Understanding the Basics of ICD-10-CM: Part 2

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Objectives

• Understand the major similarities and differences between ICD-9-CM and ICD-10-CM
• Explain the major similarities and differences between the ICD-9-CM and ICD-10-CM Official Guidelines for Coding and Reporting
  – Respiratory
  – Circulatory
  – 7th Character Code Extensions
  – Highlights from other chapters
• Compare the ICD-9-CM and ICD-10-CM codes for a select number of previously published Coding Clinic cases.
Chronic Obstructive Pulmonary Disease [COPD] and Asthma

Acute exacerbation of chronic obstructive bronchitis and asthma

The codes for chronic obstructive bronchitis and asthma 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.

Overlapping nature of the conditions that comprise COPD and asthma

Due to the overlapping nature of the conditions that make up COPD and asthma, there are many variations in the way these conditions are documented. Code selection must be based on the terms as documented. When selecting the correct code for the documented type of COPD and asthma, it is essential to first review the index, and then verify the code in the tabular list. There are many instructional notes under the different COPD subcategories and codes. It is important that all such notes be reviewed to assure correct code assignment.

Acute exacerbation of asthma and status asthmaticus

An acute exacerbation of asthma is an increased severity of the asthma symptoms, such as wheezing and shortness of breath. Status asthmaticus refers to a patient’s failure to respond to therapy administered during an asthmatic episode and is a life threatening complication that requires emergency care. If status asthmaticus is documented by the provider with any type of COPD or with acute bronchitis, the status asthmaticus should be sequenced first. It supersedes any type of COPD including that with acute exacerbation or acute bronchitis. It is inappropriate to assign an asthma code with 5th digit 2, with acute exacerbation, together with an asthma code with 5th digit 1, with status asthmatics. Only the 5th digit 1 should be assigned.

Chronic Obstructive Pulmonary Disease [COPD] and Bronchitis

Acute bronchitis with COPD

Acute bronchitis, code 466.0, is due to an infectious organism. When acute bronchitis is documented with COPD, code 491.22, Obstructive chronic bronchitis with acute bronchitis, should be assigned. It is not necessary to also assign code 466.0. If a medical record documents acute bronchitis with COPD with acute exacerbation, only code 491.22 should be assigned. The acute bronchitis included in code 491.22 supersedes the acute exacerbation. If a medical record documents COPD with acute exacerbation without mention of acute bronchitis, only code 491.21 should be assigned.
J44  Other chronic obstructive pulmonary disease

Includes:  asthma with chronic obstructive pulmonary disease
chronic asthmatic (obstructive) bronchitis
chronic bronchitis with airways obstruction
chronic bronchitis with emphysema
chronic emphysematous bronchitis
chronic obstructive asthma
chronic obstructive bronchitis
chronic obstructive tracheobronchitis

Code also type of asthma, if applicable (J45.-):
ICD-10-CM Codes for COPD

J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection
   Use additional code to identify the infection

J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
   Decompensated COPD
   Decompensated COPD with (acute) exacerbation
   Excludes2: chronic obstructive pulmonary disease [COPD] with acute bronchitis (J44.0)

J44.9 Chronic obstructive pulmonary disease, unspecified
   Chronic obstructive airway disease NOS
   Chronic obstructive lung disease NOS
ICD-10-CM Codes for Asthma

**J45 Asthma**

Includes: Allergic (predominantly) asthma
- Allergic bronchitis NOS
- Allergic rhinitis with asthma
- Atopic asthma
- Extrinsic allergic asthma
- Hay fever with asthma
- Idiosyncratic asthma
- Intrinsic nonallergic asthma
- Nonallergic asthma
J45.2 Mild intermittent asthma  
   J45.20 Mild intermittent asthma, uncomplicated  
   Mild intermittent asthma NOS  
   J45.21 Mild intermittent asthma with (acute) exacerbation  
   J45.22 Mild intermittent asthma with status asthmaticus  

J45.3 Mild persistent asthma  
   J45.30 Mild persistent asthma, uncomplicated  
   Mild persistent asthma NOS  
   J45.31 Mild persistent asthma with (acute) exacerbation  
   J45.32 Mild persistent asthma with status asthmaticus  

J45.4 Moderate persistent  
   J45.40 Moderate persistent, uncomplicated  
   Moderate persistent asthma NOS  
   J45.41 Moderate persistent with (acute) exacerbation  
   J45.42 Moderate persistent with status asthmaticus  

J45.5 Severe persistent  
   J45.50 Severe persistent, uncomplicated  
   Severe persistent asthma NOS  
   J45.51 Severe persistent with (acute) exacerbation  
   J45.52 Severe persistent with status asthmaticus
J45.9 Other and unspecified asthma

J45.90 Unspecified asthma
Asthmatic bronchitis NOS
Childhood asthma NOS
Late onset asthma
J45.901 Unspecified asthma with (acute) exacerbation
J45.902 Unspecified asthma with status asthmaticus
J45.909 Unspecified asthma, uncomplicated
   Asthma NOS

J45.99 Other asthma
J45.990 Exercise induced bronchospasm
J45.991 Cough variant asthma
J45.998 Other asthma
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.
Question:
What is the appropriate code assignment for acute exacerbation of COPD, acute bronchitis and acute exacerbation of asthma?

