ICD-10 and Family Practice

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For the past thirty-one (31) years, we have learned and used ICD-9-CM when diagnosis coding for our providers. ICD stands for International Classification of Diseases. We’ve been using the 9th Revision to code a documented medical condition. We will be replacing the 9th Revision with the 10th revision. As someone once said, just when we learned the answers, they changed the questions. Also, for years, there has been rumor that ICD-10 would be replacing ICD-9, and now this will soon be a reality.

**ICD-10 will replace ICD-9-CM as of October 1, 2014.**
There is a new rumor that ICD-10 will be bypassed with ICD-11. The problem with this new rumor is that there is nothing, in writing, about this rumor. The fact that ICD-10 will be effective as of October 1, 2014 is published by the Centers for Medicare and Medicaid Services and the World Health Organization. Anytime someone tells you something, GET IT IN WRITING! Rumors can ruin a practice and can cost a practice a lot of money because you trust the person who told you the rumor and you want to believe it, so you or you have your staff search the internet for anything that provides provenance to the rumor. In coding, there is a rule, If it isn’t documented, it doesn’t exist. If an employee or a doctor told you something, make sure that they provide you with documentation to back it up. How do I know this? My boss went to a conference and during a break, heard people talking about something. One of the speakers even said the same thing. When my boss came back, he had me stop my work and find out if what he heard was true. After a week of searching, I went back to my boss and told him that what he heard didn’t exist. His reply was, I don’t believe you. I am a speaker at conferences. Anything I present has laws, rules, or policies provided to show that what I’m saying is true, accurate, and correct. I personally attended a conference where I heard a speaker say something that didn’t sound right. I wasn’t the only one because many hands went up. The speaker had many respected certifications, yet the speaker failed to provide any proof to his statement. When I asked for his documentation, he smiled and said I’ll send it to you. It’s been 10 years and nothing has come forth. All this did was lower my respect for this person and I now question everything this person provides. I refuse to attend any conference where he still speaks. My boss was correct with saying he didn’t believe me, but he learned a hard lesson. He spent about $1,000 in payroll to have me find anything that backed up what he heard at a conference. In the end, he dismissed what he heard and from that point on, when we brought anything to him, we had to provide documented proof. That made me a better researcher. To provide proof to ICD-10 being effective on October 1, 2014, can be found here:
October 1, 2014 is on a Wednesday. What this means is, on Tuesday, September 30, 2014, you will use ICD-9-CM. At the end of the day, put your ICD-9 manuals in a safe place because you may need them later on and I will explain this. When you come in the next morning, you will open the brand new ICD-10-CM manuals and code the visit using them.

One huge change with ICD-10-CM is that there will be more codes to select from. ICD-9 has about 14,000 codes. ICD-10 starts with 68,000 codes and can go higher. ICD-9 did not have a code for a cranialrectal blockage, so you couldn’t code that diagnosis or you had to select an unspecified code, but now you can have a code for a cranialrectal blockage (YOU do know that cranialrectal blockage is not a real disease or injury). ICD-10 is going to change the way YOU do business. Why? It is 100% dependent on medical record documentation. ICD-9 was forgiving to a doctor who is lax on their documentation. Steve could visit Dr Smith with pain in his right ear. All Dr Smith had to document was that Steve has OM which is short for otitis media and the coder could select a code for simple OM.

That code is **382.9** - Unspecified otitis media, Otitis media: NOS, acute NOS, chronic NOS

**ICD-10 will require more work on the provider to document the exact type of diagnosis found with the patient.  ICD-10 demands documentation of the anatomical area affected and allows for coding of chronic modalities.**

**Under ICD-10-CM, you have the following codes for Otitis Media:**

H66.9 *Otitis media*, unspecified
H66.90 **Otitis media**, unspecified, unspecified ear

