ICD-10-CM

IT’S A BRAVE NEW WORLD

NHHIMA CODING ROUNDTABLE
JUNE 7, 2013

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AHIMA-Approved ICD-10 Trainer
Today’s Agenda

- Quick Review
- Code Structure
- Guidelines: What’s New
OLD FRIENDS, NEW LOOK:
* SEPSIS
* NEOPLASMS
* DIABETES
* HYPERTENSION
* CVA
* CAD/AMI
* ASTHMA
* RESPIRATORY FAILURE
* SKIN ULCERS
* OBSTETRICS AND NEWBORNS
* INJURIES/FRACTURES

EXTRA, EXTRA:
* GLASGOW COMA SCALE
* GUSTILO OPEN FX CLASSIFICATION
Today’s Goal

From this...

To this!
Effective with inpatient discharge date OR outpatient date of service 10-1-14, HIPAA mandates the following code sets:

- **INPATIENTS**: ICD 10 DX + ICD 10-PCS PX
- **OUTPATIENTS**: ICD-10 DX + CPT/HCPCS PX

CPT codes will NOT change.
ICD-10 IS A GOOD THING…

✓ Updated medical terminology and improved clinical accuracy
✓ Structure easily allows addition of new codes
✓ We can better reflect the true health status of our patients
✓ Collect more meaningful information about the care we provide
✓ Specificity allows improved data quality and reporting
LIKE ICD-9, ICD-10 BOOKS HAVE:

A GUIDELINES SECTION
* General Guidelines
* Chapter-Specific Guidelines

AN ALPHABETIC INDEX WITH:
* A NEOPLASM TABLE
* A TABLE OF DRUGS AND CHEMICALS
* A SEPARATE INDEX TO EXTERNAL CAUSES

* A TABULAR LIST OF CODES

SOMETHING OLD…
ICD-10 HAS 21 CHAPTERS INSTEAD OF 19

NEW:

CHAPTER 7: DISEASES OF THE EYE AND ADNEXA

CHAPTER 8: DISEASES OF THE EAR AND MASTOID PROCESS
Code Structure - A New Look

ICD-9-CM Structure

ICD-10-CM Structure

3 - 5 Characters

3 - 7 Characters
## Diagnosis Code Comparison

<table>
<thead>
<tr>
<th>ICD-9-CM “DIGITS”</th>
<th>ICD-10-CM “CHARACTERS”</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 “Digits”</td>
<td>3-7 “characters”</td>
</tr>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; digit numeric, V or E</td>
<td>1&lt;sup&gt;st&lt;/sup&gt; character is alpha (no “U”)</td>
</tr>
<tr>
<td>2&lt;sup&gt;nd&lt;/sup&gt; digit numeric</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; character is numeric</td>
</tr>
<tr>
<td>3&lt;sup&gt;rd&lt;/sup&gt;, 4&lt;sup&gt;th&lt;/sup&gt;, 5&lt;sup&gt;th&lt;/sup&gt; digits numeric</td>
<td>3-7 characters may be alpha OR numeric</td>
</tr>
<tr>
<td>Always at least 3 digits</td>
<td>Always at least 3 characters</td>
</tr>
<tr>
<td>Decimal place after first 3 digits</td>
<td>Decimal place after first 3 characters</td>
</tr>
<tr>
<td>Alpha characters not case sensitive</td>
<td>Alpha characters not case sensitive</td>
</tr>
</tbody>
</table>
X = the placeholder character that allows for future code expansion

X must be used for any code that has a placeholder or the code is not valid

Some codes have more than one X placeholder

Example: W01.0XXA - fall on same level from slipping, tripping, initial episode of care
7th characters are found only in these chapters:

- Obstetrics ch. 15 (O00-O9A)
- Musculoskeletal ch. 13 (M00-M99)
- Injuries, poisonings, adverse effects ch. 19 (S00-T88)
- External causes ch. 20 (V00-Y99)
NEC and NOS codes still exist in ICD-10.