Answer:
Assign code 491.22, Obstructive chronic bronchitis, with acute bronchitis, and code 493.22, Chronic obstructive asthma with (acute) exacerbation, for acute exacerbation of COPD, acute bronchitis and acute exacerbation of asthma.

Answer with ICD-10-CM:
Assign code J44.0, Chronic obstructive pulmonary disease with acute lower respiratory infection, for the COPD with acute bronchitis; code J44.1, Chronic obstructive pulmonary disease with (acute) exacerbation, for the acute exacerbation of COPD; and code J45.901, Unspecified asthma with (acute) exacerbation, for the acute exacerbation of asthma.
Acute Respiratory Failure as Principal Diagnosis

**ICD-9-CM**

Code 518.81, Acute 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.

**ICD-10-CM**

Code J96.0, Acute respiratory failure, or code 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 Respiratory Failure as Principal Diagnosis

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**ICD-10-CM**
Code J96.0, Acute respiratory failure, or code 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.

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Consistent across ICD-9-CM and ICD-10-CM:

- 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.

- Sequencing of acute respiratory failure and another acute 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.
Question:
When acute respiratory failure is present on admission along with aspiration or bacterial pneumonia and both conditions are equally treated can either condition be sequenced as the principal diagnosis?

For example, a 90-year-old nursing home resident was admitted to the hospital with shortness of breath, elevated white blood cell count, and bibasilar infiltrates. The provider diagnosed aspiration pneumonia and acute respiratory failure and both conditions were present on admission. Intravenous antibiotics were administered, oxygen therapy was provided and her clinical condition improved. Due to the possibility of chronic obstructive pulmonary disease (COPD), she was started on Advair. After the patient experienced a few runs of paroxysmal supraventricular tachycardia, Metoprolol therapy was initiated. The patient was transferred to the SNF in stable condition following an uneventful hospital course. Which diagnosis should be sequenced as the principal diagnosis, aspiration pneumonia or acute respiratory failure?
Answer:
In this case, sequence either code 507.0, [J69.0] Pneumonitis due to inhalation of food or vomitus, or code 518.81, [J96.0] Acute respiratory failure, as the principal diagnosis. The Official Guidelines for Coding and Reporting regarding two or more diagnoses that equally meet the definition for principal diagnosis state, "In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first."

*Coding Clinic, First Quarter 2008 Pages: 18 to 19*
Influenza Due to Certain Identified Viruses
Guidelines

ICD-9-CM

Code only confirmed cases of avian influenza (codes 488.01-488.02, 488.09, Influenza due to identified avian influenza virus) or novel H1N1 influenza virus (H1N1 or swine flu, code 488.11-488.12, 488.19). This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).

ICD-10-CM

Code only confirmed cases of avian influenza (code J09.0-, Influenza due to identified avian influenza virus) or novel H1N1 or swine flu, code J09.1-. This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).
Influenza Due to Certain Identified Viruses Guidelines (cont.)

Consistent across ICD-9-CM and ICD-10-CM:
In this context, “confirmation” does not require documentation of positive laboratory testing specific for avian or novel H1N1 influenza. However, coding should be based on the provider’s diagnostic statement that the patient has avian or novel H1N1 (H1N1 or swine flu) influenza.

**ICD-9-CM**
If the provider records “suspected or possible or probable avian or novel H1N1 influenza (H1N1 or swine flu),” the appropriate influenza code from category 487 should be assigned. A code from category 488, Influenza due to certain identified influenza viruses, should not be assigned.

**ICD-10-CM**
If the provider records “suspected or possible or probable avian influenza,” the appropriate influenza code from category J10, Influenza due to other influenza virus, should be assigned. A code from category J09, Influenza due to certain identified influenza viruses, should not be assigned.
Complications in ICD-9-CM

- Most complications are classified to the 996-999 series, Complications of surgical and medical care NEC
- Exceptions are:
  - Complications of an esophagostomy, gastrostomy, colostomy and enterostomy (classified to chapter 9, Diseases of the digestive system)
Complications in ICD-10-CM

- 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.
- Examples, categories:
  - D78 Intraoperative and postprocedural complications of spleen
  - E89 Postprocedural endocrine and metabolic complications and disorders, not elsewhere classified
  - H59 Intraoperative and postprocedural complications and disorders of eye and adnexa, not elsewhere classified
  - J95 Intraoperative and postprocedural complications and disorders of respiratory system, not elsewhere classified
• 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 but 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.