H66.91 **Otitis media**, unspecified, right ear

H66.92 **Otitis media**, unspecified, left ear

H66.93 **Otitis media**, unspecified, bilateral

As you can see, under ICD-9-CM, you have one code you can select if the documentation is not specific. The patient may have been a child with ear pain in both ears, but all the doctor wrote is “OM” and nothing more. Under ICD-10-CM, you have a possibility of five (5) codes and you do need more anatomical information to select the best possible code. Using a pure unspecified code such as H66.9 could cause your claim to be pended or placed under review, which could cause a significant revenue loss for the practice. A favorite doctor I’ve known for many years is an expert witness where he is called to determine if a malpractice lawsuit should proceed to court or if the malpractice insurance company should issue a check. Most of the time, after looking at the medical record, he recommends writing a check. He provides instruction to medical interns and residents and he tells them: “Document the visit as if you had to appear in court to defend your actions.” I usually add, “Document the visit as if your paycheck and career is on the line.” I spend a lot of my time returning medical records for additional information because the documentation is insufficient to code the visit with 100% truth, accuracy and correctness. I code to protect the doctor, the patient, and MY paycheck. I only code what is documented. I never code a visit just to get paid. There will be an unofficial rule with coding and that rule will be: If it isn’t documented, we don’t code it. We do NOT code something just to get it paid. With 30 years of clinical medicine in my personal background, I can say I know what should have been done during the visit, but I can’t
code based on that. I’ve seen doctors tell me, “I did this procedure.” I say show me where it says you did this. There is no documentation to prove that the doctor said they did what they say and the doctor loses. I also NEVER code based on what I am told on the internet. I don’t know if what I’m told is 100% true, accurate and complete. I don’t know if the person asking the question works for a doctor or if they are a coding student and I NEVER help students. If I provide them with answers, they submit my work as their own and I NEVER support fraud, including academic fraud, in any form. If I do a coder’s work for them, they will never learn to become self-sufficient. Lets say you have an untrained coder who needs to code a cranialrectalectomy. They will go to the internet and ask, I forgot what the code is for a cranialrectalectomy, can someone help me? When they don’t get a response, they become angry and then they will post, Cant anyone here help me out? They do this hoping someone will feel guilty and give them what they want. Someone may come along with a name of ToddCPC and say we use code 99999. ToddCPC is NOT a coder. ToddCPC is a schoolkid in Omaha, Nebraska having fun punking the poster. So, now the coder enters 99999 as the code and sends the claim to the insurance company. The claim is denied payment. Claim after claim is denied payment because this coder is sending claims with bad codes. The doctor begins to notice the volume of denials and notices a huge drop in his practice revenue, so he contacts a consultant. In addition, the insurance company put a halt on all claims sent by the doctor. They send a letter demanding medical records and they’re now going back 20 years. The information on the claim is wrong and it is not documented in the medical record. The next letter the doctor receives is a demand for the return of claim payments and they are demanding a 6 figure refund. The doctor can’t fight this because the claim was sent with wrong codes, codes that are not
supported by the medical record documentation. I recently went to a doctor who received a letter demanding the return of $64,000. That would cause him to go out of business. I showed how his coder was sending claim with wrong codes and that the medical record documentation was so poor, that they didn’t support any correct code that was submitted. Again, DOCUMENT THE MEDICAL RECORD AS IF YOU HAD TO GO TO COURT!

Coding Guidelines

Many of the guidelines under ICD-9-CM wont change under ICD-10-CM. You will see new guidelines because ICD-10 will offer new codes never seen before. As an example:

**ICD-9 Guideline for Symptoms:**

*Signs and symptoms*

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the physician. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0 -799.9) contain many, but not all codes for symptoms.

7. **Conditions that are an integral part of a disease process**

   Signs and symptoms that are integral to the disease process should not be assigned as additional codes.

8. **Conditions that are not an integral part of a disease process**

   Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.
**ICD-10 Guideline for Symptoms:**

**Signs and symptoms**
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

5. **Conditions that are an integral part of a disease process**
Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. **Conditions that are not an integral part of a disease process**
Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

As you can see, both guidelines are virtually identical, so the change to ICD-10 wont be a shock to a trained coder.

**Coding Guidelines**
The following are some ICD-10 coding guidelines that may impact Family Practice providers. Please note that these are not ALL of the ICD-10 guidelines, just a sample, and, again, these look identical to ICD-9 guidelines:

**Signs and symptoms**
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not
Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

**Conditions that are an integral part of a disease process**
Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

**Conditions that are not an integral part of a disease process**
Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

**Multiple coding for a single condition**
In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code. “Use additional code” notes are found in the Tabular at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition. The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.

