Today's discussion

ICD-10-CM Addenda
FY 2018 Guidelines
AHA Coding Clinic for ICD-10-CM and ICD-10-PCS

FY 2018 ICD-10-CM Addenda

ICD-10-CM TABULAR LIST of DISEASES and INJURIES
2018 Addenda

Chapter 1
No Change
No Change: Certain infections and parasitic diseases (A00-B99)
No Change: Intestinal infection diseases (A00-A09)
No Change: AM Other bacterial intestinal infections
No Change: A84.7 Enteroceols due to Clostridium difficile
Add: A84.72 Enteroceols due to C. difficile, recurrent
Add: A84.72 Enteroceols due to C. difficile, not specified as recurrent
FY 2018 ICD-10-CM Addenda

No Change

Chapter 4

Endocrine, nutritional and metabolic diseases (E00-E89)

Diabetes mellitus (E08-E13)

E11 Type 2 diabetes mellitus

Add

E11.1 Type 2 diabetes mellitus with ketoadiabetes

Add

E11.10 Type 2 diabetes mellitus with ketoadiabetes without coma

Add

E11.11 Type 2 diabetes mellitus with ketoadiabetes with coma

FY 2018 ICD-10-CM Addenda

No Change

Other disorders of the nervous system (G80-G99)

G52 Toxic encephalopathy

Add

Code first, if applicable, drug induced (T36-T50)

FY 2018 ICD-10-CM Addenda

No Change

B6 Gangrene, not elsewhere classified

Delete

Excludes 1: gangrene in diabetes mellitus (E09E13 with .Z2)

Add

Excludes 2: gangrene in diabetes mellitus (E09E13 with .Z2)
15. “With”
The word “with” or “in” 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 or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for “acute organ dysfunction that is not clearly associated with the sepsis”).
17. “Code also” note
A "code also" note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. The sequencing depends on the circumstances of the encounter.

Guideline Update FY 2018  I.C.4.a.3

3) Diabetes mellitus and the use of insulin and oral hypoglycemics
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.
An additional code should be assigned from category Z79 to identify the long-term (current) use of insulin or oral hypoglycemic drugs.
If the patient is treated with both oral medications and insulin, only the code for long-term (current) use of insulin should be assigned.
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.

Guideline Update FY 2018  I.C.9.a.11

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.
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, and myocardial infarction due to demand ischemia or secondary to ischemic balance, is assigned to code I21.A1. Myocardial infarction type 2 with a code for the underlying cause is dependent on the circumstances of admission. When a type 2 AMI code 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.

AHA Coding Clinic for ICD-10-CM and ICD-10-PCS

Coding Clinic is the official publication for ICD-10-CM/PCS coding guidelines and advice as designated by the four cooperating parties. The cooperating parties listed below have final approval of the coding advice provided in this publication:

- American Hospital Association
- American Health Information Management Association
- Centers for Medicare & Medicaid Services
- National Center for Health Statistics

Visit www.CodingClinicAdvisor.com

Access to complete text of AHA Coding Clinic for ICD-10-CM and ICD-10-PCS is essential.
As far as previously published advice on documentation is concerned, documentation issues would generally not be unique to ICD-9-CM, and so long as there is nothing new published in Coding Clinic for ICD-10-CM and ICD-10-PCS to replace it, the advice would stand.

Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).
A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses that are to be reported. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

Coding Guidelines Section II

Section II. Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No. 147), pp. 31038-40.
Coding Guidelines Section II

Section II. H. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established.

The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Coding Guidelines Section IV

Section IV. Diagnostic Coding and Reporting Guidelines 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.

Coding Guidelines Section IV

Section IV. H. Uncertain diagnosis

Do not code diagnoses documented as “probable”, “suspected”, “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty.

Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.
Coding Clinic Themes

**Coding Clinic Guidance:**
- educational points
- new guidance
- guidance that is the same as in ICD-9-CM
- reinforces new guidelines
- corrections to the classification
- corrections to previous CCs
- empowerment – CCs allow coders to decide
- complex issues with multiple examples

Coding Clinic Topics

Assigning codes using prior encounters
- Viral Sepsis
- COPD and Pneumonia
- Decompensated CHF
- Preserved/reduced ejection fraction
- Acute MI definition
- Stroke
- Sequela of CVA
- "with" guideline
- Hypertensive heart and kidney disease
- Complications of Diabetes

Assigning Codes Using Prior Encounters  Q3 2013

**Question:**

Is there a guideline or rule that indicates that you should only use the medical record documentation for that specific visit/admission for diagnosis coding purposes?

Does each visit or admission stand alone?

Would the coder go back to previous encounter records to assist in the coding of a current visit or admission?
Assigning Codes Using Prior Encounters Q3 2013

Answer:
Documentation for the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter.
Conditions documented on previous encounters may not be clinically relevant on the current encounter.
The physician is responsible for diagnosing and documenting all relevant conditions. A patient's historical problem list is not necessarily the same for every encounter/visit.
It is the physician's responsibility to determine the diagnoses applicable to the current encounter and document in the patient's record. When reporting recurring conditions and the recurring condition is still valid for the outpatient encounter or inpatient admission, the recurring condition should be documented in the medical record with each encounter/admission.

Assigning Codes Using Prior Encounters Q3 2013

Answer (continued):
However, if the condition is not documented in the current health record, it would be inappropriate to go back to previous encounters to retrieve a diagnosis without physician confirmation.
This is an area where coders and/or department managers may need to educate physicians and/or practice managers on the need to include complete diagnoses when outpatient services are ordered and to continue to document chronic or longstanding conditions on each admission/encounter record.
Please note this advice applies to both ICD-9-CM and ICD-10-CM.

Q3 2016 Sepsis Coding Issues page 8

The AHA Central Office on ICD-10-CM/PCS has received a number of inquiries about the appropriate coding of “viral sepsis.”
The following guidance has been developed to assist coders in classifying viral sepsis.
Viral sepsis is a systemic infection caused by the presence of a virus in the blood. Although sepsis is most commonly caused by bacterial infection, it may also be caused by virus, fungi, and/or parasites.
Sepsis Coding Issues - Viral Sepsis

Assign code **A41.89**, Other specified sepsis, for a diagnosis of viral sepsis.

Although codes in categories A30-A49 classify bacterial illnesses, ICD-10-CM does not provide a specific viral sepsis code, and **A41.89** is the best available option.

Code **B97.89**, Other viral agents as the cause of diseases classified elsewhere, should also be assigned as an additional code to provide further specificity and convey that the sepsis is due to a viral infection, when the specific type of viral infection is not documented.

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

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Sepsis Coding Issues - Viral Sepsis

**A41.89**, Other specified sepsis (best option)

**B97.89** Other viral agents as the cause of diseases classified elsewhere, should also be assigned as an additional code

Add

R65.20, Severe sepsis without septic shock or

R65.21 Severe sepsis with septic shock if documented.

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Viral Sepsis page 10

**Question:**

How would the diagnosis “viral sepsis” be coded in ICD-10-CM?

**Answer:**

Assign codes

**A41.89**, Other specified sepsis, and

**B97.89**, Other viral agents as the cause of diseases classified elsewhere.
**Sepsis secondary to Viral Syndrome**

**Question:**
How would a diagnosis of “sepsis secondary to viral syndrome” be coded?

**Answer:**
Assign codes:
- A41.89, Other specified sepsis, for the viral sepsis along with code
- B34.9, Viral infection, unspecified, for the viral syndrome.

In this case, code B34.9 is assigned rather than code B97.89, because “Syndrome, virus,” is specifically indexed to B34.9.

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**Viral Sepsis due to acute viral bronchitis due to influenza A**

**Question:**
What are the correct ICD-10-CM codes for a provider’s diagnostic statement of “viral sepsis due to acute viral bronchitis due to influenza A?” The sepsis was present on admission.

**Answer:**
Assign codes:
- A41.89, Other specified sepsis, for a diagnosis of sepsis due to influenza A.
- Assign also code J10.1, Influenza due to other identified influenza virus with other respiratory manifestations, and code J20.8, Acute bronchitis due to other specified organisms.

