

ICD-10-CM Updates - October 1, 2016

KEY CHANGES

- New / Revised / Deleted Codes
- CM Guideline Updates
- Principal Diagnosis Selection
- Reporting Additional Diagnoses
- Diagnostic Coding & Reporting for Outpatient Services
- POA Reporting Guidelines

New/Revised/Deleted Codes

1,943 new diagnosis codes / 422 revised titles / 305 deleted
This is the first update since 2011 when the code freezes for ICD-10 began

CM Guideline Updates

GENERAL UPDATES

Excludes1

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

Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)

- Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, **if applicable**, followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation

"With"

- The word "with" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. **The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. 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 conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.** The word "with" in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

CM Guideline Updates—continued...

Be sure to carefully review and understand the guideline updates for this year. A few key examples:

Code assignment and Clinical Criteria

- The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

Laterality

- Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides), including for the encounter to treat the first side. For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists (e.g., cataract surgery performed on each eye in separate encounters). The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously-treated site. If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.

Documentation of Complications of Care

- Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure, **unless otherwise instructed by the classification**. The guideline extends to any complications of care

-Carefully review all Chapter specific guideline updates!

Principal Diagnosis Selection & Reporting Additional Diagnoses

Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc). **The UHDDS definitions also apply to hospice services (all levels of care).**

Diagnostic Coding & Reporting for Outpatient Services

These coding guidelines for outpatient diagnoses have been approved for use by hospitals/ providers in coding and reporting hospital-based outpatient services and provider-based office visits. **Guidelines in Section I, Conventions, general coding guidelines and chapter-specific guidelines, should also be applied for outpatient services and office visits.** The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis **does not apply to hospital-based outpatient services and provider-based office visits.**

POA Reporting Guidelines

Please see the CDC website for the detailed list of ICD-10-CM codes that do not require the use of a POA indicator ([ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2017/](http://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2017/)). The conditions on this exempt list represent categories and/or codes for circumstances regarding the healthcare encounter or factors influencing health status that do not represent a current disease or injury or are always present on admission.

Codes That Contain Multiple Clinical Concepts

- Assign "N" if at least one of the clinical concepts included in the code was not present on admission (e.g., COPD with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission).
- Assign "Y" if all of the **clinical concepts included in the code** were present on admission (e.g., **duodenal ulcer that perforates prior to admission**).

For infection codes that include the causal organism, assign "Y" if the infection (or signs of the infection) **were** present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with pneumonia and the provider documents *Pseudomonas* as the causal organism a few days later).