital admission

R4Ø.2343 Coma scale, best motor response, flexion withdrawal, at hospital admission

Explanation: When individual scores for the Glasgow coma scale are documented, one code from each category is needed to complete the scale. The seventh character indicates when the scale was recorded and should match for all three codes. Assign a code from subcategory R4Ø.24- Glasgow coma scale, total score, when only the total and not the individual score(s) is documented.

f. Functional quadriplegia

GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2017

g. SIRS due to non-infectious process

The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious disease processes, such as trauma, malignant neoplasm, or pancreatitis. When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as an injury, should be assigned, followed by code R65.1Ø, Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction, or code R65.11, Systemic inflammatory response syndrome (SIRS) of non-infectious origin with acute organ dysfunction. If an associated acute organ dysfunction is documented, the appropriate code(s) for the specific type of organ dysfunction(s) should be assigned in addition to code R65.11. If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is

associated with SIRS or due to another condition (e.g., directly due to the trauma), the provider should be queried.

Systemic inflammatory response syndrome (SIRS) due to acute gallstone pancreatitis

K85.10 **Biliary acute pancreatitis without necrosis or infection**

R65.10 **Systemic inflammatory response syndrome [SIRS] of non-infectious origin without acute organ dysfunction**

Explanation: When SIRS is documented with a non-infectious condition without subsequent infection documented, the code for the underlying condition such as pancreatitis should be assigned followed by the appropriate code for SIRS of noninfectious origin, either with or without associated organ dysfunction.

h. Death NOS

Code R99, Ill-defined and unknown cause of mortality, is only for use in the very limited circumstance when a patient who has already died is brought into an emergency department or other healthcare facility and is pronounced dead upon arrival. It does not represent the discharge disposition of death.

i. NIHSS stroke scale

The NIH stroke scale (NIHSS) codes (R29.7- -) can be used in conjunction with acute stroke codes (**I60-**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.

See Section I.B.14. for NIHSS stroke scale documentation by clinicians other than patient's provider

Chapter 19. Injury, Poisoning, and Certain Other Consequences of External Causes (SØØ–T88)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

a. Application of 7th characters in Chapter 19

Most categories in chapter 19 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela. Categories for traumatic fractures have additional 7th character values. While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

For complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem. For example, code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, is used when active treatment is provided for the infection, even though the condition relates to the prosthetic device, implant or graft that was placed at a previous encounter.

7th character "A", initial encounter is used for each encounter where the patient is receiving active treatment for the condition.

Patient evaluated after fall from a skateboard onto the sidewalk, x-rays identify a nondisplaced fracture to the distal pole of the right scaphoid bone. The patient is placed in a cast.

S62.Ø14A **Nondisplaced fracture of distal pole of navicular [scaphoid] bone of right wrist, initial encounter for closed fracture**

VØØ.131A **Fall from skateboard, initial encounter**

Y93.51 **Activity, roller skating (inline) and skateboarding**

Y92.48Ø **Sidewalk as the place of occurrence of the external cause**

Y99.8 **Other external cause status**

Explanation: This fracture would be coded with a seventh character A for initial encounter because the patient received x-rays to identify the site of the fracture and treatment was rendered; this would be considered active treatment.

7th character "D" subsequent encounter is used for encounters after the patient has completed active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

Patient seen in follow-up after fall from a skateboard onto the sidewalk resulted in casting of the right arm. X-rays are taken to evaluate how well the nondisplaced fracture to the distal pole of the right scaphoid bone is healing. The physician feels the fracture is healing appropriately; no adjustments to the cast are made.

S62.Ø14D **Nondisplaced fracture of distal pole of navicular [scaphoid] bone of right wrist, subsequent encounter for fracture with routine healing**

VØØ.131D **Fall from skateboard, subsequent encounter**

Explanation: This fracture would be coded with a seventh character D for subsequent encounter, whether the same physician who provided the initial cast application or a different physician is now seeing the patient. Although the patient received x-rays, the intent of the x-rays was to assess how the fracture was healing. There was no active treatment rendered and the visit is therefore considered a subsequent encounter.

The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care. For example, for aftercare of an injury, assign the acute injury code with the 7th character "D" (subsequent encounter).

7th character "S", sequela, is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character "S", it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The "S" is added only to the injury code, not the sequela code. The 7th character "S" identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

See Section I.B.10. Sequelae, (Late Effects)

Patient with a history of a nondisplaced fracture to the distal pole of the right scaphoid bone due to a fall from a skateboard is seen for evaluation of arthritis to the right wrist that has developed as a consequence of the traumatic fracture.

M12.531 **Traumatic arthropathy, right wrist**

S62.Ø14S **Nondisplaced fracture of distal pole of navicular [scaphoid] bone of right wrist, sequela**

VØØ.131S **Fall from skateboard, sequela**

Explanation: The code identifying the specific sequela condition (traumatic arthritis) should be coded first followed by the injury that instigated the development of the sequela (fracture). The scaphoid fracture injury code is given a 7th character S for sequela to represent its role as the inciting injury. The fracture has healed and is not being managed or treated on this admit and therefore is not applicable as a first listed or principal diagnosis. However, it is directly related to the development of the arthritis and should be appended as a secondary code to signify this cause and effect relationship.

b. Coding of injuries

When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Codes from category T07, Unspecified multiple injuries should not be assigned in the inpatient setting unless information for a more specific code is not available. Traumatic injury codes (SØØ-T14.9) are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

11-year-old girl fell from her horse, resulting in a laceration to her right forearm with several large pieces of wooden fragments embedded in the wound as well as abrasions to her right ear; in addition, her right shoulder was dislocated.

S43.ØØ4A **Unspecified dislocation of right shoulder joint, initial encounter**

S51.821A **Laceration with foreign body of right forearm, initial encounter**

SØØ.411A **Abrasion of right ear, initial encounter**

V8Ø.Ø1ØA **Animal-rider injured by fall from or being thrown from horse in noncollision accident, initial encounter**

Y93.52 **Activity, horseback riding**

Explanation: Each separate injury should be reported. The patient's injury to the forearm is reported with one combination code that captures both the laceration and the foreign body.

The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.

1) **Superficial injuries**
   Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.
2) **Primary injury with damage to nerves/blood vessels**
   When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) for injuries to nerves and spinal cord (such as category SØ4), and/or injury to blood vessels (such as category S15). When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.
3) **Iatrogenic injuries**
   Injury codes from Chapter 19 should not be assigned for injuries that occur during, or as a result of, a medical intervention. Assign the appropriate complication code(s).

c. Coding of traumatic fractures

The principles of multiple coding of injuries should be followed in coding fractures. Fractures of specified sites are coded individually by site in accordance with both the provisions within categories SØ2, S12, S22, S32, S42, S49, S52, S59, S62, S72, S79, S82, S89, S92 and the level of detail furnished by medical record content.

A fracture not indicated as open or closed should be coded to closed. A fracture not indicated whether displaced or not displaced should be coded to displaced.

More specific guidelines are as follows:

1) Initial vs. subsequent encounter for fractures

Traumatic fractures are coded using the appropriate 7th character for initial encounter (A, B, C) for each encounter where the patient is receiving active treatment for the fracture. The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.

Fractures are coded using the appropriate 7th character for subsequent care for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

Care of complications of fractures, such as malunion and nonunion, should be reported with the appropriate 7th character for subsequent care with nonunion (K, M, N,) or subsequent care with malunion (P, Q, R).