• Patient admitted with pneumonia and develops VAP
  – 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.
Question:
A patient is diagnosed with ventilator associated pneumonia due to Klebsiella pneumoniae. How should this be coded?

Answer:
Hypertension Table
The Hypertension Table, found under the main term, “Hypertension”, in the Alphabetic Index, contains a complete listing of all conditions due to or associated with hypertension and classifies them according to malignant, benign, and unspecified.
Circulatory System Guidelines – Hypertension (cont.)

• **ICD-9-CM**

  **Hypertension, Essential, or NOS**
  Assign hypertension (arterial) (essential) (primary) (systemic) (NOS) to category code 401 with the appropriate fourth digit to indicate malignant (.0), benign (.1), or unspecified (.9). Do not use either .0 malignant or .1 benign unless medical record documentation supports such a designation.

• **ICD-10-CM**

  No need for guideline paralleling ICD-9-CM. Essential hypertension is classified to code I10. No additional digits needed. No distinction between malignant, benign, etc.

<table>
<thead>
<tr>
<th>I10 Essential (primary) hypertension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes: high blood pressure</td>
</tr>
<tr>
<td>hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)</td>
</tr>
</tbody>
</table>
Heart conditions (425.8, 429.0-429.3, 429.8, 429.9) are assigned to a code from category 402 when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category 428 to identify the type of heart failure in those patients with heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and congestive heart failure.

Heart conditions classified to I50.- or I51.4-I51.9, are assigned to, a code from **category I11, Hypertensive heart disease**, when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category I50, Heart failure, to identify the type of heart failure in those patients with heart failure.
“Congestive” is an nonessential modifier in the heart failure codes, rather than a separate unique code like in ICD-9-CM (428.0).

**I50.2 Systolic (congestive) heart failure**
- Excludes1: combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)
  - I50.20 Unspecified systolic (congestive) heart failure
  - I50.21 Acute systolic (congestive) heart failure
  - I50.22 Chronic systolic (congestive) heart failure
  - I50.23 Acute on chronic systolic (congestive) heart failure

**I50.3 Diastolic (congestive) heart failure**
- Excludes1: combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)
  - I50.30 Unspecified diastolic (congestive) heart failure
  - I50.31 Acute diastolic (congestive) heart failure
  - I50.32 Chronic diastolic (congestive) heart failure
  - I50.33 Acute on chronic diastolic (congestive) heart failure
Consistent across ICD-9-CM and ICD-10-CM:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>The same heart conditions (425.8, 429.0-429.3, 429.8, 429.9) with hypertension, but without a stated causal relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.</td>
<td>The same heart conditions (I50.-, I51.4-I51.9) with hypertension, but without a stated causal relationship, are coded separately. Sequence according to the circumstances of the admission/encounter.</td>
</tr>
</tbody>
</table>
### ICD-9-CM

Assign codes from category 403, Hypertensive chronic kidney disease, when conditions classified to category 585 or code 587 are present with hypertension. Unlike hypertension with heart disease, ICD-9-CM presumes a cause-and-effect relationship and classifies chronic kidney disease (CKD) with hypertension as hypertensive chronic kidney disease.

Fifth digits for category 403 should be assigned as follows:
- 0 with CKD stage I through stage IV, or unspecified.
- 1 with CKD stage V or end stage renal disease.

### ICD-10-CM

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. Unlike hypertension with heart disease, ICD-10-CM presumes a cause-and-effect relationship and classifies chronic kidney disease with hypertension as hypertensive chronic kidney disease.
I12 Hypertensive chronic kidney disease

Includes: any condition in N18.- due to hypertension
arteriosclerosis of kidney
arteriosclerotic nephritis (chronic) (interstitial)
hypertensive nephropathy
nephrosclerosis

Excludes1: hypertension due to kidney disease (I15.0, I15.1)
renovascular hypertension (I15.0)
secondary hypertension (I15.-)

Excludes2: acute kidney failure (N17.-)

I12.0 Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6)

I12.9 Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease

Hypertensive chronic kidney disease NOS
Hypertensive renal disease NOS
Use additional code to identify the stage of chronic kidney disease (N18.1-N18.4, N18.9)
Consistent across ICD-9-CM and ICD-10-CM:

**ICD-9-CM**

The appropriate code from category 585, Chronic kidney disease, should be used as a secondary code with a code from category 403 to identify the stage of chronic kidney disease.

**ICD-10-CM**

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.

