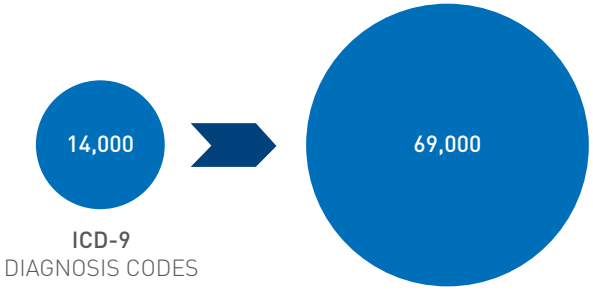
NUMBER OF CODES



ICD-9
DIAGNOSIS CODES

ICD-10
DIAGNOSIS CODES

CODE STRUCTURE

ICD-9-CM CODE FORMAT

CATEGORY — ETIOLOGY, ANATOMIC SITE, MANIFESTATION

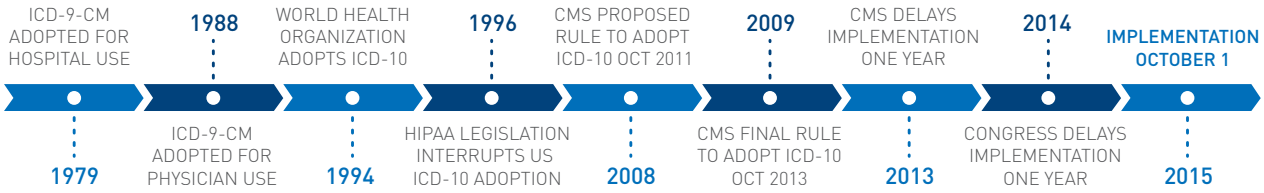
3 TO 5 CHARACTERS
FIRST DIGIT IS NUMERIC OR **E** OR **V**
ALL OTHER DIGITS ARE NUMERIC

ICD-10-CM CODE FORMAT

CATEGORY — ETIOLOGY, ANATOMIC SITE, MANIFESTATION — EXTENSION

1 TO 7 CHARACTERS
FIRST DIGIT IS ALPHA
ALL DIGITS EXCEPT SECOND ALPHA OR NUMERIC

ICD-10 HISTORY



Common Pathology Diagnoses:
ICD-9 to ICD-10 Mapping

Pathology Diagnoses: ICD-9 to ICD-10 Mapping

Introduction

ICD-10 CM coding for pathology needs increased levels of specificity that should be included in physician documentation. This document provides an overview of the top diagnosis codes for pathology and the critical changes in ICD-10 that may impact coding and claim submission.

The table on the next page shows 3 categories of changes that impact documentation:

1) Diagnoses that require specificity that must be included before claims can be submitted for payment. **If a coder receives documentation without the specificity, it must be returned to the provider for additional information**. This category is highlighted in red.

2) Diagnoses that request specificity, but "unspecified" or "other" codes are available as a default. Because the intention of ICD-10 is to capture additional detail, it is unclear whether payers will accept "unspecified" codes or if they will be denied or delayed. Therefore, we encourage providers to include the detail in their documentation; the claim will only be returned to the provider in the event of a denial from the payer. This category is highlighted in yellow.

   Conditions which generally provide a straightforward 1-to-1 transition from ICD-9 to ICD-10. No change to the documentation is required. **This category is highlighted in green.**

Subsequent pages highlight common pathology diagnoses and the specific documentation requirements and issues that impact documentation when converting from ICD-9 to ICD-10.