Malunion/nonunion: The appropriate 7th character for initial encounter should also be assigned for a patient who delayed seeking treatment for the fracture or nonunion.

Female patient fell during a forest hiking excursion almost six months ago and until recently did not feel she needed to seek medical attention for her left ankle pain; x-rays show nonunion of lateral malleolus and surgery has been scheduled

S82.62XA	**Displaced fracture of lateral malleolus of left fibula, initial encounter for closed fracture**
WØ1.ØXXA	**Fall on same level from slipping, tripping and stumbling without subsequent striking against object, initial encounter**
Y92.821	**Forest as place of occurrence of the external cause**
Y93.Ø1	**Activity, walking, marching and hiking**
Y99.8	**Other external cause status**

Explanation: A seventh character of A is used for the lateral malleolus nonunion fracture to signify that the fracture is receiving active treatment. The delayed care for the fracture has resulted in a nonunion, but capturing the nonunion in the seventh character is trumped by the provision of active care.

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).

A code from category MØØ, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

See Section I.C.13. Osteoporosis.

The aftercare Z codes should not be used for aftercare for traumatic fractures. For aftercare of a traumatic fracture, assign the acute fracture code with the appropriate 7th character.

2) Multiple fractures sequencing

Multiple fractures are sequenced in accordance with the severity of the fracture.

3) Physeal fractures

For physeal fractures, assign only the code identifying the type of physeal fracture. Do not assign a separate code to identify the specific bone that is fractured.

d. Coding of burns and corrosions

The ICD-1Ø-CM makes a distinction between burns and corrosions. The burn codes are for thermal burns, except sunburns, that come from a heat source, such as a fire or hot appliance. The burn codes are also for burns resulting from electricity and radiation. Corrosions are burns due to chemicals. The guidelines are the same for burns and corrosions.

Current burns (T20-T25) are classified by depth, extent and by agent (X code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement). Burns of the eye and internal organs (T26-T28) are classified by site, but not by degree.

1) Sequencing of burn and related condition codes

Sequence first the code that reflects the highest degree of burn when more than one burn is present.

a. When the reason for the admission or encounter is for treatment of external multiple burns, sequence first the code that reflects the burn of the highest degree.

b. When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis or first-listed diagnosis.

c. 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 or first-listed diagnosis.

Patient referred for minor first-degree burns to multiple sites of her right and left hands as well as severe smoke inhalation. While she was sleeping at home, a candle on her dresser lit the bedroom curtains on fire.

T59.811A	**Toxic effect of smoke, accidental (unintentional), initial encounter**
J7Ø.5	**Respiratory conditions due to smoke inhalation**
T23.191A	**Burn of first degree of multiple sites of right wrist and hand, initial encounter**
T23.192A	**Burn of first degree of multiple sites of left wrist and hand, initial encounter**
XØ8.8XXA	**Exposure to other specified smoke, fire and flames, initial encounter**
Y99.8	**Other external cause status**
Y92.ØØ3	**Bedroom of unspecified non-institutional (private) residence as the place of occurrence of the external cause**
Y93.84	**Activity, sleeping**

Explanation: Based on the documentation, the inhalation injury is more severe than the first-degree burns and is sequenced first. The burns to the hands are appended as secondary diagnoses.

2) Burns of the same anatomic site

Classify burns of the same anatomic site and on the same side but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis (e.g., for second and third degree burns of right thigh, assign only code T24.311-).

3) Non-healing burns

Non-healing burns are coded as acute burns.

Necrosis of burned skin should be coded as a non-healed burn.

4) Infected burn

For any documented infected burn site, use an additional code for the infection.

5) Assign separate codes for each burn site

When coding burns, assign separate codes for each burn site. Category T3Ø, Burn and corrosion, body region unspecified is extremely vague and should rarely be used.

Codes for burns of "multiple sites" should only be assigned when the medical record documentation does not specify the individual sites.

6) Burns and corrosions classified according to extent of body surface involved

Assign codes from category T31, Burns classified according to extent of body surface involved, or T32, Corrosions classified according to extent of body surface involved, for acute burns or corrosions when the site of the burn or corrosion is not specified or when there is a need for additional data. It is advisable to use category T31 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category T31 as an additional code for reporting purposes when there is mention of a third-degree burn involving 2Ø percent or more of the body surface. Codes from categories T31 and T32 should not be used for sequelae of burns or corrosions.

Categories T31 and T32 are based on the classic "rule of nines" in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one 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.

Patient seen for dressing change after he accidentally spilled acetic acid on himself two days ago. The second-degree burns to his right thigh, covering about 3 percent of his body surface, are healing appropriately.

T54.2X1D **Toxic effect of corrosive acids and acid-like substances, accidental (unintentional), subsequent encounter**

T24.611D **Corrosion of second degree of right thigh, subsequent encounter**

T32.Ø **Corrosions involving less than 1Ø% of body surface**

Explanation: Code T32.Ø provides additional information as to how much of the patient's body was affected by the corrosive substance.

7) Encounters for treatment of sequela of burns

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

8) Sequelae with a late effect code and current burn

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

See Section I.B.10. Sequela (Late Effects)

Female patient seen for second-degree burn to the left ear; she also has significant scarring on her left elbow from a third-degree burn from childhood

T2Ø.212A **Burn of second degree of left ear [any part, except ear drum], initial encounter**

L9Ø.5 **Scar conditions and fibrosis of skin**

T22.322S **Burn of third degree of left elbow, sequela**

Explanation: The patient is being seen for management of a current second-degree burn, which is reflected in the code by appending the seventh character of A, indicating active treatment or management of this burn. The elbow scarring is a sequela of a previous third-degree burn. The sequela condition precedes the original burn injury, which is appended with a seventh character of S.

9) Use of an 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.

e. Adverse effects, poisoning, underdosing and toxic effects

Codes in categories T36-T65 are combination codes that include the substance that was taken as well as the intent. No additional external cause code is required for poisonings, toxic effects, adverse effects and underdosing codes.

1) Do not code directly from the Table of Drugs

Do not code directly from the Table of Drugs and Chemicals. Always refer back to the Tabular List.

2) Use as many codes as necessary to describe

Use as many codes as necessary to describe completely all drugs, medicinal or biological substances.

3) If the same code would describe the causative agent

If the same code would describe the causative agent for more than one adverse reaction, poisoning, toxic effect or underdosing, assign the code only once.

4) If two or more drugs, medicinal or biological substances

If two or more drugs, medicinal or biological substances are taken, code each individually unless a combination code is listed in the Table of Drugs and Chemicals.

If multiple unspecified drugs, medicinal or biological substances were taken, assign the appropriate code from subcategory T5Ø.91, Poisoning by, adverse effect of and underdosing of multiple unspecified drugs, medicaments and biological substances.

5) The occurrence of drug toxicity is classified in ICD-10-CM as follows:

(a) Adverse effect

When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T5Ø). The code for the drug should have a 5th or 6th character "5" (for example T36.ØX5-) Examples of the nature of an adverse effect are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure, or respiratory failure.

(b) Poisoning

When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate code from categories T36-T5Ø. The poisoning codes have an associated intent as their 5th or 6th character (accidental, intentional self-harm, assault and undetermined). 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. Use additional code(s) for all manifestations of poisonings.

