

# Summary of Changes

## Revised ICD-9-CM Coding Guidelines FY 2011

### Effective October 1, 2011

On August 11, 2011, the Centers for Medicare and Medicaid Services (CMS) released a revision to the *Official ICD-9-CM Guidelines for Coding and Reporting*. The following is a summary of the changes made to the guidelines.

**Bold type** indicates the revised text of each of the sections below. Please review the complete *Official ICD-9-CM Guidelines for Coding and Reporting*.

The majority of the revisions were made to clarify the use of the new codes created for 2011 or to clarify existing guidelines. A **Discussion Point** is added in the case of new or revised guidance that reflects a significant change in coding practices.

### Section I. Conventions, general coding guidelines and chapter specific guidelines

#### B. General Guidelines

##### 12. Late effects

A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury. Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.

**Exceptions** to the above guidelines are those instances where the code for the late effect is followed by a manifestation code identified in the Tabular List and title, or the late effect code has been expanded (at the fourth and fifth-digit levels) to include the manifestation(s) **or the classification instructs otherwise**.

##### 18. 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. 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 an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.**

### Section I. Conventions, general coding guidelines and chapter specific guidelines

#### C. Chapter-Specific Coding Guidelines

##### 1. Chapter 1: Infectious and Parasitic Diseases (001-139)

(b) Septicemia, Systemic Inflammatory Response Syndrome (SIRS), Sepsis, Severe Sepsis, and Septic Shock

6) Septic shock

(a) **Sequencing of septic shock and postprocedural septic shock**

For cases of septic shock, the code for the systemic infection should be sequenced first, followed by codes 995.92, **Severe sepsis** and 785.52, **Septic shock or 998.02, Postoperative septic shock**. Any additional codes for other acute organ dysfunctions should also be assigned. As noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

##### (b) **Septic shock and postprocedural septic shock without documentation of severe sepsis**

**Since septic shock indicates the presence of severe sepsis, code 995.92, Severe sepsis, must be assigned with code 785.52, Septic shock, or code 998.02 Postoperative shock, septic, even if the term severe sepsis is not documented in the record.**

##### 10) Sepsis due to a postprocedural infection

##### (b) Sepsis due to postprocedural infection

In cases of postprocedural sepsis, the complication code, such as code 998.59, Other postoperative infection, or 674.3x, Other complications of obstetrical surgical wounds should be coded first followed by the appropriate sepsis codes (systemic infection code and either code 995.91 or 995.92). An additional code(s) for any acute organ dysfunction should also be assigned for cases of severe sepsis.

**See Section see Section I.C.1.b.6 if the sepsis or severe sepsis results in postprocedural septic shock.**

##### (c) **Postprocedural infection and postprocedural septic shock**

**In cases where a postprocedural infection has occurred and has resulted in severe sepsis and postprocedural septic shock, the code for the precipitating complication such as code 998.59, Other postoperative infection, or 674.3x, Other complications of obstetrical surgical wounds should be coded first followed by the appropriate sepsis codes (systemic infection code and code 995.92). Code 998.02, Postoperative septic shock, should be assigned as an additional code. In cases of severe sepsis, an additional code(s) for any acute organ dysfunction should also be assigned.**

##### 2. Chapter 2: Neoplasms (140-239)

##### c. Coding and sequencing of complications

##### 1) Anemia associated with malignancy

When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, Anemia in neoplastic disease) is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy.

Code 285.22 may also be used as a secondary code if the patient suffers from anemia and is being treated for the malignancy.

~~Code 285.22, Anemia in neoplastic disease, and code 285.3, Antineoplastic chemotherapy induced anemia, may both be~~ If anemia in neoplastic disease and anemia due to antineoplastic chemotherapy are both documented, **assign codes for both conditions**

4. Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)
  - a. Anemia of chronic disease
    - 2) Anemia in neoplastic disease
 

When assigning code 285.22, Anemia in neoplastic disease, it is also necessary to assign the neoplasm code that is responsible for the anemia. Code 285.22 is for use for anemia that is due to the malignancy, not for anemia due to antineoplastic chemotherapy drugs. Assign **the appropriate code 285.3** for anemia due to antineoplastic chemotherapy.
6. Chapter 6: Diseases of Nervous System and Sense Organs (320-389)
  - b. **Glaucoma**
    - 1) **Glaucoma**

**For types of glaucoma classified to subcategories 365.1-365.6, an additional code should be assigned from subcategory 365.7, Glaucoma stage, to identify the glaucoma stage. Codes from 365.7, Glaucoma stage, may not be assigned as a principal or first-listed diagnosis.**
    - 2) **Bilateral glaucoma with same stage**

**When a patient has bilateral glaucoma and both are documented as being the same type and stage, report only the code for the type of glaucoma and one code for the stage.**
    - 3) **Bilateral glaucoma stage with different stages**

**When a patient has bilateral glaucoma and each eye is documented as having a different stage, assign one code for the type of glaucoma and one code for the highest glaucoma stage.**
    - 4) **Bilateral glaucoma with different types and different stages**

**When a patient has bilateral glaucoma and each eye is documented as having a different type and a different stage, assign one code for each type of glaucoma and one code for the highest glaucoma stage.**
    - 5) **Patient admitted with glaucoma and stage evolves during the admission**

**If a patient is admitted with glaucoma and the stage progresses during the admission, assign the code for highest stage documented.**
    - 6) **Indeterminate stage glaucoma**

**Assignment of code 365.74, Indeterminate stage glaucoma, should be based on the clinical documentation. Code 365.74 is used for glaucoma whose stage cannot be clinically determined. This code should not be confused with code 365.70, Glaucoma stage, unspecified. Code 365.70 should be assigned when there is no documentation regarding the stage of the glaucoma.**

**Discussion Point:** This new guidance specifies when it is appropriate to assign an indeterminate stage of glaucoma, how to handle bilateral glaucoma conditions at different stages and of different types, and evolving glaucoma during admission.