**ICD-10-CM Guideline:**

If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.
N18 Chronic kidney disease (CKD)
   Code first any associated:
   - hypertensive chronic kidney disease (I12.-, I13.-)
   Use additional code to identify kidney transplant status, if applicable, (Z94.0)
N18.1 Chronic kidney disease, stage I
N18.2 Chronic kidney disease, stage II (mild)
N18.3 Chronic kidney disease, stage III (moderate)
N18.4 Chronic kidney disease, stage IV (severe)
N18.5 Chronic kidney disease, stage V
   Excludes1: chronic kidney disease, stage V requiring chronic dialysis (N18.6)
N18.6 End stage renal disease
   Chronic kidney disease requiring chronic dialysis
   Use additional code to identify dialysis status (Z99.2)
N18.9 Chronic kidney disease, unspecified
   Chronic renal disease
   Chronic renal failure NOS
   Chronic renal insufficiency
   Chronic uremia
   Renal disease NOS
### ICD-9-CM

Assign codes from combination category 404, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated. Assign an additional code from category 428, to identify the type of heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and congestive heart failure.

### ICD-10-CM

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis. Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated. If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.
Fifth digits for category 404 should be assigned as follows:

0 without heart failure and with chronic kidney disease (CKD) stage I through stage IV, or unspecified
1 with heart failure and with CKD stage I through stage IV, or unspecified
2 without heart failure and with CKD stage V or end stage renal disease
3 with heart failure and with CKD stage V or end stage renal disease

The appropriate code from category 585, Chronic kidney disease, should be used as a secondary code with a code from category 404 to identify the stage of kidney disease.

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.
ICD-10-CM Guideline:

• 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 an additional code for acute renal failure is required.
Consistent across ICD-9-CM and ICD-10-CM:

**ICD-9-CM**
First assign codes from 430-438, Cerebrovascular disease, then the appropriate hypertension code from categories 401-405.

**ICD-10-CM**
For hypertensive cerebrovascular disease, first assign the appropriate code from categories I60-I69, followed by the appropriate hypertension code.
Circulatory System Guidelines – Hypertensive Retinopathy Disease

ICD-9-CM

Two codes are necessary to identify the condition. First assign the code from subcategory 362.11, Hypertensive retinopathy, then the appropriate code from categories 401-405 to indicate the type of hypertension.

ICD-10-CM

Code H35.0, Hypertensive retinopathy, should be used with code I10, Essential (primary) hypertension, to include the systemic hypertension. The sequencing is based on the reason for the encounter.
Consistent across ICD-9-CM and ICD-10-CM:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
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<tbody>
<tr>
<td>Two codes are required: one to identify the underlying etiology and one from category 405 to identify the hypertension. Sequencing of codes is determined by the reason for admission/encounter.</td>
<td>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.</td>
</tr>
</tbody>
</table>
I15 Secondary hypertension
Code also underlying condition
Excludes1: postprocedural hypertension (I97.3)
Excludes2: secondary hypertension involving vessels of brain (I60-I69)
    secondary hypertension involving vessels of eye (H35.0)

I15.0 Renovascular hypertension
I15.1 Hypertension secondary to other renal disorders
I15.2 Hypertension secondary to endocrine disorders
I15.8 Other secondary hypertension
I15.9 Secondary hypertension, unspecified
**Circulatory System Guidelines – Transient Hypertension**

**Consistent across ICD-9-CM and ICD-10-CM:**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Assign code 796.2, Elevated blood pressure reading without diagnosis of hypertension, unless patient has an established diagnosis of hypertension. Assign code 642.3x for transient hypertension of pregnancy.</td>
<td>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.-, Gestational [pregnancy-induced] hypertension with significant proteinuria, for transient hypertension of pregnancy.</td>
</tr>
</tbody>
</table>
Controlled and Uncontrolled Hypertension

Consistent across ICD-9-CM and ICD-10-CM:

**ICD-9-CM**

**Hypertension, Controlled**
Assign appropriate code from categories 401-405. This diagnostic statement usually refers to an existing state of hypertension under control by therapy.

**Hypertension, Uncontrolled**
Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign the appropriate code from categories 401-405 to designate the stage and type of hypertension. Code to the type of hypertension.

**ICD-10-CM**

**Hypertension, Controlled**
This diagnostic statement usually refers to an existing state of hypertension under control by therapy. Assign code I10.

**Hypertension, Uncontrolled**
Uncontrolled hypertension may refer to untreated hypertension or hypertension not responding to current therapeutic regimen. In either case, assign code I10.
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.
I25.11 Atherosclerotic heart disease of native coronary artery with angina pectoris

I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
   Excludes1: unstable angina without atherosclerotic heart disease (I20.0)

I25.111 Atherosclerotic heart disease of native coronary artery with angina pectoris with documented spasm
   Excludes1: angina pectoris with documented spasm without atherosclerotic heart disease (I20.1)

I25.118 Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
   Excludes1: other forms of angina pectoris without atherosclerotic heart disease (I20.8)