If there is also a diagnosis of abuse or dependence of the substance, the abuse or dependence is assigned as an additional code.

Examples of poisoning include:

(i) Error was made in drug prescription
Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person.

(ii Overdose of a drug intentionally taken
If an overdose of a drug was intentionally taken or administered and resulted in drug toxicity, it would be coded as a poisoning.

(iii) Nonprescribed drug taken with correctly prescribed and properly administered drug
If a nonprescribed drug or medicinal agent was taken in combination with a correctly prescribed and properly administered drug, any drug toxicity or other reaction resulting from the interaction of the two drugs would be classified as a poisoning.

(iv) Interaction of drug(s) and alcohol
When a reaction results from the interaction of a drug(s) and alcohol, this would be classified as poisoning.

See Section I.C.4. if poisoning is the result of insulin pump malfunctions.

For Sequela (Late Effects) see Section I.B.1Ø.

(c) Underdosing

Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer's instruction. Discontinuing the use of a prescribed medication on the patient's own initiative (not directed by the patient's provider) is also classified as an underdosing. For underdosing, assign the code from categories T36-T5Ø (fifth or sixth character "6"). Documentation of a change in the patient's condition is not required in order to assign an underdosing code. Documentation that the patient is taking less of a medication than is prescribed or discontinued the prescribed medication is sufficient for code assignment.

Codes for underdosing should never be assigned as principal or first-listed codes. If a 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.

Noncompliance (Z91.12-, Z91.13-, Z91.14- and **Z91.A4-**) or complication of care (Y63.6-Y63.9) codes are to be used with an underdosing code to indicate intent, if known.

Patient referred for atrial fibrillation with history of chronic atrial fibrillation for which she is prescribed amiodarone. Financial concerns have left the patient unable to pay for her prescriptions and she has been skipping her amiodarone dose every other day to offset the cost.

I48.2Ø **Chronic atrial fibrillation, unspecified**

T46.2X6A **Underdosing of other antidysrhythmic drugs, initial encounter**

Z91.12Ø **Patient's intentional underdosing of medication regimen due to financial hardship**

Explanation: By skipping her amiodarone pill every other day, the patient's atrial fibrillation returned. The condition for which the drug was being taken is reported first, followed by an underdosing code to show that the patient was not adhering to her prescription regiment. The Z code helps elaborate on the patient's social and/or economic circumstances that led to the patient taking less then what she was prescribed.

(d) Toxic effects

When a harmful substance is ingested or comes in contact with a person, this is classified as a toxic effect. The toxic effect codes are in categories T51–T65. **When coding a toxic effect, assign the toxic effect code first, followed by codes for all associated manifestations of the toxic effect.**

Toxic effect codes have an associated intent: accidental, intentional self-harm, assault and undetermined.

For Sequela (Late Effects) see Section I.B.1Ø. Sequela

f. Adult and child abuse, neglect and other maltreatment

Sequence first the appropriate code from categories T74, Adult and child abuse, neglect and other maltreatment, confirmed, or T76, Adult and child abuse, neglect and other maltreatment, suspected, for abuse, neglect and other maltreatment, followed by any accompanying mental health or injury code(s).

If the documentation in the medical record states abuse or neglect, it is coded as confirmed (T74.-). It is coded as suspected if it is documented as suspected (T76.-).

For cases of confirmed abuse or neglect an external cause code from the assault section (X92-YØ9) should be added to identify the cause of any physical injuries. A perpetrator code (YØ7) should be added when the perpetrator of the abuse is known. For suspected cases of abuse or neglect, do not report external cause or perpetrator code.

If a suspected case of abuse, neglect or mistreatment is ruled out during an encounter code ZØ4.71, Encounter for examination and observation following alleged physical adult abuse, ruled out, or code ZØ4.72, Encounter for examination and observation following alleged child physical abuse, ruled out, should be used, not a code from T76.

If a suspected case of alleged rape or sexual abuse is ruled out during an encounter code ZØ4.41, Encounter for examination and observation following alleged adult rape or code ZØ4.42, Encounter for examination and observation following alleged child rape, should be used, not a code from T76.

If a suspected case of forced sexual exploitation or forced labor exploitation is ruled out during an encounter, code ZØ4.81, Encounter for examination and observation of victim following forced sexual exploitation, or code ZØ4.82, Encounter for examination and observation of victim following forced labor exploitation, should be used, not a code from T76.

See Section I.C.15. Abuse in a pregnant patient.

g. Complications of care

1) General guidelines for complications of care

(a) Documentation of complications of care

See Section I.B.16. for information on documentation of complications of care.

2) Pain due to medical devices

Pain associated with devices, implants or grafts left in a surgical site (for example painful hip prosthesis) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. Specific codes for pain due to medical devices are found in the T code section of the ICD-1Ø-CM. Use additional code(s) from category G89 to identify acute or chronic pain due to presence of the device, implant or graft (G89.18 or G89.28).

Chronic left breast pain secondary to breast implant

T85.848A **Pain due to other internal prosthetic devices, implants and grafts, initial encounter**

N64.4 **Mastodynia**

G89.28 **Other chronic postprocedural pain**

Explanation: As the pain is a complication related to the breast implant, the complication code is sequenced first. The T code does not describe the site or type of pain, so additional codes may be appended to indicate that the patient is experiencing chronic pain in the breast.

3) Transplant complications

(a) Transplant complications other than kidney

Codes under category T86, Complications of transplanted organs and tissues, are for use for both complications and rejection of transplanted organs. A transplant complication code is only assigned if the complication affects the function of the transplanted organ. Two codes are required to fully describe a transplant complication: the appropriate code from category T86 and a secondary code that identifies the complication.

Pre-existing conditions or conditions that develop after the transplant are not coded as complications unless they affect the function of the transplanted organs.

See I.C.21. for transplant organ removal status

See I.C.2. for malignant neoplasm associated with transplanted organ.

See I.C.1.d.4. for sequencing of sepsis due to infection in transplanted organ

(b) Kidney transplant complications

Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function. Code T86.1- should be assigned for documented complications of a kidney transplant, such as transplant failure or rejection or other transplant complication. Code T86.1- should not be assigned for post kidney transplant patients who have chronic kidney (CKD) unless a transplant complication such as transplant failure or rejection is documented. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

Conditions that affect the function of the transplanted kidney, other than CKD, should be assigned a code from subcategory T86.1, Complications of transplanted organ, Kidney, and a secondary code that identifies the complication.

For patients with CKD following a kidney transplant, but who do not have a complication such as failure or rejection, *see section I.C.14. Chronic kidney disease and kidney transplant status*.

See I.C.1.d.4. for sequencing of sepsis due to infection in transplanted organ

Patient seen for chronic kidney disease stage 2; history of successful kidney transplant with no complications identified

N18.2 **Chronic kidney disease, stage 2 (mild)**

Z94.Ø **Kidney transplant status**

Explanation: This patient's stage 2 CKD is not indicated as being due to the transplanted kidney but instead is just the residual disease the patient had prior to the transplant.

4) Complication codes that include the external cause

As with certain other T codes, some of the complications of care codes have the external cause included in the code. The code includes the nature of the complication as well as the type of procedure that caused the complication. No external cause code indicating the type of procedure is necessary for these codes.

5) Complications of care codes within the body system chapters

Intraoperative and postprocedural complication codes are found within the body system chapters with codes specific to the organs and structures of that body system. These codes should be sequenced first, followed by a code(s) for the specific complication, if applicable.