**NEC**: documented specified condition without a corresponding code in I-10

**NOS**: When documentation is insufficient to assign a more specific code
HIPAA REQUIRES ADHERENCE TO THE OFFICIAL CODING GUIDELINES IN ALL HEALTHCARE SETTINGS

UHDDS GUIDELINES STAY THE SAME FOR REPORTING:

- INPT PRINCIPAL DX
- INPT REPORTABLE SECONDARY DX
- OUTPT FIRST DX
- OTHER OUTPT DXS
EXCLUDES 1 NOTES

**NOT CODED HERE!**
The two conditions are mutually exclusive and are NEVER coded together.

Example:
**A09** – infectious gastroenteritis and colitis, unspecified

**Excludes 1:** colitis NOS; diarrhea NOS; enteritis NOS; gastroenteritis NOS

EXCLUDES 2 NOTES

**NOT INCLUDED HERE!**
The condition excluded is not part of the condition represented by the code, but if the patient has it, you can code it.

Example:
**J37.1** Chronic laryngotracheitis

**Excludes 2:** acute laryngotracheitis

cutheitis
LATERALITY:
* Final character in I-10 code indicates laterality –
* Right, left, bilateral, or unspecified
* If no bilateral code is provided, assign separate codes for right and left

DOCUMENTATION OF COMPLICATIONS OF CARE:
Documentation must reflect a cause-effect relationship between the care provided and the condition, and an indication that it is a complication...

This is a biggie!
LET’S CODE!

G56 Mononeuropathies of upper limb

Excludes 1: current traumatic nerve disorder - see nerve injury by body region

G56.0 Carpal tunnel syndrome
  G56.00 Carpal tunnel syndrome, unspecified upper limb
  G56.01 Carpal tunnel syndrome, right upper limb
  G56.02 Carpal tunnel syndrome, left upper limb
NEW INSTRUCTION: use additional code to identify resistance to antimicrobial drugs: **Z16.10-Z16.39**

If the Chapter 1 code includes “drug resistant” in the definition, do not use a Z code.

See code range in your handouts, pages 1 and 2
R78.81, is in Chapter 18, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings.

REMEMBER: If we have a related definitive dx established by a provider, that definitive dx is either coded alone or sequenced first, depending on whether the bacteremia is an integral part of the disease process.

NO CHANGE IN GUIDELINES FROM I-9 TO I-10
Many combination codes include both sepsis and the causative organism, eliminating the need for 2 codes.

EXAMPLES:

* B37.7 – Sepsis due to candida
* A41.81 – Sepsis due to enterococcus

**A41.9 - SEPSIS, UNSPECIFIED**
Severe sepsis or sepsis with organ dysfunction still need at least 2 codes:

- a code from category **A41** for the sepsis
- a code for the bug if not included in your sepsis code already

- a code from category **R65.2** to denote severe sepsis

- Also assign code(s) for any documented associated organ dysfunction
Septic shock is a type of acute organ dysfunction with severe sepsis.

Assign:

✓ a code from category A41 for the sepsis

✓ A code for the bug if not included in your sepsis code already

✓ R65.21: Severe sepsis with septic shock.

✓ A code for each acute organ dysfunction.
MRSA SEPSIS
Handout pages 3-8

A41.02
HOW MANY ICD-10 DX CODES??

An 89-year-old female is taken to the ED with fever of over 101 degrees F., BP of 88/50, heart rate of 100 and a respiratory rate of 24.

On admission to ICU, the physician documents severe sepsis with acute respiratory failure. The final dx provided by the physician is severe enterococcal sepsis with acute respiratory failure.

Handout pages 3-8
3
- 1 code for the sepsis (includes the cause)
- 1 code for severe sepsis
- 1 code for the acute respiratory failure

A41.81, enterococcal sepsis

R65.20, Severe sepsis without septic shock

J96.00, Acute respiratory failure
First go to the:

**Table of Neoplasms** following the Index to Diseases

**UNLESS:** If the narrative dx gives you a histologic term, like *adenoma*, look up that term in the general index to determine the correct column to use in the neoplasm table.

- ✓ Current disease, if still under treatment
- ✓ History of disease, if treatment complete (Z codes)
ANEMIA WITH ASSOCIATED MALIGNANCY

When admission/encounter is for management of anemia associated with malignancy, and treatment is only for the anemia, sequence the code for the malignancy FIRST, followed by the appropriate anemia code.
Patient is seen in Oncology Clinic for blood transfusion due to anemia associated with ascending colon cancer. Due to the patient’s profound weakness, no chemotherapy is administered during this visit. (handout pages 10-11)

What are the codes and what is the correct coding sequence?