ICD10 Change	Condition	Documentation Requirements
Critical: Must be Included in Documentation	**Encounter/Episode of Care**	Episode of care must be included for injuries, poisonings and other conditions. Designations include initial, subsequent, sequela. There is no "not otherwise specified" or "unspecified" option; the code must include the episode of care to be complete.
	Fracture Type	Additional details related to fracture type must be included, such as whether the fracture is open or closed, as well as details about the healing phase whether healing is routine or with complications such as delayed healing, nonunion or malunion. Open fractures should include the Gustillo open fracture classification. There is no "not otherwise specified" option.
Important: Codes provide "Unspecified" option but lack of specificity may result in delayed or denied payments by payor.	**Site Specificity**	Greater level of specificity required, including: * Specific area of limb (calf, ankle, etc) * Specific quadrant of breast or area of chest wall Unspecified codes are available.
	Laterality	Identify right/left/bilateral/unilateral limb, body location when available. Unspecified codes are available.
	Primary/Post Traumatic/ Secondary	Conditions such as osteoarthritis, urethritis, and other UTI diagnoses should include whether it is primary, secondary, or post-traumatic.
	Type of Tear	Type of tear needed. Examples for cartilage/meniscus (bucket-handle, peripheral, complex) or rotator cuff (incomplete/complete). "Unspecified" and "Other" codes are available.
	Patient History	Neoplasm screening should include applicable patient history resulting in need for service
	Disease Type	Type and origin of the disease should be included for diagnoses such as hypertension, COPD, and hyperlipedemia.
	Acute V Chronic	Conditions such as respiratory or digestive orders should be designated as "acute" or "chronic"
1-to-1 conversion from ICD9 to ICD10; no additional documentation required	**Normal or C-section birth/delivery**	1-to-1 correlation for this diagnosis code is available
	Calculus of gallbladder or kidney	With some exceptions, there is typically a 1-to-1 correlation for most diagnosis codes

Acute Pancreatitis

Coding for acute pancreatitis in ICD-10 requires additional specificity regarding the cause of the disease, as illustrated below. Note that "other" and "unspecified" codes are available.

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Acute pancreatitis	577.0	K85	Category: Acute Pancreatitis
		K85.0	Idiopathic acute pancreatitis
		K85.1	Biliary acute pancreatitis
		K85.2	Alcohol induced acute pancreatitis
		K85.3	Drug induced acute pancreatitis
		K85.8	Acute pancreatitis, other
		K85.9	Acute pancreatitis, unspecified

Colon Screenings

ICD-10 has greater specificity for the specific location of benign neoplasms. Here is an example of the level of specificity. Please note that colon polyp has been given its own separate code.

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Benign neoplasm of colon	211.3	D12.0	Category: Benign neoplasm of colon, rectum, anus and anal canal
		D12.0	Benign neoplasm of cecum
		D12.1	Benign neoplasm of appendix
		D12.2	Benign neoplasm of ascending colon
		D12.3	Benign neoplasm of transverse colon
		D12.4	Benign neoplasm of descending colon
		D12.5	Benign neoplasm of sigmoid colon
		D12.6	Benign neoplasm of colon, unspecified
		K63.5	Polyp of colon

Diverticulitis of Intestine/Colon

ICD-10 coding for diverticulitis of the intestine requires additional specificity regarding the absence/presence of perforation, abscess, and/or bleeding, as noted here:

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Diverticulitis of intestine	562	K57	Category: Diverticular disease of intestine
		K57.00	Diverticulitis of small intestine with perforation and abscess without bleeding
		K57.01	Diverticulitis of small intestine with perforation and abscess with bleeding
		K57.12	Diverticulitis of small intestine without perforation or abscess without bleeding
		K57.13	Diverticulitis of small intestine without perforation or abscess with bleeding
		K57.20	Diverticulitis of large intestine with perforation and abscess without bleeding
		K57.21	Diverticulitis of large intestine with perforation and abscess with bleeding
		K57.32	Diverticulitis of large intestine without perforation or abscess without bleeding
		K57.33	Diverticulitis of large intestine without perforation or abscess with bleeding
		K57.40	Diverticulitis of both small and large intestine with perforation and abscess without bleeding
		K57.41	Diverticulitis of both small and large intestine with perforation and abscess with bleeding
		K57.52	Diverticulitis of both small and large intestine without perforation or abscess without bleeding
		K57.53	Diverticulitis of both small and large intestine without perforation or abscess with bleeding
		K57.80	Diverticulitis of intestine, part unspecified, with perforation and abscess without bleeding
		K57.81	Diverticulitis of intestine, part unspecified, with perforation and abscess with bleeding
		K57.92	Diverticulitis of intestine, part unspecified, without perforation or abscess without bleeding
		K57.93	Diverticulitis of intestine, part unspecified, without perforation or abscess with bleeding

Gynecological Examination

Many of the standard encounters for gynecological examinations offer a 1-to-1 transition from ICD-9 to ICD-10. One exception includes a routine gynecological examination, which requests detail regarding with / without abnormal findings.