Postprocedural ischemic infarction of the left middle cerebral artery due to cardiac surgery

I97.82Ø **Postprocedural cerebrovascular infarction following cardiac surgery**

I63.512 **Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery**

Explanation: The infarction was caused by the cardiac procedure and is coded as a postprocedural complication. The postprocedural cerebrovascular infarction is the first-listed diagnosis, followed by the code for the infarction itself.

Complication codes from the body system chapters should be assigned for intraoperative and postprocedural complications (e.g., the appropriate complication code from chapter 9 would be assigned for a vascular intraoperative or postprocedural complication) unless the complication is specifically indexed to a T code in chapter 19.

Chapter 20. External Causes of Morbidity (V00–Y99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

The external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis.

External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event, and the person's status (e.g., civilian, military).

There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

a. General external cause coding guidelines

1) Used with any code in the range of A00.0–T88.9, Z00–Z99

An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that represents a health condition due to an external cause. Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

Actinic reticuloid due to tanning bed use

L57.1 Actinic reticuloid

W89.1XXA Exposure to tanning bed, initial encounter

Explanation: An external cause code may be used with any code in the range of A00.0–T88.9, Z00–Z99, classifications that describe health conditions due to an external cause. Code W89.1 Exposure to tanning bed requires a seventh character of A to report this initial encounter, with a placeholder X for the fifth and sixth characters.

2) External cause code used for length of treatment

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

Most categories in chapter 20 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values: A, initial encounter, D, subsequent encounter and S, sequela. While the patient may be seen by a new or different provider over the course of treatment for an injury or condition, assignment of the 7th character for external cause should match the 7th character of the code assigned for the associated injury or condition for the encounter.

3) Use the full range of external cause codes

Use the full range of external cause codes to completely describe the cause, the intent, the place of occurrence, and if applicable, the activity of the patient at the time of the event, and the patient's status, for all injuries, and other health conditions due to an external cause.

4) Assign as many external cause codes as necessary

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.

5) The selection of the appropriate external cause code

The selection of the appropriate external cause code is guided by the Alphabetic Index of External Causes and by Inclusion and Exclusion notes in the Tabular List.

6) External cause code can never be a principal diagnosis

An external cause code can never be a principal (first-listed) diagnosis.

7) Combination external cause codes

Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

Toddler tripped and fell while walking and struck his head on an end table, sustaining a scalp contusion

S00.03XA Contusion of scalp, initial encounter

W01.190A Fall on same level from slipping, tripping and stumbling with subsequent striking against furniture, initial encounter

Explanation: Combination external cause codes identify sequential events that result in an injury, such as a fall resulting in striking against an object. The injury may be due to either or both events.

8) No external cause code needed in certain circumstances

No external cause code from Chapter 20 is needed if the external cause and intent are included in a code from another chapter (e.g., T36.0X1-, Poisoning by penicillins, accidental (unintentional)).

b. Place of occurrence guideline

Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use after other external cause codes to identify the location of the patient at the time of injury or other condition.

Generally, a place of occurrence code is assigned only once, at the initial encounter for treatment. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned. No 7th characters are used for Y92.

Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

A farmer was working in his barn and sustained a foot contusion when the horse stepped on his left foot

S90.32XA Contusion of left foot, initial encounter

W55.19XA Other contact with horse, initial encounter

Y92.71 Barn as the place of occurrence of the external cause

Explanation: A place-of-occurrence code from category Y92 is assigned at the initial encounter to identify the location of the patient at the time the injury occurred.

c. Activity code

Assign a code from category Y93, Activity code, to describe the activity of the patient at the time the injury or other health condition occurred.

An activity code is used only once, at the initial encounter for treatment. Only one code from Y93 should be recorded on a medical record.

The activity codes are not applicable to poisonings, adverse effects, misadventures or sequela.

Do not assign Y93.9, Unspecified activity, if the activity is not stated.

A code from category Y93 is appropriate for use with external cause and intent codes if identifying the activity provides additional information about the event.

Ranch hand who was grooming a horse sustained a foot contusion when the horse stepped on his left foot

S90.32XA Contusion of left foot, initial encounter

W55.19XA Other contact with horse, initial encounter

Y93.K3 Activity, grooming and shearing an animal

Explanation: One activity code from category Y93 is assigned at the initial encounter only to describe the activity of the patient at the time the injury occurred.

d. Place of occurrence, activity, and status codes used with other external cause code

When applicable, place of occurrence, activity, and external cause status codes are sequenced after the main external cause code(s). Regardless of the number of external cause codes assigned, generally there should be only one place of occurrence code, one activity code, and one external cause status code assigned to an encounter. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned.

e. If the reporting format limits the number of external cause codes

If the reporting format limits the number of external cause codes that can be used in reporting clinical data, report the code for the cause/intent most related to the principal diagnosis. If the format permits capture of additional external cause codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity, or external status.

f. Multiple external cause coding guidelines

More than one external cause code is required to fully describe the external cause of an illness or injury. The assignment of external cause codes should be sequenced in the following priority:

If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:

External codes for child and adult abuse take priority over all other external cause codes.

See Section I.C.19., Child and Adult abuse guidelines.

External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.

External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse and terrorism.

External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, child and adult abuse and terrorism.

Activity and external cause status codes are assigned following all causal (intent) external cause codes.

The first-listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident, or self-harm, following the order of hierarchy listed above..

30-year-old man accidentally discharged his hunting rifle, sustaining an open gunshot wound, with no retained bullet fragments, to the right thigh, which caused him to fall down the stairs, resulting in closed displaced comminuted fracture of his left radial shaft

S71.131A	**Puncture wound without foreign body, right thigh, initial encounter**
W33.Ø2XA	**Accidental discharge of hunting rifle, initial encounter**
S52.352A	**Displaced comminuted fracture of shaft of radius, left arm, initial encounter for closed fracture**
W1Ø.9XXA	**Fall (on) (from) unspecified stairs and steps, initial encounter**

Explanation: If two or more events cause separate injuries, an external cause code should be assigned for each cause.

g. Child and adult abuse guideline

Adult and child abuse, neglect and maltreatment are classified as assault. Any of the assault codes may be used to indicate the external cause of any injury resulting from the confirmed abuse.

For confirmed cases of abuse, neglect and maltreatment, when the perpetrator is known, a code from YØ7, Perpetrator of maltreatment and neglect, should accompany any other assault codes.

See Section I.C.19. Adult and child abuse, neglect and other maltreatment

h. Unknown or undetermined intent guideline

If the intent (accident, self-harm, assault) of the cause of an injury or other condition is unknown or unspecified, code the intent as accidental intent. All transport accident categories assume accidental intent.

1) Use of undetermined intent

External cause codes for events of undetermined intent are only for use if the documentation in the record specifies that the intent cannot be determined.

i. Sequelae (late effects) of external cause guidelines

1) Sequelae external cause codes

Sequela are reported using the external cause code with the 7th character "S" for sequela. These codes should be used with any report of a late effect or sequela resulting from a previous injury.

See Section I.B.10. Sequela (Late Effects)

2) Sequela external cause code with a related current injury

A sequela external cause code should never be used with a related current nature of injury code.