Codes from subcategory J09.X-, Influenza due to identified novel influenza A virus, are intended for a specific strain of influenza A, such as “novel” influenza A, and not the ordinary seasonal influenza A.

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**Coding Influenza**

**December 1, 2016 | Libman Education**

Now that flu season is approaching I would like to offer a friendly reminder as to how to code flu. Remember: Influenza A is not the same as Novel Influenza A.

Influenza A is just plain old influenza and coded to J10-, Influenza due to identified influenza virus or J11-, Influenza due to unidentified influenza virus. Influenza A is often documented as being diagnosed on the basis of a nasal swab.

Novel Influenza A is either H1N1 or H5N1 which are both animal-born influenzas (either swine or bird in origin) and are coded to the J09- category.
**Sepsis due to Lyme disease**  
*Question:* How should sepsis due to Lyme disease be coded?  
*Answer:*  
Assign code:  
**A41.89**, Other specified sepsis, for a diagnosis of sepsis due to Lyme disease. Although codes A30-A49 classify bacterial illnesses, there is no specific code for sepsis due to Lyme disease.  
Assign also code:  
**A69.29**, Other conditions associated with Lyme disease.

**Acute Respiratory Failure due to severe viral sepsis**  
*Question:* How should acute respiratory failure due to severe viral sepsis be coded?  
*Answer:*  
Assign code **A41.89**, Other specified sepsis, for a diagnosis of viral sepsis.  
Assign also codes  
**B97.89**, Other viral agents as the cause of diseases classified elsewhere,  
**R65.20**, Severe sepsis without septic shock, and  
**J96.00**, Acute respiratory failure, unspecified whether with hypoxia or hypercapnia.

**FY 2017 Official Coding Guidelines**  
I.C.1.d.1.b.  
(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.
Question: The patient has chronic obstructive pulmonary disease (COPD), and is admitted to the hospital for treatment of lobar pneumonia. Under code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, there is a note instructing: "Use additional code to identify the infection." Based on this note is the COPD required to be sequenced first?

Answer: Yes, based on the instructional note, the COPD must be sequenced first. Assign code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, as the principal diagnosis. Code J18.1, Lobar pneumonia, unspecified organism, should be assigned as an additional diagnosis.

Use additional code vs code also

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

17. "Code also" note A "code also" note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction. The sequencing depends on the circumstances of the encounter.
Acute Exacerbation of COPD with Pneumonia

**Question:**
What are the diagnosis code assignments for an acute exacerbation of COPD with pneumonia?

**Answer:**
Yes, it is appropriate to assign both codes (J44.0 and J44.1). Either code may be sequenced first, based on the reason for the admission.

Assign codes:
- J44.0, COPD with acute lower respiratory infection, code J18.9, Pneumonia, unspecified organism, and code J44.1, COPD with (acute) exacerbation.

As stated in the ICD-10-CM Official Guidelines for Coding and Reporting in relation to category J44, “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 Exacerbation of COPD with Acute Bronchitis

**Question:**
The patient has an acute exacerbation of chronic obstructive pulmonary disease, and acute bronchitis. What are the diagnosis code assignments?

**Answer:**
Assign codes
- J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection,
- J44.1, Chronic obstructive pulmonary disease with (acute) exacerbation, and
- J20.9, Acute bronchitis, unspecified, to fully capture the provider’s diagnostic statement.

Lower Respiratory Infections Included with COPD

**Question:**
The title of code J44.0 states, “Chronic obstructive pulmonary disease with acute lower respiratory infection.” What infections are included in “lower respiratory infections?”

**Answer:**
Acute bronchitis and pneumonia are included, but influenza is not. Influenza involves both upper and lower respiratory infection. When present with COPD, additional codes should be assigned to specify the infection, such as bronchitis or pneumonia.
**Q1 2017 Aspiration Pneumonia and COPD pg 24**

**Question:**
Does the advice published in *Coding Clinic*, Third Quarter 2016, pages 15-16, regarding COPD and pneumonia apply to all pneumonias, including aspiration pneumonia?
Is the correct sequencing J44.0 and J69.0, in that order,
or would the instructional note not apply to aspiration pneumonia and COPD?