For example, for bacterial infections that are not included in chapter 1, a secondary code from category B95, Streptococcus, Staphylococcus, and Enterococcus, as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, may be required to identify the bacterial organism causing the infection. A “use additional code” note will normally be found at the infectious disease code, indicating a need for the organism code to be added as a secondary code.

“Code first” notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a “code first” note and an underlying condition is present, the underlying condition should be sequenced first.
“Code, if applicable, any causal condition first”, notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code
for that condition should be sequenced as the principal or first-listed diagnosis.

Multiple codes may be needed for late effects, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

**Acute and Chronic Conditions**
If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

**Diabetes mellitus**
The diabetes mellitus codes are combination codes that include the type of DM, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08 – E13 as needed to identify all of the associated conditions that the patient has.

**Type of diabetes**
The age of a patient is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason type 1 diabetes mellitus is also referred to as juvenile diabetes.

**Type of diabetes mellitus not documented**
If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2 diabetes mellitus.

**Diabetes mellitus and the use of insulin**
If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned for type 2 patients who routinely use insulin, code Z79.4, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin. Code Z79.4 should not be
assigned if insulin is given temporarily to bring a type 2 patient’s blood sugar under control during an encounter.

**Secondary Diabetes Mellitus**
Codes under category E08, Diabetes mellitus due to underlying condition, and E09, Drug or chemical induced diabetes mellitus, identify complications/manifestations associated with secondary diabetes mellitus. Secondary diabetes is always caused by another condition or event (e.g., cystic fibrosis, malignant neoplasm of pancreas, pancreatectomy, adverse effect of drug, or poisoning).

**Secondary diabetes mellitus and the use of insulin**
For patients who routinely use insulin, code Z79.4, Long-term (current) use of insulin, should also be assigned. Code Z79.4 should not be assigned if insulin is given temporarily to bring a patient’s blood sugar under control during an encounter.

**Assigning and sequencing secondary diabetes codes and its causes**
The sequencing of the secondary diabetes codes in relationship to codes for the cause of the diabetes is based on the tabular instructions for categories E08 and E09. For example, for category E08, Diabetes mellitus due to underlying condition, code first the underlying condition; for category E09, Drug or chemical induced diabetes mellitus, code first the drug or chemical (T36-T65).

Secondary diabetes due to drugs Secondary diabetes may be caused by an adverse effect of correctly administered medications, poisoning or late effect of poisoning.

See section I.C.19.e for coding of adverse effects and poisoning, and section I.C.20 for external cause code reporting.

**Hypertension with Heart Disease**
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.

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.

**Hypertensive Cerebrovascular Disease**
For hypertensive cerebrovascular disease, first assign the appropriate code from categories I60-I69, followed by the appropriate hypertension code.

**Hypertension, Secondary**
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.

**Hypertension, Transient**
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.

**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.

**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.

**Acute respiratory failure as principal diagnosis**
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 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**
When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation.

This applies whether the other acute condition is a respiratory or nonrespiratory 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.
**Influenza due to certain identified influenza viruses**

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).

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

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.

### Family Practice Diagnosis Codes

Lets look at some of the most used codes in some Family Practice practices. Please understand that this guide does NOT contain all codes used. This guide does not take the place of coding or published coding manuals. These codes may change in October 2014. They are current as of the day this guide was prepared. If additional information is needed to obtain a more accurate code, it will be noted. Some ICD-9-CM codes do NOT convert easily to ICD-10-CM. The medical record documentation will need to be more specific.