3) Use of sequela external cause codes for subsequent visits

Use a late effect external cause code for subsequent visits when a late effect of the initial injury is being treated. Do not use a late effect external cause code for subsequent visits for follow-up care (e.g., to assess healing, to receive rehabilitative therapy) of the injury when no late effect of the injury has been documented.

j. Terrorism guidelines

1) Cause of injury identified by the Federal Government (FBI) as terrorism

When the cause of an injury is identified by the Federal Government (FBI) as terrorism, the first-listed external cause code should be a code from category Y38, Terrorism. The definition of terrorism employed by the FBI is found at the inclusion note at the beginning of category Y38. Use additional code for place of occurrence (Y92.-). More than one Y38 code may be assigned if the injury is the result of more than one mechanism of terrorism.

2) Cause of an injury is suspected to be the result of terrorism

When the cause of an injury is suspected to be the result of terrorism a code from category Y38 should not be assigned. Suspected cases should be classified as assault.

3) Code Y38.9, Terrorism, secondary effects

Assign code Y38.9, Terrorism, secondary effects, for conditions occurring subsequent to the terrorist event. This code should not be assigned for conditions that are due to the initial terrorist act.

It is acceptable to assign code Y38.9 with another code from Y38 if there is an injury due to the initial terrorist event and an injury that is a subsequent result of the terrorist event.

k. External cause status

A code from category Y99, External cause status, should be assigned whenever any other external cause code is assigned for an encounter, including an Activity code, except for the events noted below. Assign a code from category Y99, External cause status, to indicate the work status of the person at the time the event occurred. The status code indicates whether the event occurred during military activity, whether a non-military person was at work, whether an individual including a student or volunteer was involved in a non-work activity at the time of the causal event.

A code from Y99, External cause status, should be assigned, when applicable, with other external cause codes, such as transport accidents and falls. The external cause status codes are not applicable to poisonings, adverse effects, misadventures or late effects.

Do not assign a code from category Y99 if no other external cause codes (cause, activity) are applicable for the encounter.

An external cause status code is used only once, at the initial encounter for treatment. Only one code from Y99 should be recorded on a medical record.

Do not assign code Y99.9, Unspecified external cause status, if the status is not stated.

Chapter 21. Factors Influencing Health Status and Contact with Health Services (Z00–Z99)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the d Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

Note: The chapter-specific guidelines provide additional information about the use of Z codes for specified encounters.

a. Use of Z Codes in any healthcare setting

Z codes are for use in any healthcare setting. Z codes may be used as either a first-listed (principal diagnosis code in the inpatient setting) or secondary code, depending on the circumstances of the encounter. Certain Z codes may only be used as first-listed or principal diagnosis.

Patient with middle lobe lung cancer presents for initiation of chemotherapy

Z51.11 Encounter for antineoplastic chemotherapy

C34.2 Malignant neoplasm of middle lobe, bronchus or lung

Explanation: A Z code can be used as first-listed in this situation based on guidelines in this chapter as well as chapter 2, "Neoplasms."

Patient has chronic lymphocytic leukemia for which the patient had previous chemotherapy and is now in remission

C91.11 Chronic lymphocytic leukemia of B-cell type in remission

Z92.21 Personal history of antineoplastic chemotherapy

Explanation: The personal history Z code is used to describe a secondary (supplementary) diagnosis to identify that this patient has had chemotherapy in the past.

b. Z Codes indicate a reason for an encounter or provide additional information about a patient encounter

Z codes are not procedure codes. A corresponding procedure code must accompany a Z code to describe any procedure performed.

c. Categories of Z Codes

1) Contact/exposure

Category Z20 indicates contact with, and suspected exposure to, communicable diseases. These codes are for patients who are suspected to have been exposed to a disease by close personal contact with an infected individual or are in an area where a disease is epidemic.

Category Z77, Other contact with and (suspected) exposures hazardous to health, indicates contact with and suspected exposures hazardous to health.

Contact/exposure codes may be used as a first-listed code to explain an encounter for testing, or, more commonly, as a secondary code to identify a potential risk.

2) Inoculations and vaccinations

Code Z23 is for encounters for inoculations and vaccinations. It indicates that a patient is being seen to receive a prophylactic inoculation against a disease. Procedure codes are required to identify the actual administration of the injection and the type(s) of immunizations given. Code Z23 may be used as a secondary code if the inoculation is given as a routine part of preventive health care, such as a well-baby visit.

3) Status

Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code Z94.1, Heart transplant status, should not be used with a code from subcategory T86.2, Complications of heart transplant. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

For encounters for weaning from a mechanical ventilator, assign a code from subcategory J96.1, Chronic respiratory failure, followed by code Z99.11, Dependence on respirator [ventilator] status.

The status Z codes/categories are:

Z14 Genetic carrier

Genetic carrier status indicates that a person carries a gene, associated with a particular disease, which may be passed to offspring who may develop that disease. The person does not have the disease and is not at risk of developing the disease.

Z15 Genetic susceptibility to disease

Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease.

Codes from category Z15 should not be used as principal or first-listed codes. If the patient has the condition to which he/she is susceptible, and that condition is the reason for the encounter, the code for the current condition should be sequenced first. If the patient is being seen for follow-up after completed treatment for this condition, and the condition no longer exists, a follow-up code should be sequenced first, followed by the appropriate personal history and genetic susceptibility codes. If the purpose of the encounter is genetic counseling associated with procreative management, code Z31.5, Encounter for genetic counseling, should be assigned as the first-listed code, followed by a code from category Z15. Additional codes should be assigned for any applicable family or personal history.

Z16 Resistance to antimicrobial drugs

This code indicates that a patient has a condition that is resistant to antimicrobial drug treatment. Sequence the infection code first.

Z17 Estrogen receptor status

Z18 Retained foreign body fragments

Z19 Hormone sensitivity malignancy status

Z21 Asymptomatic HIV infection status

This code indicates that a patient has tested positive for HIV but has manifested no signs or symptoms of the disease.

Z22 Carrier of infectious disease

Carrier status indicates that a person harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection.

Z28.3 Underimmunization status

See Section I.B.14. for underimmunization documentation by clinicians other than the patient's provider.

Z33.1 Pregnant state, incidental

This code is a secondary code only for use when the pregnancy is in no way complicating the reason for visit. Otherwise, a code from the obstetric chapter is required.

Z66 Do not resuscitate

This code may be used when it is documented by the provider that a patient is on do not resuscitate status at any time during the stay.

Z67 Blood type

Z68 Body mass index (BMI)

BMI codes should only be assigned when there is an associated, reportable diagnosis (such as obesity). Do not assign BMI codes during pregnancy.

See Section I.B.14. for BMI documentation by clinicians other than the patient's provider.

Patient seen today for chest pain, noncardiac in nature. Nurses notes identify a BMI of 20.5.

R07.89 Other chest pain

Explanation: Section I.B.14 stipulates that the BMI can be assigned from documentation of someone other than the patient's provider, such as nursing notes, only when the provider has documented that the diagnosis is associated with the BMI. As there is no supporting documentation from the provider linking the BMI to an associated condition, no code is assigned for the BMI.

Z74.01 Bed confinement status

Z76.82 Awaiting organ transplant status

Z78 Other specified health status

Code Z78.1, Physical restraint status, may be used when it is documented by the provider that a patient has been put in restraints during the current encounter. Please note that this code should not be reported when it is documented by the provider that a patient is temporarily restrained during a procedure.