**Answer:**
No, the instructional note at code J44.0, Chronic obstructive pulmonary disease, with acute lower respiratory infection, stating “Use additional code to identify the infection,” does not apply to aspiration pneumonia.
The ICD-10-CM code for aspiration pneumonia does not fall in the “respiratory infection” codes.
**Code J69.0, Pneumonitis due to inhalation of food and vomit, is under the section titled “Lung diseases due to external agents.”**
Aspiration pneumonia is an inflammation of the lungs caused by the inhalation of solid and/or liquid matter.

Assign codes J44.9, Chronic obstructive pulmonary disease, unspecified, and J69.0, Pneumonitis due to inhalation of food and vomit, for a patient with chronic obstructive pulmonary disease and aspiration pneumonia.
**Sequencing of the two conditions will depend on the circumstances of admission.**
Question:
Does the instructional note providing sequencing guidance at code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, apply also to ventilator associated pneumonia?

Answer:
No, the instructional note “Use additional code to identify the infection,” at code J44.0 does not apply to ventilator associated pneumonia. The ICD-10-CM code for ventilator associated pneumonia does not fall in the “respiratory infection” codes. Code J95.851, Ventilator associated pneumonia, is under the section titled “Intraoperative and postprocedural complications and disorders of respiratory system, not elsewhere classified.”

Assign codes J44.9, Chronic obstructive pulmonary disease, unspecified, and J95.851, Ventilator associated pneumonia, for a patient with chronic obstructive pulmonary disease and ventilator associated pneumonia. Sequencing will depend on the circumstances of admission. For example, if the reason for admission is the ventilator associated pneumonia, code J95.851 would be sequenced as principal diagnosis.
**Decompensated Systolic Heart Failure**

**Q2 2013**

**Question:**

*Coding Clinic, Third Quarter 2008, p. 12,* states “decompensated indicates that there has been a flare-up (acute phase) of a chronic condition.”

Should this general definition of decompensated be applied when assigning ICD-10-CM codes as well?

For example, what is the appropriate ICD-10-CM code assignment for a diagnosis of chronic systolic heart failure, currently decompensated?

**Answer:**

Assign code I50.23, Acute on chronic systolic heart failure, for decompensated systolic heart failure.

As previously stated “decompensated” indicates there has been a flare-up (acute phase) of a condition.

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**Q1 2016  HFpEF and HFrEF**

**Question:**

Please reconsider the advice previously published in *Coding Clinic, First Quarter 2014, page 25,* stating that the coder cannot assume either diastolic or systolic failure or a combination of both, based on documentation of heart failure with preserved ejection fraction (HFpEF) or heart failure with reduced ejection fraction (HFrEF).

Would it be appropriate to code diastolic or systolic heart failure when the provider documents HFpEF or HFrEF?
Q1 2016 HFpEF and HFrEF

answer:

Based on additional information received from the American College of Cardiology (ACC), the Editorial Advisory Board for Coding Clinic for ICD-10-CM/PCS has reconsidered previously published advice about coding heart failure with preserved ejection fraction (HFpEF), and heart failure with reduced ejection fraction (HFrEF).

**HFpEF** may also be referred to as heart failure with preserved systolic function, and this condition may also be referred to as **diastolic heart failure**.

**HFrEF** may also be called heart failure with low ejection fraction, or heart failure with reduced systolic function, or other similar terms meaning **systolic heart failure**. These terms HFpEF and HFrEF are more contemporary terms that are being more frequently used, and can be further described as acute or chronic.

Therefore, when the provider has documented HFpEF, HFrEF, or other similar terms noted above, the coder may interpret these as “diastolic heart failure” or “systolic heart failure,” respectively, or a combination of both if indicated, and assign the appropriate ICD-10-CM codes.