C18.2 Malignant neoplasm of ascending colon
D63.0 Anemia in neoplastic disease
Other Malignancy-related Conditions

DEHYDRATION
If encounter is for management of dehydration due to malignancy and only the dehydration is being treated, code the dehydration first followed by the malignancy code.

PAIN
G89.3 is assigned to pain documented as being related, associated or due to malignancy. If encounter is for pain control, it is sequenced first.

If encounter is for cancer management and pain is also documented, it is a secondary dx.
There are two basic changes in ICD-10 diabetes classification:

- Complex diabetes cases that require multiple ICD-9 codes can be coded with one ICD-10 code.

- No more coding and documentation hassles with uncontrolled diabetes.

- **ICD-10 does not contain DM codes that use the term uncontrolled.** If the words *inadequately controlled, poorly controlled* or *out of control* are used, that documentation translates to diabetes by type with hyperglycemia.
5 Diabetes Categories

E08 DM due to underlying condition
   e.g. due to pancreatic neoplasm, cushing’s syndrome, cystic fibrosis

E09 DM induced by drug or chemical (e.g. steroid-induced)

E10 Type I DM
E11 Type II DM

E13 Other specified DM
   e.g. post-pancreatectomy DM

E11.9 is the new 250.00

Z79.4 Use for any non-type I diabetic on long-term insulin therapy
“Type 1 diabetic with nonproliferative retinopathy and macular edema” can be completely described with a single ICD-10 code.

**E10.321** Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema

Replaces

- **250.51** *Diabetes with ophthalmic manifestations, type I [juvenile type], not stated as uncontrolled*
- **362.04** *Mild nonproliferative diabetic retinopathy*
- **362.07** *Diabetic macular edema*
Poorly controlled Type II diabetes with periodontal disease  (handout pages 12-14)

And the codes are...

E11.630  Type 2 diabetes mellitus with periodontal disease

E11.65  Type 2 diabetes mellitus with hyperglycemia
Chapter 9 Diseases of the Circulatory System I00-I99

I00-I02 Acute rheumatic fever
I05-I09 Chronic rheumatic heart diseases
I10-I15 Hypertensive diseases
I20-I25 Ischemic heart diseases
I26-I28 Pulmonary heart disease and diseases of pulmonary circulation
I30-I52 Other forms of heart disease
I60-I69 Cerebrovascular diseases
I70-I79 Diseases of arteries, arterioles and capillaries
I80-I89 Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified
I95-I99 Other and unspecified disorders of the circulatory system
I10 Essential (primary) hypertension

**INCLUDES**
- high blood pressure
- hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)

**EXCLUDES 1**
- hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O16)

**EXCLUDES 2**
- essential (primary) hypertension involving vessels of brain (I60-I69)
- essential (primary) hypertension involving vessels of eye (H35.0-)

*Hello I10, farewell 401.0, 401.1 401.9*
CVA – Categories I60-I63

MANY CODES!

➢ **Location**
  Precerebral artery: vertebral, carotid, other, laterality
  Cerebral artery: multiple code choices for specific arteries/laterality

➢ **Cause** - hemorrhage, thrombosis, embolism, unspecified occlusion

I63.9 The go-to code for cerebral Infarction, unspecified

➢ Also, as with I-9, assign separate codes for any acute neurologic deficits.
**Dominant/nondominant side**

“Should the affected side be documented but not specified as dominant or nondominant, the defaults are:”

For ambidextrous patient – default is dominant
Left side – nondominant
Right side – dominant

Applies to all codes in category G81 and codes in subcategories G83.1, G83.2, and G83.3 (handout pages 17-18)
TIA doesn’t live here anymore...