I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
   Atherosclerotic heart disease with angina NOS
   Atherosclerotic heart disease with ischemic chest pain
   Excludes1: unspecified angina pectoris without atherosclerotic heart disease (I20.9)
ICD-10-CM Sample Codes: Atherosclerosis Coronary Artery Bypass Graft, Unspecified, and Angina

I25.70 Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris
  I25.700 Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris
    Excludes 1: unstable angina pectoris without atherosclerosis of coronary artery bypass graft (I20.0)
  I25.701 Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm
    Excludes 1: angina pectoris with documented spasm without atherosclerosis of coronary artery bypass graft (I20.1)
  I25.708 Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris
    Excludes 1: other forms of angina pectoris without atherosclerosis of coronary artery bypass graft (I20.8)
  I25.709 Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris
    Excludes 1: unspecified angina pectoris without atherosclerosis of coronary artery bypass graft (I20.9)
I25.71 Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris
  I25.710 Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris
    Excludes1: unstable angina without atherosclerosis of autologous vein coronary artery bypass graft(s) (I20.0)
  I25.711 Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm
    Excludes1: angina pectoris with documented spasm without atherosclerosis of autologous vein coronary artery bypass graft(s) (I20.1)
  I25.718 Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris
    Excludes1: other forms of angina pectoris without atherosclerosis of autologous vein coronary artery bypass graft(s) (I20.8)
  I25.719 Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris
    Excludes1: unspecified angina pectoris without atherosclerosis of autologous vein coronary artery bypass graft(s) (I20.9)
ICD-10-CM Sample Codes: Atherosclerotic Autologous Artery Coronary Artery Bypass and Angina

I25.72 Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris
    Atherosclerosis of internal mammary artery graft with angina pectoris
      I25.720 Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris
          Excludes1: unstable angina without atherosclerosis of autologous artery coronary artery bypass graft(s) (I20.0)
      I25.721 Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm
          Excludes1: angina pectoris with documented spasm without atherosclerosis of autologous artery coronary artery bypass graft(s) (I20.1)
      I25.728 Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris
          Excludes1: other forms of angina pectoris without atherosclerosis of autologous artery coronary artery bypass graft(s) (I20.8)
      I25.729 Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris
          Excludes1: unspecified angina pectoris without atherosclerosis of autologous artery coronary artery bypass graft(s) (I20.9)
ICD-10-CM Sample Codes: Atherosclerotic Nonautologous Biological Coronary Artery Bypass Graft(s) and Angina

I25.73 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris

I25.730 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris

Excludes1: unstable angina without atherosclerosis of nonautologous biological coronary artery bypass graft(s) (I20.0)

I25.731 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm

Excludes1: angina pectoris with documented spasm without atherosclerosis of nonautologous biological coronary artery bypass graft(s) (I20.1)

I25.738 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris

Excludes1: other forms of angina pectoris without atherosclerosis of nonautologous biological coronary artery bypass graft(s) (I20.8)

I25.739 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris

Excludes1: unspecified angina pectoris without atherosclerosis of nonautologous biological coronary artery bypass graft(s) (I20.9)
I25.75 Atherosclerosis of native coronary artery of transplanted heart with angina pectoris

Excludes1: atherosclerosis of native coronary artery of transplanted heart without angina pectoris (I25.811)

I25.750 Atherosclerosis of native coronary artery of transplanted heart with unstable angina
I25.751 Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm
I25.758 Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris
I25.759 Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris
I25.76 Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris

   Excludes1: atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris (I25.812)
I25.760 Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina
I25.761 Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm
I25.768 Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris
I25.769 Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris
ICD-10-CM Sample Codes: Atherosclerosis Other Coronary Bypass Graft(s) and Angina

I25.79 Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris

I25.790 Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris
   Excludes 1: unstable angina without atherosclerosis of other coronary artery bypass graft(s) (I20.0)

I25.791 Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm
   Excludes 1: angina pectoris with documented spasm without atherosclerosis of other coronary artery bypass graft(s) (I20.1)

I25.798 Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris
   Excludes 1: other forms of angina pectoris without atherosclerosis of other coronary artery bypass graft(s) (I20.8)

I25.799 Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris
   Excludes 1: unspecified angina pectoris without atherosclerosis of other coronary artery bypass graft(s) (I20.9)
A patient was admitted to the hospital with unstable angina and was treated in the hospital with intravenous nitrate therapy. After stabilization, the patient, while still in the hospital, underwent a diagnostic cardiac catheterization and was proved to have atherosclerotic heart disease. The patient subsequently was weaned off the nitroglycerin drip and placed on intensified antianginal therapy and was discharged home symptom-free without further therapeutic interventions.
The unstable angina led to the admission and is therefore the principal diagnosis. The underlying disease, coronary atherosclerosis, 414.0, is also reported.