**FY 2018 ICD-10-CM Addenda**

<table>
<thead>
<tr>
<th>No Change</th>
<th>150 Heart failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rv to</td>
<td>150.1 Left ventricular failure</td>
</tr>
<tr>
<td>No Change</td>
<td>150.2 Systolic (congestive) heart failure</td>
</tr>
<tr>
<td>Rv to</td>
<td>150.2 Systolic left ventricular failure, unspecified</td>
</tr>
<tr>
<td>Add</td>
<td>Heart failure with reduced ejection fraction (HFpEF)</td>
</tr>
<tr>
<td>Add</td>
<td>Systolic left ventricular heart failure</td>
</tr>
<tr>
<td>Add</td>
<td>Code also end stage heart failure, if applicable (I50.84)</td>
</tr>
<tr>
<td>No Change</td>
<td>150.3 Diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>Rv to</td>
<td>150.3 Diastolic left ventricular heart failure</td>
</tr>
<tr>
<td>Add</td>
<td>Heart failure with normal ejection fraction</td>
</tr>
<tr>
<td>Add</td>
<td>Heart failure with reduced ejection fraction (HFrEF)</td>
</tr>
<tr>
<td>Add</td>
<td>Code also end stage heart failure, if applicable (I50.84)</td>
</tr>
</tbody>
</table>
Question:
A patient, who is three weeks post-acute myocardial infarction, is readmitted for treatment of exacerbated chronic obstructive pulmonary disease and acute bronchitis. During the hospital stay, the patient is continued on cardiac medications. Based on chapter 9 of the ICD-10-CM Official Guidelines for Coding and Reporting would the myocardial infarction still be coded as acute with a code from category I21, or would this be considered history of myocardial infarction?

Answer:
Continue to assign a code from category I21, ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction, as the patient is within four weeks of the initial acute myocardial infarction. The updated ICD-10-CM Official Guidelines for Coding and Reporting for acute myocardial infarction state "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."
Q2 2017 Cerebral Infarction with Hemorrhagic Conversion  pg 10

Question:
A patient was admitted through the ED for sudden onset of weakness and difficulty speaking. The provider diagnosed an ischemic infarction of the left posterior cerebral artery. A repeat CT scan showed hemorrhagic conversion of the left posterior cerebral artery ischemic stroke. What is the diagnosis code assignment for the ischemic infarction with hemorrhagic conversion?

Answer:
Assign code I63.532, Cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery, for the initial infarction as the principal diagnosis and Assign the appropriate code from category I61, Nontraumatic intracerebral hemorrhage, for the hemorrhagic conversion as an additional diagnosis.

Raising the question about how to code sequela(e) of cerebral infarction with hemorrhagic conversion??
Not addressed by Coding Clinic
**Residual Right-Sided Weakness Due to Previous Cerebral Infarction Q1 2015**

**Question:**
The patient is a 72-year-old male admitted to the hospital, because of gastrointestinal bleeding. The provider documented that the patient had a history of acute cerebral infarction with residual right-sided weakness (dominant side), and ordered an evaluation ... What is the appropriate code assignment for residual right-sided weakness, resulting from an old CVA without mention of hemiplegia/hemiparesis?

**Answer:**
Assign code I69.351, Hemiplegia and hemiparesis following cerebral infarction, affecting right dominant side, for the residual right-sided weakness due to cerebral infarction. When unilateral weakness is clearly documented as being associated with a stroke, it is considered synonymous with hemiparesis/hemiplegia. Unilateral weakness outside of this clear association cannot be assumed as hemiparesis/hemiplegia, unless it is associated with some other brain disorder or injury.

**Q2 2017 Encephalopathy associated with CVA pg 9**

**Question:**
A patient is admitted to the hospital due to altered mental status, and is diagnosed with an acute lacunar infarct and encephalopathy secondary to the lacunar infarction. Would the encephalopathy be coded separately or is it considered inherent to the acute lacunar infarct?

**Answer:**
Assign code G93.49, Other encephalopathy, for encephalopathy that occurs secondary to an acute cerebrovascular accident/stroke. Although the encephalopathy is associated with an acute lacunar infarct, it is not inherent, and therefore is coded when it occurs.
Guideline “with”

15. “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.