8. Chapter 8: Diseases of Respiratory System (460-519)
  - d. Influenza due to certain identified viruses

Code only confirmed cases of avian influenza (codes 488.01-488.02, 488.09, Influenza due to identified avian influenza virus), ~~or novel 2009 H1N1 influenza virus (H1N1 or swine flu, code codes 488.11-488.12, 488.19), or novel influenza A (codes 488.81-488.82, 488.89, Influenza due to identified novel influenza A virus).~~ This is an exception to the hospital inpatient guideline Section II, H. (Uncertain Diagnosis).

In this context, "confirmation" does not require documentation of positive laboratory testing specific for avian, **2009 H1N1** or novel influenza **A virus**. However, coding should be based on the provider's diagnostic statement that the patient has avian **influenza, 2009 H1N1 influenza**, or novel influenza **A**.

If the provider records "suspected" or "possible" or "probable" avian, ~~or novel 2009 H1N1, or novel H1N1 influenza A (H1N1 or swine)~~, the appropriate influenza code from category 487, **Influenza due to certain identified influenza viruses**, should be assigned. A code from category 488, Influenza due to certain identified influenza viruses, should not be assigned.

17. Chapter 17: Injury and Poisoning (800-999)
  - f. Complications of care
    - 1) General guidelines for complications of care
      - (a) Documentation of complications of care
 

~~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.~~

**See Section I.B.18. for information on documentation of complications of care.**
      - (b) **Use additional code to identify nature of complication**

**An additional code identifying the complication should be assigned with codes in categories 996-999, Complications of Surgical and Medical Care NEC, when the additional code provides greater specificity as to the nature of the condition. If the complication code fully describes the condition, no additional code is necessary.**
    - 2) Transplant complications
      - (b) Kidney transplant complications
 

Patients who have undergone kidney transplant may still have some form of chronic kidney disease (CKD) because the kidney transplant may not fully restore kidney function. Code 996.81 should be assigned for documented complications of a kidney transplant, such as transplant failure or rejection or other transplant complication. Code 996.81 should not be assigned for post kidney transplant patients who have chronic kidney (CKD) unless a transplant complication such as transplant failure or rejection is documented. If the documentation is unclear as to whether the patient has a complication of the transplant, query the provider.

**Conditions that affect the function of the transplanted kidney, other than CKD, should be assigned code 996.81, Complications of transplanted organ, Kidney, and a secondary code that identifies the complication.**

## 18. Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V91)

## d. Categories of V Codes

## 1) Contact/Exposure

**Codes V15.84 – V15.86 describe contact with or (suspected) exposure to asbestos, potentially hazardous body fluids, and lead.**

**Subcategories V87.0 – V87.3 describe contact with or (suspected) exposure to hazardous metals, aromatic compounds, other potentially hazardous chemicals, and other potentially hazardous substances.**

## 4) History (of)

The history V code categories are:

V10 Personal history of malignant neoplasm

V12 Personal history of certain other diseases

V13 Personal history of other diseases

Except: V13.4, Personal history of arthritis, and subcategory V13.6, Personal history of congenital (corrected) malformations. These conditions are life-long so are not true history codes.

V14 Personal history of allergy to medicinal agents

V15 Other personal history presenting hazards to health

Except: **Codes V15.7, Personal history of contraception; V15.84, Contact with and (suspected) exposure to asbestos; V15.85, Contact with and (suspected) exposure to potentially hazardous body fluids; V15.86, Contact with and (suspected) exposure to lead.**

V16 Family history of malignant neoplasm

V17 Family history of certain chronic disabling diseases

V18 Family history of certain other specific diseases

V19 Family history of other conditions

V87 Other specified personal exposures and history presenting hazards to health

**Except: Subcategories V87.0, Contact with and (suspected) exposure to hazardous metals; V87.1, Contact with and (suspected) exposure to hazardous aromatic compounds; V87.2, Contact with and (suspected) exposure to other potentially hazardous chemicals; and V87.3, Contact with and (suspected) exposure to other potentially hazardous substances.**

## 14) Miscellaneous V codes

Miscellaneous V code categories/codes:

**V40.31 Wandering in diseases classified elsewhere**

## 15) Nonspecific V codes

Nonspecific V code categories/codes:

V11 Personal history of mental disorder

A code from the mental disorders chapter, with an in remission fifth-digit, should be used.

V13.4 Personal history of arthritis

V13.6 Personal history of congenital malformations

V15.7 Personal history of contraception

V23.2 Pregnancy with history of abortion

V40 Mental and behavioral problems

**Exception: V40.31 Wandering in diseases classified elsewhere**

## APPENDIX 1. PRESENT ON ADMISSION REPORTING GUIDELINES

### Assigning the PAO Indicator

#### Congenital conditions and anomalies

Assign "Y" for congenital conditions and anomalies, **except for categories 740-759, Congenital anomalies, which are on the exempt list.** Congenital conditions are always considered present on admission.