TIA in ICD-10 codes to Chapter 6- Diseases of the Nervous System

G45 Transient cerebral ischemic attacks and related syndromes
Other CVA-related codes

Category I69 – Sequelae of acute CVA

* Take the place of our 438.xx series of codes
* Use to capture residual neurologic deficits that remain after the acute stroke

Z86.73 – Personal hx of stroke or TIA without any sequelae

Z92.82 – s/p tPA in a different facility within 24 hrs of admission to current facility

Z79.01 – long-term use of anticoagulant
Cerebral infarction due to thrombosis of right vertebral artery with right-sided hemiparesis in a left-hand dominant patient. tPA administered at critical access hospital 3 hours prior to admission at this medical center. Pt. also has dysphasia from an old CVA 2 years prior to admission. (Handout pages 19-22)

**And the codes are:**

- **I63.011**  CVA due to thrombosis of rt vertebral artery
- **I69.321**  Dysphasia following cerebral infarction
- **G81.93**   Hemiplegia unspec., affecting rt nondominant side
- **Z92.82**   tPA other facility within 24 hrs of admission
I20.0-I25.9 Angina, coronary artery disease, acute MI all fall within this code range.

Generally easier and more efficient than ICD9.

Combination codes eliminate the need for multiple codes.
CAD of native artery with unstable angina:

**I25.110** *Atherosclerotic heart disease of native coronary artery with unstable angina pectoris*

Replaces

**414.01** *Coronary atherosclerosis of native coronary artery*

AND

**411.1** *Intermediate coronary syndrome*
CHANGE: Time period for reporting AMI is 4 WEEKS

- **I21** – AMI codes
  - **I22.0 SUBSEQUENT AMI** Use a code from category **I22** to report a new acute MI that occurs within 4 wks of a prior MI
    - Always coded in conjunction with a code from category **I21**
    - **I22** codes are never used alone

- **I25.2** – OLD MI (i.e. occurring over 4 wks. Ago)

- **Z95.1** - Presence of aortocoronary bypass graft (s/p CABG)
74-year-old man presents with an acute NSTEMI. Patient is 3 weeks out from an anterior wall STEMI involving the left anterior descending coronary artery. The patient was originally diagnosed with CAD 8 years ago and suffered a prior large anterior wall AMI 4 years ago at which time he underwent a 3-vessel CABG. (hint: 5 codes) pgs 23-27

I22.2 – Subsequent NSTEMI
I21.02 – Acute MI of LAD, 4 wks or less duration
I25.10 – Coronary artery disease NOS
I25.2- old MI
Z95.1 - Presence of aortocoronary bypass graft
Chapter 10 – Diseases of the Respiratory System (J00-J99)

Category J45 – ASTHMA
New axes for coding asthma that make more sense

<table>
<thead>
<tr>
<th>Mild</th>
<th>Intermittent</th>
<th>Uncomplicated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>Persistent</td>
<td>Exacerbation</td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td>Status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>asthmaticus</td>
</tr>
</tbody>
</table>
A 10-year-old child presents to her pediatrician’s office with shortness of breath. The provider documents exacerbation of her moderate persistent asthma. (pages 28-30)

And the code is...

**J45.41**- Moderate persistent asthma w/ acute exacerbation
Category J96 – Respiratory failure, not elsewhere classified

Significant reimbursement implications

ICD9: 518.81 – Acute respiratory failure OR respiratory failure NOS

However, ICD-10 has a separate code for respiratory failure, unspecified. (pages 31-32)
VENT TIME

CHANGE: CALCULATION OF MECHANICAL VENT TIME

ICD-10 PCS breaks down mechanical vent time into 3 distinct codes:

5A1935Z - Less than 24 consecutive hrs

5A1945Z - 24-96 consecutive hrs

5A1955Z - Greater than 96 consecutive hrs
The only additional piece of information we need is laterality for sites that are bilateral, such as elbow, ankle, etc.

✓ Site + Stage in one code

**EXAMPLE:** L89.132 – Pressure ulcer rt lower back, stage 2
- Instead of -
  707.03 - Pressure ulcer, lower back
  707.22 - Pressure ulcer stage II
CODE FIRST ANY ASSOCIATED GANCRENE!