Z79 Long-term (current) drug therapy

Codes from this category indicate a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have addictions to drugs. This subcategory is not for use of medications for detoxification or maintenance programs to prevent withdrawal symptoms (e.g., methadone maintenance for opiate dependence). Assign the appropriate code for the drug use, abuse, or dependence instead.

Assign a code from Z79 if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer). Do not assign a code from category Z79 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acute bronchitis).

Z88 Allergy status to drugs, medicaments and biological substances

Except: Z88.9, Allergy status to unspecified drugs, medicaments and biological substances status

Z89 Acquired absence of limb

Z90 Acquired absence of organs, not elsewhere classified

Z91.0- Allergy status, other than to drugs and biological substances

Z92.82 Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility

Assign code Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility, as a secondary diagnosis when a patient is received by transfer into a facility and documentation indicates they were administered tissue plasminogen activator (tPA) within the last 24 hours prior to admission to the current facility.

This guideline applies even if the patient is still receiving the tPA at the time they are received into the current facility.

The appropriate code for the condition for which the tPA was administered (such as cerebrovascular disease or myocardial infarction) should be assigned first.

Code Z92.82 is only applicable to the receiving facility record and not to the transferring facility record.

Z93 Artificial opening status

Z94 Transplanted organ and tissue status

Z95 Presence of cardiac and vascular implants and grafts

Z96 Presence of other functional implants

Z97 Presence of other devices

Z98 Other postprocedural states

Assign code Z98.85, Transplanted organ removal status, to indicate that a transplanted organ has been previously removed. This code should not be assigned for the encounter in which the transplanted organ is removed. The complication necessitating removal of the transplant organ should be assigned for that encounter.

See section I.C.19. for information on the coding of organ transplant complications.

Z99 Dependence on enabling machines and devices, not elsewhere classified

Note: Categories Z89-Z90 and Z93-Z99 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent.

4) History (of)

There are two types of history Z codes, personal and family. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

The reason for the encounter (for example, screening or counseling) should be sequenced first and the appropriate personal and/or family history code(s) should be assigned as additional diagnos(es).

The history Z code categories are:

Z80 Family history of primary malignant neoplasm

Z81 Family history of mental and behavioral disorders

Z82 Family history of certain disabilities and chronic diseases (leading to disablement)

Z83 Family history of other specific disorders

Z84 Family history of other conditions

Z85 Personal history of malignant neoplasm

Z86 Personal history of certain other diseases

Z87 Personal history of other diseases and conditions

Z91.4- Personal history of psychological trauma, not elsewhere classified

Z91.5- Personal history of self-harm

Z91.81 History of falling

Z91.82 Personal history of military deployment

Z91.85 Personal history of military service

Z92 Personal history of medical treatment

Except: Z92.0, Personal history of contraception

Except: Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility

5) Screening

Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for the disease (e.g., screening mammogram).

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the reason for the test.

A screening code may be a first-listed code if the reason for the visit is specifically the screening exam. It may also be used as an additional code if the screening is done during an office visit for other health problems. A screening code is not necessary if the screening is inherent to a routine examination, such as a pap smear done during a routine pelvic examination.

Should a condition be discovered during the screening then the code for the condition may be assigned as an additional diagnosis.

Prostate screening of healthy 50-year-old male patient; PSA noted to be elevated but normal digital rectal exam

Z12.5 Encounter for screening for malignant neoplasm of prostate

R97.20 Elevated prostate specific antigen [PSA]

Explanation: The patient had no signs or symptoms of any prostate-related illness prior to coming in for the screening. The screening code is appropriately used as the first-listed code to signify that this was for routine screening. The elevated PSA is reported as a secondary diagnosis to reflect that an abnormal lab value was found as a result of the screening procedure(s).

The Z code indicates that a screening exam is planned. A procedure code is required to confirm that the screening was performed.

The screening Z codes/categories:

Z11 Encounter for screening for infectious and parasitic diseases

Z12 Encounter for screening for malignant neoplasms

Z13 Encounter for screening for other diseases and disorders

Except: Z13.9, Encounter for screening, unspecified

Z36 Encounter for antenatal screening for mother

6) Observation

There are three observation Z code categories. They are for use in very limited circumstances when a person is being observed for a suspected condition that is ruled out. The observation codes are not for use if an injury or illness or any signs or symptoms related to the suspected condition are present. In such cases the diagnosis/symptom code is used with the corresponding external cause code.

The observation codes are primarily to be used as a principal/first-listed diagnosis. An observation code may be assigned as a secondary diagnosis code when the patient is being observed for a condition that is ruled out and is unrelated to the principal/first-listed diagnosis. Also, when the principal diagnosis is required to be a code from category Z38, Liveborn infants according to place of birth and type of delivery. Then a code from category Z05, Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out, is sequenced after the Z38 code. Additional codes may be used in addition to the observation code but only if they are unrelated to the suspected condition being observed.

Codes from subcategory Z03.7, Encounter for suspected maternal and fetal conditions ruled out, may either be used as a first-listed or as an additional code assignment depending on the case. They are for use in very limited circumstances on a maternal record when an encounter is for a suspected maternal or fetal condition that is ruled out during that encounter (for example, a maternal or fetal condition may be suspected due to an abnormal test result). These codes should not be used when the condition is confirmed. In those cases, the confirmed condition should be coded. In addition, these codes are not for use if an illness or any signs or symptoms related to the suspected condition or problem are present. In such cases the diagnosis/symptom code is used.

Additional codes may be used in addition to the code from subcategory Z03.7, but only if they are unrelated to the suspected condition being evaluated.

Codes from subcategory Z03.7 may not be used for encounters for antenatal screening of mother. *See Section I.C.21. Screening*.

For encounters for suspected fetal condition that are inconclusive following testing and evaluation, assign the appropriate code from category O35, O36, O40 or O41.

The observation Z code categories:

Z03	Encounter for medical observation for suspected diseases and conditions ruled out
Z04	Encounter for examination and observation for other reasons Except: Z04.9, Encounter for examination and observation for unspecified reason
Z05	Encounter for observation and evaluation of newborn for suspected diseases and conditions ruled out

7) Aftercare

Aftercare visit codes cover situations when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare Z code should not be used if treatment is directed at a current, acute disease. The diagnosis code is to be used in these cases. Exceptions to this rule are codes Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy. These codes are to be first listed, followed by the diagnosis code when a patient's encounter is solely to receive radiation therapy, chemotherapy, or immunotherapy for the treatment of a neoplasm. If the reason for the encounter is more than one type of antineoplastic therapy, code Z51.0 and a code from subcategory Z51.1 may be assigned together, in which case one of these codes would be reported as a secondary diagnosis.

The aftercare Z codes should also not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the appropriate 7th character (for subsequent encounter).

The aftercare codes are generally first listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

Aftercare codes should be used in conjunction with other aftercare codes or diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. The sequencing of multiple aftercare codes depends on the circumstances of the encounter.

Patient presents for third round of gemcitabine and first dose of antineoplastic radiation therapy for advanced pancreatic carcinoma

Z51.11 Encounter for antineoplastic chemotherapy

Z51.0 Encounter for antineoplastic radiation therapy

C25.9 Malignant neoplasm of pancreas, unspecified

Explanation: Gemcitabine is an antineoplastic chemotherapy. Since the encounter was solely to administer antineoplastic treatment, both forms of treatment are reported and either code can be the first-listed diagnosis, followed by the neoplastic condition code. Aftercare codes are typically not assigned for current treatment of disease; however, Z51.0 and subcategory Z51.1 are an exception to this standard.