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Gynecological Examination	**V72.3**	**Z01.41**	**Encounter for Routine Gynecological Examination**
Routine gynecological examination	V72.31	Z01.411	Encounter for gynecological examination (general) (routine) with abnormal findings
		Z01.419	Encounter for gynecological examination (general) (routine) without abnormal findings
Encounter for Papanicolaou cervical smear to confirm findings of recent normal smear following initial abnormal smear	V72.32	Z01.42	Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear

Hemorrhoids

In ICD-10, Hemorrhoids are categorized by degree of severity from 1st to 4th degree, as demonstrated in the table below. ICD-10 does provide an "Other" category if the degree is not documented. This example of the ICD-9 to ICD-10 transition is for internal hemorrhoids w/out mention of complication.

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Hemorrhoids	**455**	**K64**	**Hemorrhoids and perianal venous thrombosis**
Internal hemorrhoids w/out mention of complication	455.0	K64.8	Other hemorrhoids
		K64.0	1st degree hemorrhoids
		K64.1	2nd degree hemorrhoids
		K64.2	3rd degree hemorrhoids
		K64.3	4th degree hemorrhoids

Post-Operative Infection

As with diagnoses related to injuries, post-operative infections must include the episode of care (initial, subsequent, sequela). Below is an example.

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Postoperative Infection	**998.5**		
	998.51	T81.4XXA	Initial encounter
		T81.4XXD	Subsequent encounter
		T81.4XXS	Sequela

Osteomyelitis

Documentation for proper coding of osteomyelitis should include specificity in two areas:

- Laterality. Documentation should include right / left side of body affected.
- Acute/subacute/chronic condition should be included in the documentation.

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Osteomyelitis	730	M86.04	Osteomyelitis – Hand
Acute osteomyelitis, hand	730.04	M86.041	Acute hematogenous – right hand
		M86.042	Acute hematogenous – left hand
		M86.049	Acute hematogenous – unspecified
		M86.141	Other acute osteomyelitis – right hand
		M86.142	Other acute osteomyelitis – left hand
		M86.149	Other acute osteomyelitis – unspecified hand
		M86.241	Subacute osteomyelitis – right hand
		M86.242	Subacute osteomyelitis – left hand
		M86.249	Subacute osteomyelitis – unspecified hand
Chronic osteomyelitis, hand	730.14	M86.341	Chronic multifocal osteomyelitis – right hand
		M86.342	Chronic multifocal osteomyelitis – left hand
		M86.349	Chronic multifocal osteomyelitis – unspecified
		M86.441	Chronic osteomyelitis w/draining sinus – right hand
		M86.442	Chronic osteomyelitis w/draining sinus – left hand
		M86.449	Chronic osteomyelitis w/draining sinus – unspecified
		M86.541	Other chronic hematogenous osteomyelitis – right hand
		M86.542	Other chronic hematogenous osteomyelitis – left hand
		M86.549	Other chronic hematogenous osteomyelitis – unspecified
		M86.641	Other chronic osteomyelitis – right hand
		M86.642	Other chronic osteomyelitis – left hand
		M86.649	Other chronic osteomyelitis – unspecified

Sarcoidosis

New in ICD-10 is the requirement to specify where the sarcoidosis is located. Below is an example of the level of detail requested. Note that there are "unspecified" or "other sites" options available.

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Sarcoidosis	**135**	**D86**	
		D86.9	unspecified
		D86.0	Of Lung
		D86.1	Of lymph nodes
		D86.2	Of lung and lymph nodes
		D86.3	Of skin
Of other sites		D86.8	
		D86.81	Sarcoid Meningitis
		D86.82	Multiple cranial nerve palsies
		D86.83	iridocyclitis
		D86.84	pyelonephritis
		D86.85	myocarditis
		D86.86	arthropathy
		D86.87	myositis
		D86.89	Of other sites

Ulcers

Documentation for treating ulcers of the limb requires two different types of specificity in ICD-10:

- **Site Specificity.** Documentation should include the specific area of the body impacted. For example, in ICD-9, Ulcer of the limb was acceptable. In ICD-10, documentation should provide the detail required to identify the specific area of the limb (i.e, thigh, calf, ankle).
- **Laterality**. In addition to site specificity, documentation should include the specific side of the body impacted (right ankle, left calf).

