ICD-10-CM Official Guidelines for Coding & Reporting

- CHANGES FOR FY2023
- Guideline I.A.19 (p. 12)
- Code assignment and Clinical Criteria
- The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis. If there is conflicting medical record documentation, query the provider.

ICD-10-CM Official Guidelines for Coding & Reporting (cont.)

- I.B.14. Documentation by Clinicians Other than the Patient's Provider. Code assignment is based on the documentation by the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis).
- These exceptions include codes for:
  - Body Mass Index (BMI)
  - Depth of non-pressure chronic ulcers
  - Pressure ulcer stage
  - Coma scale
  - NIH stroke scale (NIHSS)
  - Social determinants of health (SDOH)
  - Laterality
  - Blood alcohol level
  - Underimmunization status
- The BMI, coma scale, NIHSS, blood alcohol level codes, codes for social determinants of health and underimmunization status should only be reported as secondary diagnoses.
- See Section I.C.21.c.17. for additional information regarding coding social determinants of health

This change was released in April 2022, so in case you missed this change, it is here.

ICD-10-CM Official Guidelines for Coding & Reporting (cont.)

- Guideline I.B.16. (p. 16)
- Documentation of Complications of Care. Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure, unless otherwise instructed by the classification. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and **the condition, and the documentation must support that the condition is clinically significant. It is not necessary for the provider to explicitly document the term "complication." For example, if the condition alters the course of the surgery as documented in the operative report, then it would be appropriate to report a complication code.** Query the provider for clarification **if the documentation is not clear as to the relationship between the condition and the care or procedure.**

Chapter Guideline: Chapter 1 Infectious Diseases

- Selection and sequencing of HIV codes
- (a) Patient admitted for HIV-related condition If a patient is admitted for an HIV-related condition, the principal diagnosis should be B20, Human immunodeficiency virus [HIV] disease followed by additional diagnosis codes for all reported HIV-related conditions. An exception to this guideline is if the reason for admission is hemolytic-uremic syndrome associated with HIV disease. Assign code D59.31, Infection-associated hemolytic-uremic syndrome, followed by code B20, Human immunodeficiency virus [HIV] disease.
- HIV managed by antiretroviral medication If a patient with documented HIV disease, **HIV-related illness or AIDS** is currently managed on antiretroviral medications, assign code B20, Human immunodeficiency virus [HIV] disease. Code Z79.899, Other long term (current) drug therapy, may be assigned as an additional code to identify the long-term (current) use of antiretroviral medications

New ICD-10-CM codes for Hemolytic-uremic Syndrome FY2023.

Chapter 1 Infectious Diseases (cont.)

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

Important Sequencing Instruction.

Chapter Guideline: Chapter 2 Neoplasm

- I.C.2.a. ***Admission/Encounter for treatment of primary site***
- If the malignancy **is chiefly responsible for occasioning the patient admission/encounters and treatment is directed at the primary site,** designate the **primary** malignancy as the principal/**first-listed** diagnosis.
- The only exception to this guideline is if the administration of chemotherapy, immunotherapy or external beam radiation therapy **is chiefly responsible for occasioning the admission/encounter. In that case,** assign the appropriate Z51.-- code as the first-listed or principal diagnosis, and the **underlying** diagnosis or problem for which the service is being performed as a secondary diagnosis.
- **NEW**
- **I.C.2.t. Secondary malignant neoplasm of lymphoid tissue**
- **When a malignant neoplasm of lymphoid tissue metastasizes beyond the lymph nodes, a code from categories C81-C85 with a final character "9" should be assigned identifying "extranodal and solid organ sites" rather than a code for the secondary neoplasm of the affected solid organ. For example, for metastasis of B-cell lymphoma to the lung, brain and left adrenal gland, assign code C83.39, Diffuse large B-cell lymphoma, extranodal and solid organ sites.**

Admission referring to inpatient, encounter meaning outpatient.