Certain aftercare Z code categories need a secondary diagnosis code to describe the resolving condition or sequelae. For others, the condition is included in the code title.

Additional Z code aftercare category terms include fitting and adjustment, and attention to artificial openings.

Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare. For example code Z95.1, Presence of aortocoronary bypass graft, may be used with code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system, to indicate the surgery for which the aftercare is being performed. A status code should not be used when the aftercare code indicates the type of status, such as using Z43.0, Encounter for attention to tracheostomy, with Z93.0, Tracheostomy status.

The aftercare Z category/codes:

Z42	Encounter for plastic and reconstructive surgery following medical procedure or healed injury
Z43	Encounter for attention to artificial openings
Z44	Encounter for fitting and adjustment of external prosthetic device
Z45	Encounter for adjustment and management of implanted device
Z46	Encounter for fitting and adjustment of other devices
Z47	Orthopedic aftercare
Z48	Encounter for other postprocedural aftercare
Z49	Encounter for care involving renal dialysis
Z51	Encounter for other aftercare and medical care

8) Follow-up

The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes, or injury codes with a 7th character for subsequent encounter, that explain ongoing care of a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code.

A follow-up code may be used to explain multiple visits. Should a condition be found to have recurred on the follow-up visit, then the diagnosis code for the condition should be assigned in place of the follow-up code.

The follow-up **Z codes/categories**:

Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z09	Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Codes Z08, Encounter for follow-up examination after completed treatment for malignant neoplasm, and Z09, Encounter for follow up examination after completed treatment for conditions other than malignant neoplasm, may be assigned following any type of completed treatment modality (including both medical and surgical treatments).

Z39	Encounter for maternal postpartum care and examination

Follow-up for patient several months after completing a regime of IV antibiotics for recurrent pneumonia; lungs are clear and pneumonia is resolved

Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm

Z87.01 Personal history of pneumonia (recurrent)

Explanation: Code Z09 identifies the follow-up visit as being unrelated to a malignant neoplasm, and code Z87 describes the condition that has now resolved.

Follow-up for patient several months after completing a regime of IV antibiotics for recurrent pneumonia; pneumonia has recurred, and a new antibiotic regimen has been prescribed

J18.9 Pneumonia, unspecified organism

Explanation: Since the follow-up exam for pneumonia determined that the pneumonia was not resolved or recurred, code Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, no longer applies. Instead the first-listed code describes the pneumonia.

9) Donor

Codes in category Z52, Donors of organs and tissues, are used for living individuals who are donating blood or other body tissue. These codes are for individuals donating for others, as well as for self-donations. They are not used to identify cadaveric donations.

10)Counseling

Counseling Z codes are used when a patient or family member receives assistance in the aftermath of an illness or injury, or when support is required in coping with family or social problems.

The counseling Z codes/categories:

- Z30.0- Encounter for general counseling and advice on contraception
- Z31.5 Encounter for procreative genetic counseling
- Z31.6- Encounter for general counseling and advice on procreation
- Z32.2 Encounter for childbirth instruction
- Z32.3 Encounter for childcare instruction
- Z69 Encounter for mental health services for victim and perpetrator of abuse
- Z70 Counseling related to sexual attitude, behavior and orientation
- Z71 Persons encountering health services for other counseling and medical advice, not elsewhere classified

  Note: Code Z71.84, Encounter for health counseling related to travel, is to be used for health risk and safety counseling for future travel purposes.

  Code Z71.85, Encounter for immunization safety counseling, is to be used for counseling of the patient or caregiver regarding the safety of a vaccine. This code should not be used for the provision of general information regarding risks and potential side effects during routine encounters for the administration of vaccines.

  Code Z71.87, Encounter for pediatric-to-adult transition counseling, should be assigned when pediatric-to-adult transition counseling is the sole reason for the encounter or when this counseling is provided in addition to other services, such as treatment of a chronic condition. If both transition counseling and treatment of a medical condition are provided during the same encounter, the code(s) for the medical condition(s) treated and code Z71.87 should be assigned, with sequencing depending on the circumstances of the encounter.
- Z76.81 Expectant mother prebirth pediatrician visit

11)Encounters for obstetrical and reproductive services

See Section I.C.15. Pregnancy, Childbirth, and the Puerperium, for further instruction on the use of these codes.

Z codes for pregnancy are for use in those circumstances when none of the problems or complications included in the codes from the Obstetrics chapter exist (a routine prenatal visit or postpartum care). Codes in category Z34, Encounter for supervision of normal pregnancy, are always first-listed and are not to be used with any other code from the OB chapter.

Codes in category Z3A, Weeks of gestation, may be assigned to provide additional information about the pregnancy. Category Z3A codes should not be assigned for pregnancies with abortive outcomes (categories O00-O08), elective termination of pregnancy (code Z33.2), nor for postpartum conditions, as category Z3A is not applicable to these conditions. The date of the admission should be used to determine weeks of gestation for inpatient admissions that encompass more than one gestational week.

The outcome of delivery, category Z37, should be included on all maternal delivery records. It is always a secondary code.

Codes in category Z37 should not be used on the newborn record.

Z codes for family planning (contraceptive) or procreative management and counseling should be included on an obstetric record either during the pregnancy or the postpartum stage, if applicable.

Z codes/categories for obstetrical and reproductive services:

- Z30 Encounter for contraceptive management
- Z31 Encounter for procreative management
- Z32.2 Encounter for childbirth instruction
- Z32.3 Encounter for childcare instruction
- Z33 Pregnant state
- Z34 Encounter for supervision of normal pregnancy
- Z36 Encounter for antenatal screening of mother
- Z3A Weeks of gestation
- Z37 Outcome of delivery
- Z39 Encounter for maternal postpartum care and examination
- Z76.81 Expectant mother prebirth pediatrician visit

12)Newborns and infants

See Section I.C.16. Newborn (Perinatal) Guidelines, for further instruction on the use of these codes.

Newborn Z codes/categories:

- Z76.1 Encounter for health supervision and care of foundling
- Z00.1- Encounter for routine child health examination
- Z38 Liveborn infants according to place of birth and type of delivery

13)Routine and administrative examinations

The Z codes allow for the description of encounters for routine examinations, such as, a general check-up, or, examinations for administrative purposes, such as, a pre-employment physical. The codes are not to be used if the examination is for diagnosis of a suspected condition or for treatment purposes. In such cases the diagnosis code is used. During a routine exam, should a diagnosis or condition be discovered, it should be coded as an additional code. Pre-existing and chronic conditions and history codes may also be included as additional codes as long as the examination is for administrative purposes and not focused on any particular condition.

Some of the codes for routine health examinations distinguish between "with" and "without" abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded. For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for "without abnormal findings." When assigning a code for "with abnormal findings," additional code(s) should be assigned to identify the specific abnormal finding(s).

12-month-old boy presented for well-child visit; pediatrician notices some eczema on the child's scalp and back of the knees

Z00.121 Encounter for routine child health examination with abnormal findings

L30.9 Dermatitis, unspecified

Explanation: The Z code identifying that this is a routine well-child visit is reported first. Because an abnormal finding (eczema) was documented, a code for this condition may also be appended.