- **I96 Gangrene, not elsewhere classified**
  - Gangrenous cellulitis

- **Excludes 1**
  - Gangrene in atherosclerosis of native arteries of the extremities (I70.26)
  - Gangrene in diabetes mellitus (E08-E13)
  - Gangrene in hernia (K40.1, K40.4, K41.1, K41.4, K42.1, K43.1-, K44.1, K45.1, K46.1)
  - Gangrene in other peripheral vascular diseases (I73.-)
  - Gangrene of certain specified sites - see Alphabetical Index
  - Gas gangrene (A48.0)
  - Pyoderma gangrenosum (L88)
Non-pressure chronic ulcer – site, laterality and extent of tissue involved:

- Skin breakdown
- Fat layer exposed
- Necrosis of muscle
- Necrosis of bone

☑ Code first associated underlying condition
☑ Code first any associated gangrene
1. Nonpressure skin ulcer right calf limited to skin breakdown

2. Decubitus ulcer, right upper back stage 2  (handout pages 33-37)

And the codes are:

L97.211- non-pressure chronic ulcer rt calf limited to breakdown of skin
L89.112- pressure ulcer right upper back stage 2
TRIMESTER determines the final character of the code

1st trimester = less than 14 wks 0 days
2nd trimester = 14 wks 0 days to less than 28 wks 0 days
3rd trimester = 28 wks 0 days until delivery

➤ Always assign an ICD-10-PCS procedure when coding delivery admissions

Category Z37 - Outcome of delivery codes required on all delivery admits
Category Z3A - Use additional code from this category to identify the # wks of pregnancy
O80 - Encounter for full term uncomplicated delivery (old 650)
When to Use OB 7TH Characters

The 7th character is only used for complications that most often occur with multiple gestations to identify the fetus affected by the complication. (13 categories)

These are our 7th character choices:

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

These are the code categories:

031, 032, 033.3-033.6, 035, 036, 040, 041, 060.1, 060.2, 064, 069
OB 7th Characters

Use 7th character “0” for

✓ single gestations

✓ When the documentation is insufficient to determine the fetus affected

✓ When it is not clinically possible to determine which fetus is affected.

Example: Pt. with breech presentation, single fetus

O32.1XX0 – maternal care for breech presentation, not applicable or unspecified

Placeholders!
20 weeks - Time frame for differentiating between abortion and fetal death has been reduced from 22 weeks to 20 wks.

20 weeks – Time frame for differentiating early and late vomiting in pregnancy reduced from 22 wks to 20 wks.

Preterm labor: labor occurring prior to 37 completed weeks of gestation
Pregnancy Z Code Categories

**Z32**  Encounter for pregnancy test and childbirth and 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
Let’s Code!

24-wk pregnancy complicated by gestational diabetes:
(pages 40-43)

And the codes are:

O24.410 - GDM in pregnancy, diet-controlled
Z3A.24 - 24 wks gestation of pregnancy
**Category Z38** - Assign a PDX code from this category, Liveborn according to place of birth and type of delivery, for the birth episode of care.

**Z38.00** – single liveborn, vaginal delivery, born in hospital  
**Z38.01** – single liveborn, C-section delivery, born in hospital
Chapter 16: Certain conditions originating in the perinatal period: P00-P96

**P00-P04** - take the place of ICD-9 V29 series of codes

✓ Codes from these categories are used for newborns who are suspected of having an abnormal condition resulting from exposure from the mother or the birth process, **but without signs or symptoms**, and, which after examination and observation, is found not to exist.

✓ Use these codes even if treatment is started for a condition that is ruled out.

➢ Don’t use a code from these categories for infants who have **symptoms** of a suspected problem: code the signs or symptoms instead.
Prematurity and Fetal Growth Retardation–P05-P07

**P05-P07** describe newborn gestational age and weight disorders

Only code if provider documents!

Code selection is based on the recorded birth weight and EGA

When both birth weight and gestational age are known, code both, sequencing the birth weight first.
Newborn delivered by Cesarean section, 34 wks gestational age, birth weight 1900 gm. (pages 44-46)

And the codes are...

Z38.01- single liveborn delivered by C-section
P07.17- low birthwt 1750-1999 gm
P07.37 - Preterm gest age 34 completed wks
NEW: Grouped by BODY PART rather than type of injury

**S** – Various types of injuries related to single body regions

*examples: fractures, open wounds, sprains, concussion*

**T** - Injuries to unspecified body regions, poisonings, other

*examples: venomous bites, poisoning, heat exhaustion*
NEW: 7th Characters, All Injuries

A Initial encounter – used when pt is receiving active treatment
  • surgical treatment, ED treatment, eval by new provider

D Subsequent encounter – Routine f/u care during healing/recovery

S Sequela - Complications or conditions arising from an injury
  Example: Recheck, open wound, left ring finger, routine healing:
  S61.215D
Examples of Injury Codes

S91.322A – Laceration of left heel with foreign body, initial encounter.