Chapter Guideline: Chapter 4

- Diabetes mellitus and the use of insulin, oral hypoglycemics, and injectable non-insulin drugs
- If the patient is treated with both oral **hypoglycemic drugs** and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs should be assigned.
- If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long term (current) use of insulin, and **Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.**
- If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long term (current) use of oral hypoglycemic drugs, **and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.**

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Chapter Guideline: Chapter 5 Mental, Behavioral and Neurodevelopmental disorders

- **NEW**
- **d. Dementia**
- **The ICD-10-CM classifies dementia (categories F01, F02, and F03) on the basis of the etiology and severity (unspecified, mild, moderate or severe). Selection of the appropriate severity level requires the provider's clinical judgment and codes should be assigned only on the basis of provider documentation (as defined in the Official Guidelines for Coding and Reporting), unless otherwise instructed by the classification. If the documentation does not provide information about the severity of the dementia, assign the appropriate code for unspecified severity.**
- **If a patient is admitted to an inpatient acute care hospital or other inpatient facility setting with dementia at one severity level and it progresses to a higher severity level, assign one code for the highest severity level reported during the stay.**

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Chapter Guideline: Chapter 15

- **NEW**
- **7) Completed weeks of gestation**
- **In ICD-10-CM, "completed" weeks of gestation refers to full weeks. For example, if the provider documents gestation at 39 weeks and 6 days, the code for 39 weeks of gestation should be assigned, as the patient has not yet reached 40 completed weeks.**
- **NEW**
- **4) Hemorrhage following elective abortion**
- **For hemorrhage post elective abortion, assign code O04.6, Delayed or excessive hemorrhage following (induced) termination of pregnancy. Do not assign code O72.1, Other immediate postpartum hemorrhage, as this code should not be assigned for post abortion conditions. Do not assign code Z33.2, Encounter for elective termination of pregnancy, when the patient experiences a complication post elective abortion**.

Chapter Guideline: Chapter 20

- Use of Z05 codes
- Assign a code from category Z05, Observation and evaluation of newborn for suspected **diseases and** conditions ruled out, to identify those instances when a healthy newborn is evaluated for a suspected condition**/disease** that is determined after study not to be present. Do not use a code from category Z05 when the patient **is documented to have** signs or symptoms of a suspected problem; in such cases code the sign or symptom.
- (c) Underdosing
- Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer's instruction. Discontinuing the use of a prescribed medication on the patient's own initiative (not directed by the patient's provider) is also classified as an underdosing. For underdosing, assign the code from categories T36-T50 (fifth or sixth character "6").
- **Documentation of a change in the patient's condition is not required in order to assign an underdosing code. Documentation that the patient is taking less of a medication than is prescribed or discontinued the prescribed medication is sufficient for code assignment.**

Chapter Guideline: Chapter 20

- Z71 Persons encountering health services for other counseling and medical advice, not elsewhere classified
- **Code Z71.87, Encounter for pediatric-to-adult transition counseling, should be assigned when pediatric-to-adult transition counseling is the sole reason for the encounter or when this counseling is provided in addition to other services, such as treatment of a chronic condition. If both transition counseling and treatment of a medical condition are provided during the same encounter, the code(s) for the medical condition(s) treated and code Z71.87 should be assigned, with sequencing depending on the circumstances of the encounter**.
- 17) Social Determinants of Health
- Codes describing **problems or risk factors related to** social determinants of health (SDOH) should be assigned when this information is documented. **Assign as many SDOH codes as are necessary to describe all of the problems or risk factors. These codes should be assigned only when the documentation specifies that the patient has an associated problem or risk factor. For example, not every individual living alone would be assigned code Z60.2, Problems related to living alone.**

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Official Guidelines

- SECTION II: Selection of Principal Diagnosis –NO CHANGES for FY2023
- SECTION III: Reporting Additional Diagnoses –NO CHANGES for FY2023
- SECTION IV: Diagnostic Coding and Reporting Guidelines for Outpatient Services –NO CHANGES for FY2023
- APPENDIX I –Present on Admission Reporting Guidelines –NO CHANGES for FY2023

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