Pre-operative examination and pre-procedural laboratory examination Z codes are for use only in those situations when a patient is being cleared for a procedure or surgery and no treatment is given.

The Z codes/categories for routine and administrative examinations:

- Z00 Encounter for general examination without complaint, suspected or reported diagnosis
- Z01 Encounter for other special examination without complaint, suspected or reported diagnosis
- Z02 Encounter for administrative examination

  Except: Z02.9, Encounter for administrative examinations, unspecified
- Z32.0- Encounter for pregnancy test

14)Miscellaneous Z codes

The miscellaneous Z codes capture a number of other health care encounters that do not fall into one of the other categories. Some of these codes identify the reason for the encounter; others are for use as additional codes that provide useful information on circumstances that may affect a patient's care and treatment.

Prophylactic organ removal

For encounters specifically for prophylactic removal of an organ (such as prophylactic removal of breasts due to a genetic susceptibility to cancer or a family history of cancer), the principal or first-listed code should be a code from category Z40, Encounter for prophylactic surgery, followed by the appropriate codes to identify the associated risk factor (such as genetic susceptibility or family history).

If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory Z40.0, Encounter for prophylactic surgery for risk factors related to malignant neoplasms. A Z40.0 code

should not be assigned if the patient is having organ removal for treatment of a malignancy, such as the removal of the testes for the treatment of prostate cancer.

Miscellaneous Z codes/categories:

- Z28 Immunization not carried out
  - Except: Z28.3-, Underimmunization status
- Z29 Encounter for other prophylactic measures
- Z40 Encounter for prophylactic surgery
- Z41 Encounter for procedures for purposes other than remedying health state
  - Except: Z41.9, Encounter for procedure for purposes other than remedying health state, unspecified
- Z53 Persons encountering health services for specific procedures and treatment, not carried out
- Z72 Problems related to lifestyle
  - Note: These codes should be assigned only when the documentation specifies that the patient has an associated problem
- Z73 Problems related to life management difficulty
  - Note: These codes should be assigned only when the documentation specifies that the patient has an associated problem.
- Z74 Problems related to care provider dependency
  - Except: Z74.01, Bed confinement status
- Z75 Problems related to medical facilities and other health care
- Z76.0 Encounter for issue of repeat prescription
- Z76.3 Healthy person accompanying sick person
- Z76.4 Other boarder to healthcare facility
- Z76.5 Malingerer [conscious simulation]
- Z91.1- Patient's noncompliance with medical treatment and regimen
- **Z91.A- Caregiver's noncompliance with patient's medical treatment and regimen**
- Z91.83 Wandering in diseases classified elsewhere
- Z91.84- Oral health risk factors
- Z91.89 Other specified personal risk factors, not elsewhere classified

See Section I.B.14. for Z55-Z65 Persons with potential health hazards related to socioeconomic and psychosocial circumstances, documentation by clinicians other than the patient's provider

15)Nonspecific Z codes

Certain Z codes are so non-specific, or potentially redundant with other codes in the classification, that there can be little justification for their use in the inpatient setting. Their use in the outpatient setting should be limited to those instances when there is no further documentation to permit more precise coding. Otherwise, any sign or symptom or any other reason for visit that is captured in another code should be used.

Nonspecific Z codes/categories:

- Z02.9 Encounter for administrative examinations, unspecified
- Z04.9 Encounter for examination and observation for unspecified reason
- Z13.9 Encounter for screening, unspecified
- Z41.9 Encounter for procedure for purposes other than remedying health state, unspecified
- Z52.9 Donor of unspecified organ or tissue
- Z86.59 Personal history of other mental and behavioral disorders
- Z88.9 Allergy status to unspecified drugs, medicaments and biological substances status
- Z92.0 Personal history of contraception

16)Z codes that may only be principal/first-listed diagnosis

The following Z codes/categories may only be reported as the principal/first-listed diagnosis, except when there are multiple encounters on the same day and the medical records for the encounters are combined:

- Z00 Encounter for general examination without complaint, suspected or reported diagnosis
  - Except: Z00.6
- Z01 Encounter for other special examination without complaint, suspected or reported diagnosis
- Z02 Encounter for administrative examination
- Z04 Encounter for examination and observation for other reasons
- Z33.2 Encounter for elective termination of pregnancy
- Z31.81 Encounter for male factor infertility in female patient
- Z31.83 Encounter for assisted reproductive fertility procedure cycle
- Z31.84 Encounter for fertility preservation procedure
- Z34 Encounter for supervision of normal pregnancy
- Z39 Encounter for maternal postpartum care and examination
- Z38 Liveborn infants according to place of birth and type of delivery
- Z40 Encounter for prophylactic surgery
- Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury
- Z51.0 Encounter for antineoplastic radiation therapy
- Z51.1- Encounter for antineoplastic chemotherapy and immunotherapy
- Z52 Donors of organs and tissues
  - Except: Z52.9, Donor of unspecified organ or tissue
- Z76.1 Encounter for health supervision and care of foundling
- Z76.2 Encounter for health supervision and care of other healthy infant and child
- Z99.12 Encounter for respirator [ventilator] dependence during power failure

Female patient seen at 32 weeks' gestation to check the progress of her first pregnancy

Z34.03 Encounter for supervision of normal first pregnancy, third trimester

Z3A.32 32 weeks gestation of pregnancy

Explanation: Category Z34 is appropriate as a first-listed diagnosis. Category Z3A helps to clarify at which point in the pregnancy the patient was provided supervision.

17)Social determinants of health

Social determinants of health (SDOH) codes describing social problems, conditions, or risk factors that influence a patient's health should be assigned when this information is documented in the patient's medical record. Assign as many SDOH codes as are necessary to describe all of the social problems, conditions, or risk factors documented during the current episode of care. For example, a patient who lives alone may suffer an acute injury temporarily impacting their ability to perform routine activities of daily living. When documented as such, this would support assignment of code Z60.2, Problems related to living alone. However, merely living alone, without documentation of a risk or unmet need for assistance at home, would not support assignment of code Z60.2. Documentation by a clinician (or patient-reported information that is signed off by a clinician) that the patient expressed concerns with access and availability of food would support assignment of code Z59.41, Food insecurity. Similarly, medical record documentation indicating the patient is homeless would support assignment of a code from subcategory Z59.0-, Homelessness.

For social determinants of health **classified to chapter 21**, such as information found in categories Z55-Z65, Persons with potential health hazards related to socioeconomic and psychosocial circumstances, code assignment may be based on medical record documentation from clinicians involved in the care of the patient who are not the patient's provider since this information represents social information, rather than medical diagnoses. For example, coding professionals may utilize documentation of social information from social workers, community health workers, case managers, or nurses, if their documentation is included in the official medical record.

Patient self-reported documentation may be used to assign codes for social determinants of health, as long as the patient self-reported information is signed-off by and incorporated into the medical record by either a clinician or provider.

Social determinants of health codes are located primarily in these Z code categories:

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z58 Problems related to physical environment
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

See Section I.B.14. Documentation by Clinicians Other than the Patient's Provider.

Chapter 22. Codes for Special Purposes (UØØ–U85)

Chapter-specific Guidelines

U07.Ø Vaping-related disorder (see Section I.C.10.e., Vaping-related disorders)

U07.1 COVID-19 (see Section I.C.1.g.1., COVID-19 infection)

U09.9 Post COVID-19 condition, unspecified (see Section I.C.1.g.1.m.)