ICD-9 codes are 3, 4, or 5 numbers with E or V codes being a letter and a set of numbers, up to 5 digits. ICD-10 is a letter and numbers. It can go up to 7 digits. Code I06.8 is not one zero six point eight. It is letter eye zero six point eight. V70.0 is an ICD-9 code, not an ICD-10 code.
<table>
<thead>
<tr>
<th>NUMERICAL ORDER BY ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD-9-CM</strong></td>
</tr>
<tr>
<td><strong>250.00</strong> - Diabetes mellitus; w/o mention of complication or manifestation; type II, controlled</td>
</tr>
<tr>
<td><strong>ICD-10-CM</strong></td>
</tr>
<tr>
<td><strong>E11.9</strong> - Type 2 diabetes mellitus without complications</td>
</tr>
<tr>
<td><strong>Note:</strong> There are too many diabetes codes to mention. Documentation of the correct type is important in order to select the correct code.</td>
</tr>
<tr>
<td><strong>ICD-9-CM</strong></td>
</tr>
<tr>
<td><strong>272.4</strong> - Other and unspecified hyperlipidemia, Alpha-lipoproteinemia, Combined hyperlipidemia, Hyperlipidemia NOS, Hyperlipoproteinememia NOS</td>
</tr>
<tr>
<td><strong>ICD-10-CM</strong></td>
</tr>
<tr>
<td><strong>E78.5</strong> - Hyperlipidemia, unspecified</td>
</tr>
<tr>
<td><strong>ICD-9-CM</strong></td>
</tr>
<tr>
<td><strong>285.9</strong> - Anemia, unspecified, Anemia: NOS, essential, normocytic, not due to blood loss, profound, progressive, secondary, Oligocythemia,</td>
</tr>
<tr>
<td><strong>ICD-10-CM</strong></td>
</tr>
<tr>
<td><strong>D64.9</strong> - Anemia, unspecified</td>
</tr>
</tbody>
</table>
**ICD-9-CM**

401.1 - Essential hypertension; benign

**ICD-10-CM**

I10 - Essential (primary) hypertension

Note: There are too many hypertension codes to list. Documentation is key to select the correct code!

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**ICD-9-CM**

427.31 - Atrial fibrillation

**ICD-10-CM**

I48.0 - Atrial fibrillation

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**ICD-9-CM**

466.0 - Acute bronchitis

**ICD-10-CM**

J20.9 - Acute bronchitis, unspecified

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**ICD-9-CM**

493.90 - Asthma, unspecified

**ICD-10-CM**

J45.90 – Unspecified Asthma
ICD-9-CM
530.81 - Gastroesophageal reflux,

ICD-10-CM
K21.9 - Gastro-esophageal reflux disease without esophagitis

ICD-9-CM
564.1 - Irritable bowel syndrome, Irritable colon, Spastic colon

ICD-10-CM
K58.0 - Irritable bowel syndrome with diarrhea

ICD-9-CM
786.52 - Painful respiration

ICD-10-CM
R07.1 - Chest pain on breathing

Alphabetical Index of Codes by Disease

Asthma, unspecified
493.90 (ICD-9-CM)
J45.90 (ICD-10-CM)

Anemia, unspecified
285.9 (ICD-9-CM)
D64.9 (ICD-10-CM)

Atrial fibrillation
427.31 (ICD-9-CM)
I48.0 (ICD-10-CM)

Bronchitis
466.0 (ICD-9-CM)
J20.9 (ICD-10-CM)

Chest pain, Painful respiration
786.52 (ICD-9-CM)  
**R07.1** – (ICD-10-CM)

Diabetes mellitus; w/o mention of complication or manifestation; type II, controlled  
250.00 (ICD-9-CM)  
**E11.9** (ICD-10-CM)

Gastroesophageal reflux  
530.81 (ICD-9-CM)  
**K21.9** (ICD-10-CM)

Hypertension  
401.1 (ICD-9-CM)  
**I10** (ICD-10-CM)

Hyperlipidemia, unspecified  
272.4 (ICD-9-CM)  
**E78.5** (ICD-10-CM)

Irritable Bowel Syndrome  
564.1 (ICD-9-CM)  
**K58.0** (ICD-10-CM)

The process for coding ICD-10 is no different than that of ICD-9, but documentation will be the success or failure of ICD-10. Improper or lack of documentation will only delay claims processing and will decrease practice revenue. The coder reads the medical record. The coder reads that the doctor documented “Chest pain”. The coder opens the ICD-10 manual, goes to the Index (words) and looks up the condition, which in this case is Pain.
As you can see from the above ICD-10 index, you have chest pain listed as R07.4. Next you want to go to the tabular section to make sure that R07.4 is the correct code and to see if there are any coding conventions. Coding conventions provide us with additional information we need to ensure we have the correct code. The tabular for R07 is below.