S91.322D – Laceration left heel with foreign body, subsequent encounter for routine healing

S91.322S – Laceration left heel with foreign body, subsequent encounter with wound infection

Only change is last character
A Burn is a Burn…
Unless it’s a Corrosion!

Burn codes ➔ thermal burns (except sunburns) caused by a heat source, such as fire, hot appliance, electricity, radiation.

Corrosions ➔ burns due to chemicals.

Guidelines are the same for burns and corrosions in terms of 1st, 2nd, 3rd degree, etc. and extent of body surface involved.
New concept ➔ Underdosing

Taking less of a medication than is prescribed by a provider or a manufacturer's instruction.

✓ T36–T50: Poisoning, Adverse effect of, and Underdosing

✓ NEVER a principal or first-listed dx.

✓ If a patient has a relapse or exacerbation of the condition for which the drug is prescribed because of the reduction in dose, then code the medical condition.

✓ Codes for noncompliance (Z91.12-, Z91.13-) or complication of care (Y63.61, Y63.8–Y63.9) should be used with an underdosing code to indicate intent, if known.
61-year-old woman presents with worsening bacterial pneumonia. She cut her tetracycline dose in half because she could not afford to take it as prescribed. (pages 47-49)

And the codes are:

**J15.9 Unspecified bacterial pneumonia**

**T36.4X6A Underdosing of tetracycline, 1st encounter**

**Z91.1120 Intentional underdosing due to financial hardship**
NEW: Is it a Sprain or a Strain?

Separate code categories for sprains and strains

**SPRAIN** – Joints and ligaments: (e.g. PCL, ACL)

**STRAIN** – Muscles, tendons, fascia (e.g. Achilles tendon)
1. Sprain of the right rotator cuff capsule, initial encounter.
2. Strain of left rotator cuff, routine follow up visit
   (pages 50-51)

And the codes are...

**S43.421A** - Rt rotator cuff sprain initial episode of care

**S46.012D** - Strain of muscle(s) and tendon(s) of rotator cuff of left shoulder
For aftercare of an injury, assign the acute injury code with the 7th character "D" for subsequent encounter.

Examples:

A patient has a displaced, closed fracture of the greater trochanter of the right femur.

✓ Admitted to long-term care for rehabilitation after ORIF: $S72.111D$, Subsequent encounter for closed fracture with routine healing

✓ Discharged from long-term care for continued physical therapy: $S72.111D$, Subsequent encounter for closed fracture with routine healing

✓ Patient to physician office for follow-up visit: $S72.111D$, Subsequent encounter for closed fracture with routine healing
Patient is brought by ambulance to the ED from her home shortly after she sustained a subdural bleed with a documented LOC of 10 minutes after falling down her basement stairs carrying a basket full of laundry. (page 52)

**S06.5X1A** traumatic subdural hemorrhage w/ LOC 30 min or less, initial encounter

**W10.8XXA** fall down stairs, initial encounter

**Y92.018** Other place in private home as place of occurrence of external cause

**Y93.E2** Activity, laundry

THE CAUSE OF INJURY CODE ALSO NEEDS A 7TH CHARACTER FOR EPISODE OF CARE
Glasgow Coma Scale: Subcategory R40.2

- Used to assess level of consciousness
- The Glasgow coma scale codes can be used with traumatic brain injury codes, acute CVA or sequelae of CVA codes.
  - NOT REQUIRED
- Primarily used by trauma registries BUT may be used in any setting
- Sequence after the diagnosis codes.
<table>
<thead>
<tr>
<th>Feature</th>
<th>Scale Responses</th>
<th>Score Notation</th>
</tr>
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<tbody>
<tr>
<td>Eye opening</td>
<td>Spontaneous</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>To speech</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>To pain</td>
<td>2</td>
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<tr>
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<td>None</td>
<td>1</td>
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<tr>
<td>Verbal response</td>
<td>Orientated</td>
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<tr>
<td></td>
<td>Confused conversation</td>
<td>4</td>
</tr>
<tr>
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<td>Words (inappropriate)</td>
<td>3</td>
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<tr>
<td></td>
<td>Sounds (incomprehensible)</td>
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<td>None</td>
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<tr>
<td>Best motor response</td>
<td>Obey commands</td>
<td>6</td>
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<tr>
<td></td>
<td>Localise pain</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Flexion – Normal</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>– Abnormal</td>
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</tr>
<tr>
<td></td>
<td>Extend</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>None</td>
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</tr>
</tbody>
</table>