Principal diagnosis:
- 411.1 Intermediate coronary syndrome

Additional diagnosis:
- 414.0 Coronary atherosclerosis [414.01 Coronary atherosclerosis of native coronary artery, as of 10/1/94]

ICD-10-CM
I25.110, Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
ICD-9-CM Guideline: Postoperative Cerebrovascular Accident

• A cerebrovascular hemorrhage or infarction that occurs as a result of medical intervention is coded to 997.02, iatrogenic cerebrovascular infarction or hemorrhage. Medical record documentation should clearly specify the cause-and-effect relationship between the medical intervention and the cerebrovascular accident in order to assign this code. A secondary code from the code range 430-432 or from a code from subcategories 433 or 434 with a fifth digit of “1” should also be used to identify the type of hemorrhage or infarct.

• This guideline conforms to the use additional code note instruction at category 997. Code 436, Acute, but ill-defined, cerebrovascular disease, should not be used as a secondary code with code 997.02.
ICD-10-CM Guideline: 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.
For intraoperative or postprocedural cerebrovascular infarction:
1. Determine whether intra or post operative
2. Cardiac surgery or other type of surgery

I97.8 Other intraoperative and postprocedural complications and disorders of the circulatory system, not elsewhere classified
Use additional code, if applicable, to further specify disorder
   I97.81 Intraoperative cerebrovascular infarction
   I97.810 Intraoperative cerebrovascular infarction during cardiac surgery
   I97.811 Intraoperative cerebrovascular infarction during other surgery
   I97.82 Postprocedural cerebrovascular infarction
   I97.820 Postprocedural cerebrovascular infarction during cardiac surgery
   I97.821 Postprocedural cerebrovascular infarction during other surgery
For intraoperative cerebrovascular hemorrhage complicating a nervous system procedure:

**G97.3 Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating a procedure**

Excludes1: intraoperative hemorrhage and hematoma of a nervous system organ or structure due to accidental puncture and laceration during a procedure (G97.4-)

**G97.31 Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating a nervous system procedure**

**G97.32 Intraoperative hemorrhage and hematoma of a nervous system organ or structure complicating other procedure**

Other similar codes in other body system chapters depending on system where procedure was performed.
Consistent across ICD-9-CM and ICD-10-CM:

- **Category 438, Late Effects of Cerebrovascular disease**
  Category 438 is used to indicate conditions classifiable to categories 430-437 as the causes of late effects (neurologic deficits), themselves classified elsewhere. These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to 430-437. 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 430-437.

- **Category I69, Sequelae of Cerebrovascular disease**
  Category **I69** is used to indicate conditions classifiable to categories **I60-I67** as the causes of late effects (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**.
<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
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<tr>
<td><strong>Codes from category 438 with codes from 430-437</strong>&lt;br&gt;Codes from category 438 may be assigned on a health care record with codes from 430-437, if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA</td>
<td><strong>Codes from category I69 with codes from I60-I67</strong>&lt;br&gt;Codes from category I69 may be assigned on a health care record with codes from I60-I67, if the patient has a current cerebrovascular accident (CVA) and deficits from an old CVA.</td>
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Consistent across ICD-9-CM and ICD-10-CM:

**ICD-9-CM**

**Code V12.54**
Assign code V12.54, Transient ischemic attack (TIA), and cerebral infarction without residual deficits (and not a code from category 438) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.

**ICD-10-CM**

**Code Z86.73**
Assign code Z86.73, Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits (and not a code from category I69) as an additional code for history of cerebrovascular disease when no neurologic deficits are present.
Consistent across ICD-9-CM and ICD-10-CM:

**ICD-9-CM**
ST elevation myocardial infarction (STEMI) and non ST elevation myocardial infarction (NSTEMI)
The ICD-9-CM codes for acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories 410.0-410.6 and 410.8 are used for ST elevation myocardial infarction (STEMI). Subcategory 410.7, Subendocardial infarction, is used for non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs.

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

Consistent across ICD-9-CM and ICD-10-CM:

**ICD-9-CM**

**Acute myocardial infarction, unspecified**
Subcategory 410.9 is the default for the unspecified term acute myocardial infarction. If only STEMI or transmural MI without the site is documented, query the provider as to the site, or assign a code from subcategory 410.9.

**ICD-10-CM**

**Acute myocardial infarction, unspecified**
Code I21.3, ST elevation (STEMI) myocardial infarction of unspecified site, is the default for the unspecified term acute myocardial infarction. If only STEMI or transmural MI without the site is documented, query the provider as to the site, or assign code I21.3.
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. If NSTEMI evolves to STEMI, assign the STEMI code. If STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI.
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 an 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.
ICD-10-CM Category I22 Tabular List

I22 Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction

Includes: acute myocardial infarction occurring within four weeks (28 days) of a previous acute myocardial infarction, regardless of site of cardiac infarction, coronary (artery) embolism, coronary (artery) occlusion, coronary (artery) rupture, coronary (artery) thrombosis, infarction of heart, myocardium, or ventricle, recurrent myocardial infarction, reinfarction of myocardium, rupture of heart, myocardium, or ventricle.