When reporting ulcers using ICD-10-CM, the severity of the ulcer should be documented. For nonpressure ulcers, the following levels should be included in the documentation:

- **Limited to breakdown of skin**
- **Fat layer exposed**
- **With Necrosis of muscle**
- **With Necrosis of bone**
- **With unspecified severity**

For pressure ulcers, severity should use the National Pressure Ulcer Advisory Panel (NPUAP) stages 1-4 and unstageable, listed here:

- **Stage 1:** Pressure pre-ulcer skin changes limited to persistent focal edema
- **Stage 2:** Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
- **Stage 3:** Pressure ulcer with full thickness skin loss involving damage or necrosis if subcutaneous tissue
- **Stage 4 :** Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone
- **Unstageable:** Based on clinical documentation pressure ulcers are those "whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma."
- **Unspecified:** The ICD-10-CM unspecified coding option is not considered a part of the NPUAP staging but is provided for reporting when the documentation is insufficient to assign a more specific code.

The Draft Guidelines note that if the documentation does not provide enough information to stage the pressure ulcer, the provider should be queried. Pressure ulcers are not reported if they are documented as healed.

Below is an example of the transition from ICD-9 to ICD-10 adding site specificity, laterality and pressure ulcer stage:

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Pressure Ulcer of ankle	707.06	L89.5	Category: Pressure ulcer of ankle
		L89.500	Pressure ulcer of unspecified ankle, unstageable
		L89.501	Pressure ulcer of unspecified ankle, stage 1
		L89.502	Pressure ulcer of unspecified ankle, stage 2
		L89.503	Pressure ulcer of unspecified ankle, stage 3
		L89.504	Pressure ulcer of unspecified ankle, stage 4
		L89.509	Pressure ulcer of unspecified ankle, unspecified stage
		L89.510	Pressure ulcer of right ankle, unstageable
		L89.511	Pressure ulcer of right ankle, stage 1
		L89.512	Pressure ulcer of right ankle, stage 2
		L89.513	Pressure ulcer of right ankle, stage 3
		L89.514	Pressure ulcer of right ankle, stage 4
		L89.519	Pressure ulcer of right ankle, unspecified stage
		L89.520	Pressure ulcer of left ankle, unstageable
		L89.521	Pressure ulcer of left ankle, stage 1
		L89.522	Pressure ulcer of left ankle, stage 2
		L89.523	Pressure ulcer of left ankle, stage 3
		L89.524	Pressure ulcer of left ankle, stage 4
		L89.529	Pressure ulcer of left ankle, unspecified stage

Non-specific Abnormal Findings in Cerebrospinal Fluid

ICD-10 requires additional specificity and detail for abnormal findings, as noted in this example and excerpt. Please note that "Other" or "Unspecified" codes are available.

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Nonspecific abnormal findings in body substances	**792**	**R83**	
Cerebrospinal fluid	792.0	R83.9	Unspecified finding
		R83.0	Abnormal level enzymes
		R83.1	Abnormal level Hormones
		R83.2	Abnormal level other drugs, medicaments, biological substances
		R83.3	Abnormal level substances chiefly nonmedicinal
		R83.4	Abnormal findings immunological
		R83.5	Abnormal findings microbiological
		R83.6	Abnormal findings cytological
		R83.8	Other abnormal findings
Stool contents	792.1	R19.5	Other Fecal abnormalities
Semen	792.2	R86.9	From specimens from male genital organs
		R86.0	Abnormal level enzymes
		R86.1	Abnormal level Hormones
		R86.2	Abnormal level other drugs, medicaments, biological substances
		R86.3	Abnormal level substances chiefly nonmedicinal
		R86.4	Abnormal findings immunological
		R86.5	Abnormal findings microbiological
		R86.6	Abnormal findings cytological
		R86.7	Histological findings from male genital organs
		R86.8	Other abnormal findings