**TOTAL COMA ‘SCORE’**

3/15 – 15/15
To choose the correct ICD-10-CM code, we need to know:

✔ Laterality when applicable
✔ Specific bone/bones
✔ Displaced or nondisplaced (default is DISPLACED)
✔ Open or closed (default is CLOSED)
✔ Type of visit
7th Characters for Fractures... So Many Choices!

A Initial encounter for closed fx
B Initial encounter for open fx I or II (or open fx NOS)*
C Initial encounter for open fx type IIIA, IIIB or IIIC*
D Subsequent encounter for fx with routine healing
E Subsequent encounter for open fx type I or II, routine*
F Subsequent encounter for open fx type IIIA, IIIB or IIIC*
G Subsequent encounter for fx with delayed healing
H Subsequent encounter for open fx type I or II, delayed healing*
J Subsequent encounter for open fx type IIIA, IIIB or IIIC, delayed healing*

...wait, there’s more!
Fracture Code Extensions, cont.

K Subsequent encounter for fx with nonunion
M Subsequent encounter for open fx type I or II with nonunion*
N Subsequent encounter for open fx type IIIA, IIIB or IIIC*
P Subsequent encounter for fx with malunion
S Sequelae

* These 7th characters only apply to open fractures of the radius, ulna, femur, tib/fib.
Gustilo Open Fracture Classification System

- Most commonly used classification system for open fractures.
- Identifies the severity of soft tissue damage
- Provider must document, coder cannot infer

Expanded 7th character choices in the following code categories capture both type of encounter and Gustilo classification:

**REQUIRED, BUT ONLY FOR THESE 3 CATEGORIES:**

- **S52** (fracture of forearm)
- **S72** (fracture of femur)
- **S82** (fracture of lower leg, including ankle)
<table>
<thead>
<tr>
<th>Gustilo Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Open fracture, clean wound, wound &lt;1 cm in length</td>
</tr>
<tr>
<td>II</td>
<td>Open fracture, wound &gt; 1 cm in length without extensive soft-tissue damage, flaps, avulsions</td>
</tr>
<tr>
<td>III</td>
<td>Open fracture with extensive soft-tissue laceration, damage, or loss or an open segmental fracture. This type also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hr prior to treatment</td>
</tr>
<tr>
<td>IIIA</td>
<td>Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage</td>
</tr>
<tr>
<td>IIIB</td>
<td>Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e. free or rotational flap)</td>
</tr>
<tr>
<td>IIIC</td>
<td>Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury.</td>
</tr>
</tbody>
</table>
17-year-old female brought in from Cannon Mt. to ED via ambulance after she sustained an open Type II fracture of the head of the right radius when she lost control of her skis on some ice and struck another skier who was stopped on the hill below her. (pages 53-54)

**S52.121B** – Displaced fx head rt radius, init. encounter for open dx type I or II

**V00.322A** snow skier colliding with stationary object init. episode

**Y92.39** – other sports and athletic area as place of occurrence

**Y99.8** other external cause status
Did we make it?
Websites & Resources

**CMS**
General ICD-10 Information
http://www.cms.hhs.gov/ICD10

MS-DRG impact
http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/MS_DRG_Conversion_Project.html

ICD-10-PCS Guidelines and codes

**CDC**
Complete ICD-10-CM pdf for download
http://www.cdc.gov/nchs/icd/icd10cm.htm#10update
AHA
* AHA Central Office ICD-10 Resource Center
* [http://www.ahacentraloffice.org/ICD-10](http://www.ahacentraloffice.org/ICD-10)

AHIMA
* ICD-10 General Information
* [http://www.ahima.org/icd10](http://www.ahima.org/icd10)

AAPC
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