Note: A code from category I22 must be used in conjunction with a code from category I21. The I22 code should be sequenced first, if it the reason for encounter, or, it should be sequenced after the I21 code if the subsequent MI occurs during the encounter for the initial MI.
The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.

- Should a patient who is in the hospital due to an AMI have a subsequent AMI while still in the hospital code I21 would be sequenced first as the reason for admission, with code I22 sequenced as a secondary code.
- Should a patient have a subsequent AMI after discharge for care of an initial AMI, and the reason for admission is the subsequent AMI, the I22 code should be sequenced first followed by the I21. An I21 code must accompany an I22 code to identify the site of the initial AMI, and to indicate that the patient is still within the 4 week time frame of healing from the initial AMI.

The guidelines for assigning the correct I22 code are the same as for the initial AMI.
• I22.0 Subsequent ST elevation (STEMI) myocardial infarction of anterior wall
• I22.1 Subsequent ST elevation (STEMI) myocardial infarction of inferior wall
• I22.2 Subsequent non-ST elevation (NSTEMI) myocardial infarction
• I22.8 Subsequent ST elevation (STEMI) myocardial infarction of other sites
• I22.9 Subsequent ST elevation (STEMI) myocardial infarction of unspecified site
Overview of Other Major ICD-10-CM Guideline Differences

• Chapter 6: Diseases of Nervous System and Sense Organs (G00-G99)
  – Dominant/nondominant side
• Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
  – Site and laterality
  – Bone versus joint
Overview of Other ICD-10-CM Guideline Differences

• Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00-T88)
  – 7th character code extensions
  – Burns and corrosions
  – Combination codes including substances related to adverse effects, poisonings, toxic effects and underdosing, as well as the external cause into single code
  – A code from categories T36-T65 is sequenced first, followed by the code(s) that specify the nature of the adverse effect, poisoning, or toxic effect.
  – Underdosing
Most categories in chapter 19 have 7th character extensions that are required for each applicable code. Most categories in this chapter have three extensions (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela.

- Extension “A”, initial encounter is used while the patient is receiving active treatment for the injury. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.
- Extension “D” subsequent encounter is used for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase. Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following injury treatment.

- The aftercare Z codes should not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the 7th character “D” (subsequent encounter).
Extension “S”, sequela, is for use for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequelae of the burn. When using extension “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 “S” extension identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.
S00  Superficial injury of head

Excludes1: diffuse cerebral contusion (S06.2-)
focal cerebral contusion (S06.3-)
injury of eye and orbit (S05.-)
open wound of head (S01.-)
The appropriate 7th character is to be added to each code from category S00

A  initial encounter
D  subsequent encounter
S  sequela

S00.0  Superficial injury of scalp
S00.00  Unspecified superficial injury of scalp
S00.01  Abrasion of scalp
S00.02  Blister (nonthermal) of scalp
S00.03  Contusion of scalp
  Bruise of scalp
  Hematoma of scalp
S00.04  External constriction of part of scalp
S00.05  Superficial foreign body of scalp
  Splinter in the scalp
S00.06  Insect bite (nonvenomous) of scalp
S00.07  Other superficial bite of scalp
  Excludes1: open bite of scalp (S01.05)
S02 Fracture of skull and facial bones
Code also any associated intracranial injury (S06.-)
The appropriate 7th character is to be added to each code from category S02
A fracture not indicated as open or closed should be coded to closed
A  initial encounter for closed fracture
B  initial encounter for open fracture
D  subsequent encounter for fracture with routine healing
G  subsequent encounter for fracture with delayed healing
K  subsequent encounter for fracture with nonunion
S  sequela
S02.0 Fracture of vault of skull
Fracture of frontal bone
Fracture of parietal bone
The open fracture designations are based on the Gustilo open fracture classification:

A  initial encounter for closed fracture
B  initial encounter for open fracture type I or II
C  initial encounter for open fracture type IIIA, IIIB, or IIIC
D  subsequent encounter for closed fracture with routine healing
E  subsequent encounter for open fracture type I or II with routine healing
F  subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
G  subsequent encounter for closed fracture with delayed healing
H  subsequent encounter for open fracture type I or II with delayed healing
J  subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
K  subsequent encounter for closed fracture with nonunion
M  subsequent encounter for open fracture type I or II with nonunion
N  subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
P  subsequent encounter for closed fracture with malunion
Q  subsequent encounter for open fracture type I or II with malunion
R  subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
S  sequela
The ICD-10-CM distinguishes 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.
T23 Burn and corrosion of wrist and hand
The appropriate 7th character is to be added to each code from category T23
A initial encounter
D subsequent encounter
S sequela