- **R07** Pain in throat and chest
  - Excludes: dysphagia (R13) epidemic myalgia (B33.0) pain in: breast (N64.4)
  - neck (M54.2)
  - sore throat (acute) NOS (J02.9)
- **R07.0** Pain in throat
- **R07.1** Chest pain on breathing
  - Incl.: Painful respiration
- **R07.2** Precordial pain
- **R07.3** Other chest pain
  - Incl.: Anterior chest-wall pain NOS
- **R07.4** Chest pain, unspecified

If you look at the above tabular section, you can see coding conventions identical to those from ICD-9-CM. You can see NOS which means Not Otherwise Specified, Incl which means Includes and excludes which means these medical conditions are not included in this code. Code R07.4 has no coding conventions or additional information, so, based on the medical record documentation of chest pain, we can select R07.4. Again, if you
can code ICD-9, you can code ICD-10. If you don’t have the training in the process of coding, you won’t be able to code under ICD-10.

**CODING CHAPTERS**

Under ICD-9-CM, you have the following:

- Chapter 1: Infectious and Parasitic Diseases (001-139)
- Chapter 2: Neoplasms (140-239)
- Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
- Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)
- Chapter 5: Mental Disorders (290-319)
- Chapter 6: Diseases of Nervous System and Sense Organs (320-389)
- Chapter 7: Diseases of Circulatory System (390-459)
- Chapter 8: Diseases of Respiratory System (460-519)
- Chapter 9: Diseases of Digestive System (520-739)
- Chapter 10: Diseases of Genitourinary System (580-629)
- Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-677)
- Chapter 12: Diseases Skin and Subcutaneous Tissue (680-709)
- Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710-739)
- Chapter 14: Congenital Anomalies (740-759)
- Chapter 15: Newborn (Perinatal) Guidelines (760-779)
- Chapter 16: Signs, Symptoms and Ill-Defined Conditions (780-799)
- Chapter 17: Injury and Poisoning (800-999)
- Chapter 18: Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V84) and Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)

Under ICD-10, you have the following:

- Chapter 1: Certain infectious and parasitic diseases (A00-B99)
- Chapter 2: Neoplasms (C00-D48)
Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
Chapter 4: Endocrine, nutritional and metabolic diseases (E00-E90)
Chapter 5: Mental and behavioral disorders (F01-F99)
Chapter 6: Diseases of the nervous system (G00-G99)
Chapter 7: Diseases of the eye and adnexa (H00-H59)
Chapter 8: Diseases of the ear and mastoid process (H60-H95)
Chapter 9: Diseases of the circulatory system (I00-I99)
Chapter 10: Acute upper respiratory infections (J00-J06)
Chapter 11: Diseases of oral cavity and salivary glands (K00-K14)
Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)
Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)
Chapter 14: Diseases of the genitourinary system (N00-N99)
Chapter 15: Pregnancy, childbirth and the puerperium (O00-O99)
Chapter 16: Certain conditions originating in the perinatal period (P00-P96)
Chapter 17: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
Chapter 18: Symptoms and signs involving the circulatory and respiratory systems (R00-R09)
Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T98)
Chapter 20: External causes of morbidity (V01-Y98)
Factors influencing health status and contact with health services (Z00-Z99)

E Codes will become V-Y Codes
V Codes will become Z Codes.

The Table of Drugs and Biologicals that were 900 series codes and E Codes are now T Codes.

There were 18 Chapters in ICD-9-CM and we have 20 chapters under ICD-10-CM.
The proposed effective date for ICD-10 is October 1, 2014.

The key to the successful use and transition to ICD-10 is going to ensure our Providers are aware of their responsibility towards better documentation of the patient’s medical condition(s).

I can be reached at steve_verno@yahoo.com

That is steve_verno.

I wish all much success and
Never Give Up, Never Surrender!

Steven M. Verno