In other words...

if a subterm in the index says “with” the documentation in the medical record does not have to link the two conditions

Q1 2017 HTN and CHF page 47

Question:
In the guideline for hypertension with heart disease, category I50, Heart failure, is included in the list of heart conditions that are classified as hypertensive heart disease, but it is not included in the Alphabetic Index nor Tabular List. Is congestive heart failure (CHF) in a patient with hypertension coded as hypertensive heart disease with failure, when the provider’s documentation has not explicitly linked the two conditions?
Answer:
Assign code I11.0, Hypertensive heart disease, with failure, along with the appropriate code from category I50, Heart failure, for CHF in a patient with hypertension.
The classification presumes a causal relationship between hypertension and heart involvement unless the provider documents that the conditions are unrelated.

Although heart failure is not in the list of heart conditions in the inclusion note, in ICD-10-CM, there is a note instructing “Use additional code to identify type of heart failure” in the Tabular List.
The code range under category I11, Hypertensive heart failure, is not intended to be an all-inclusive list.
The range of heart conditions in the Alphabetic Index and Tabular List will be considered for future modification through the Coordination and Maintenance Committee.

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-I51.9, are assigned to a code from category I11, Hypertensive heart disease. Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.

ICD-10-CM Index

Hypertension I10
- with
  -- heart involvement (conditions in I51.4 - I51.9) - see Hypertension, heart
  - heart (disease) (conditions in I51.4 - I51.9 due to hypertension) I11.9
    -- with
      --- heart failure (congestive) I11.0

ICD-10-CM Tabular

I11 Hypertensive heart disease

Includes: any condition in I51.4-I51.9 due to hypertension
I11.0 Hypertensive heart disease with heart failure
Hypertensive heart failure

Use additional code to identify type of heart failure (I50.-)
I11.9 Hypertensive heart disease without heart failure
Hypertensive heart disease NOS
Hypertension with Heart Disease

ICD-10-CM Tabular

ISO Heart failure

- Code first heart failure complicating abortion or ectopic or molar pregnancy (000-007, 008.8)
- heart failure due to hypertension (115.8)
- heart failure due to hypertension with chronic kidney disease (I13.-)
- heart failure following surgery (697.13)
- obstetric surgery and procedures (691.4)
- rheumatic heart failure (099.81)

With

Guidelines Section I.A.15

“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.

I.C.9.a.3. page 43

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.
DM with Associated Conditions Q1 2016

Question:
The ICD-10-CM Alphabetic Index entry for 'Diabetes with' includes listings for conditions associated with diabetes, which was not the case in ICD-9-CM.

Does the provider need to document a relationship between the two conditions or should the coder assume a causal relationship?

Answer:
According to the ICD-10-CM Official Guidelines for Coding and Reporting, the term "with" means "associated with" or "due to," when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List, and this is how it's meant to be interpreted when assigning codes for diabetes with associated manifestations and/or conditions.

The classification assumes a cause-and-effect relationship between diabetes and certain diseases of the kidneys, nerves, and circulatory system. Assumed cause-and-effect relationships in the classification are not necessarily the same in ICD-9-CM and ICD-10-CM.

Q1 2017 Uncontrolled DM pg 42

Question:
How is uncontrolled diabetes mellitus (DM) coded in ICD-10-CM? Is uncontrolled the same as "poorly controlled" or "out of control? Currently, only "out of control" and "poorly controlled" diabetes mellitus are coded as diabetes with hyperglycemia.
Answer:
There is no default code for "uncontrolled diabetes." Effective October 1, 2016, uncontrolled diabetes is classified by type and whether it is hyperglycemia or hypoglycemia.

If the documentation is not clear, query the provider for clarification whether the patient has hyperglycemia or hypoglycemia so that the appropriate code may be reported; uncontrolled diabetes indicates that the patient's blood sugar is not at an acceptable level, because it is either too high or too low.

L89 Pressure ulcer
Includes: bed sore
decubitus ulcer
plaster ulcer
pressure area
pressure sore
Code first any associated gangrene (I96)

Z92.8 Personal history of other medical treatment
Z92.81 Personal history of extracorporeal membrane oxygenation (ECMO)
Questions?

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