T23.0 Burn of unspecified degree of wrist and hand
Use additional external cause code to identify the source, place and intent of the burn
(X00-X19, X75-X77, X96-X98, Y92)

T23.00 Burn of unspecified degree of hand, unspecified site
T23.001 Burn of unspecified degree of right hand, unspecified site
T23.002 Burn of unspecified degree of left hand, unspecified site
T23.009 Burn of unspecified degree of unspecified hand, unspecified site

T23.01 Burn of unspecified degree of thumb (nail)
T23.011 Burn of unspecified degree of right thumb (nail)
T23.012 Burn of unspecified degree of left thumb (nail)
T23.019 Burn of unspecified degree of unspecified thumb (nail)
T26  Burn and corrosion confined to eye and adnexa
   The appropriate 7th character is to be added to each code from category T26
      A  initial encounter
      D  subsequent encounter
      S  sequela
T26.0  Burn of eyelid and periocular area
   Use additional external cause code to identify the source, place and intent
      of the burn (X00-X19, X75-X77, X96-X98, Y92)
T26.00  Burn of eyelid and periocular area, unspecified side
T26.01  Burn of right eyelid and periocular area
T26.02  Burn of left eyelid and periocular area
Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances (T36-T50)

Includes:
- poisoning is defined as:
- overdose of substances
- wrong substance given or taken in error
- adverse effect is defined as:
  "hypersensitivity", "reaction", etc. of correct substance properly administered
- underdosing is defined as:
  taking less of a medication than is prescribed or instructed by the manufacturer, whether inadvertently or deliberately
T36  Poisoning by, adverse effect of and underdosing of systemic antibiotics
   Excludes1: antineoplastic antibiotics (T45.1-)
       locally applied antibiotic NEC (T49.0)
       topically used antibiotic for ear, nose and throat (T49.6)
       topically used antibiotic for eye (T49.5)
   The appropriate 7th character is to be added to each code from category T36
       A  initial encounter
       D  subsequent encounter
       S  sequela

T36.0  Poisoning by, adverse effect of and underdosing of penicillins
   T36.0x Poisoning by, adverse effect of and underdosing of penicillins
   T36.0x1  Poisoning by penicillins, accidental (unintentional)
   Poisoning by penicillins NOS
   T36.0x2  Poisoning by penicillins, intentional self-harm
   T36.0x3  Poisoning by penicillins, assault
   T36.0x4  Poisoning by penicillins, undetermined
   T36.0x5  Adverse effect of penicillins
   T36.0x6  Underdosing of penicillins
• Chapter 20: External Causes of Morbidity (V01-Y95)
  – Use of 7th character extensions
  – Combination external cause codes
  – Place of Occurrence Guideline
    • Use place of occurrence code Y92.9 if the place is not stated or is not applicable
  – Activity Codes
    • Use activity code Y93.9 if the activity of the patient is not stated or is not applicable.
• Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer’s instruction. For underdosing, assign the code from categories T36-T50 (fifth or sixth character “6”).
• 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-) or complication of care (Y63.61, Y63.8-Y63.9) codes are to be used with an underdosing code to indicate intent, if known.
Noncompliance Z Codes

Z91.12 Patient's intentional underdosing of medication regimen
   Code first underdosing of medication (T36-T50) with fifth or sixth character 6
   Excludes1: adverse effect of prescribed drug taken as directed- code to adverse effect poisoning (overdose) -code to poisoning

Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
Z91.128 Patient's intentional underdosing of medication regimen for other reason

Z91.13 Patient's unintentional underdosing of medication regimen
   Code first underdosing of medication (T36-T50) with fifth or sixth character 6
   Excludes1: adverse effect of prescribed drug taken as directed- code to adverse effect poisoning (overdose) -code to poisoning

Z91.130 Patient's unintentional underdosing of medication regimen due to age-related debility
Z91.138 Patient's unintentional underdosing of medication regimen for other reason
Y63     Failure in dosage during surgical and medical care
Excludes2: accidental overdose of drug or wrong drug given in error (T36-T50)
Y63.0   Excessive amount of blood or other fluid given during transfusion or infusion
Y63.1   Incorrect dilution of fluid used during infusion
Y63.2   Overdose of radiation given during therapy
Y63.3   Inadvertent exposure of patient to radiation during medical care
Y63.4   Failure in dosage in electroshock or insulin-shock therapy
Y63.5   Inappropriate temperature in local application and packing
Y63.6   Underdosing and nonadministration of necessary drug, medicament or biological substance
  Y63.61  Underdosing of necessary drug, medicament or biological substance
  Y63.62  Nonadministration of necessary drug, medicament or biological substance
Y63.8   Failure in dosage during other surgical and medical care
Y63.9   Failure in dosage during unspecified surgical and medical care