ICD-10 and General Surgery

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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. Its 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: http://www.cms.gov/Medicare/Coding/ICD10/Index.html

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. Let's say you have an untrained coder who needs to code a cranialrectal resection. They will go to the internet and ask, I forgot what the code is for a cranialrectal resection, can someone help me? When they don't get a response, they become angry and then they will post, Can't 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.

**ICD-10-CM Coding Guidelines for Surgery**

**Sepsis due to a postprocedural infection**
Sepsis resulting from a postprocedural infection is a complication of medical care. For such cases, the postprocedural infection code, such as, T80.2, Infections following infusion, transfusion, and therapeutic injection, T81.4, Infection following a procedure, T88.0, Infection following immunization, or O86.0, Infection of obstetric surgical wound, should be
coded first, followed by the code for the specific infection. If the patient has severe sepsis the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

**Treatment of a complication resulting from a surgical procedure**
When the admission/encounter is for treatment of a complication resulting from a surgical procedure, designate the complication as the principal or first-listed diagnosis if treatment is directed at resolving the complication.

**Episode of care involves surgical removal of neoplasm**
When an episode of care involves the surgical removal of a neoplasm, primary or secondary site, followed by adjunct chemotherapy or radiation treatment during the same episode of care, the neoplasm code should be assigned as principal or first-listed diagnosis, using codes in the C00-D49 series or where appropriate in the C83-C90 series.

**Complication from surgical procedure for treatment of a neoplasm**
When an encounter is for treatment of a complication resulting from a surgical procedure performed for the treatment of the neoplasm, designate the complication as the principal/first listed diagnosis. See guideline regarding the coding of a current malignancy versus personal history to determine if the code for the neoplasm should also be assigned.

**Current malignancy versus personal history of malignancy**
When a primary malignancy has been excised but further treatment, such as an additional surgery for the malignancy, radiation therapy or chemotherapy is directed to that site, the primary malignancy code should be used until treatment is completed.

**Aftercare following surgery for neoplasm**
*See Section I.C.21. Factors influencing health status and contact with health services, Aftercare*

**Secondary diabetes mellitus due to pancreatectomy**
For postpancreatectomy diabetes mellitus (lack of insulin due to the surgical removal of all or part of the pancreas), assign code E89.1, Postsurgical hypoinsulinemia. Assign a code from category E08.
and code Z79.4, Other acquired absence of organ, as additional codes.

**Postoperative Pain**
The provider’s documentation should be used to guide the coding of postoperative pain, as well as *Section III. Reporting Additional Diagnoses* and *Section IV. Diagnostic Coding and Reporting in the Outpatient Setting*. The default for post-thoracotomy and other postoperative pain not specified as acute or chronic is the code for the acute form. Routine or expected postoperative pain immediately after surgery should not be coded.

**Postoperative pain not associated with specific postoperative complication**
Postoperative pain not associated with a specific postoperative complication is assigned to the appropriate postoperative pain code in category G89.

**Postoperative pain associated with specific postoperative complication**
Postoperative pain associated with a specific postoperative complication (such as painful wire sutures) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. If appropriate, use additional code(s) from category G89 to identify acute or chronic pain (G89.18 or G89.28).

**Chronic pain**
Chronic pain is classified to subcategory G89.2. There is no time frame defining when pain becomes chronic pain. The provider’s documentation should be used to guide use of these codes.

**In utero surgery**
In cases when surgery is performed on the fetus, a diagnosis code from category O35, Maternal care for known or suspected fetal abnormality and damage, should be assigned identifying the fetal condition. Assign the appropriate procedure code for the procedure performed.
No code from Chapter 16, the perinatal codes, should be used on the mother’s record to identify fetal conditions. Surgery performed in utero on a fetus is still to be coded as an obstetric encounter.

**Coding of Injuries**
When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. Multiple injury codes are provided in ICD-10-CM, but should not be assigned unless information for a more specific code is not available. These **traumatic injury** codes (S00-T14.9) are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.

**Pain due to medical devices**
Pain associated with devices, implants or grafts left in a surgical site (for example painful hip prosthesis) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. Specific codes for pain due to medical devices are found in the T code section of the ICD-10-CM. Use additional code(s) from category G89 to identify acute or chronic pain due to presence of the device, implant or graft (G89.18 or G89.28).

Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare. For example code Z95.1, Presence of aortocoronary bypass graft, may be used with code Z48.812, Encounter for surgical aftercare following surgery on the circulatory system, to indicate the surgery for which the aftercare is being performed. A status code should not be used when the aftercare code indicates the type of status, such as using Z43.0, Encounter for attention to tracheostomy, with Z93.0, Tracheostomy status.
The aftercare Z category/codes:
Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury
Z43 Encounter for attention to artificial openings
Z44 Encounter for fitting and adjustment of external prosthetic device
Z45 Encounter for adjustment and management of implanted device
Z46 Encounter for fitting and adjustment of other devices
Z47 Orthopedic aftercare
Z48 Encounter for other postprocedural aftercare
Z49 Encounter for care involving renal dialysis
Z51 Encounter for other aftercare

Pre-operative examination and pre-procedural laboratory examination Z codes are for use only in those situations when a patient is being cleared for a procedure or surgery and no treatment is given. The Z codes/categories for routine and administrative examinations:
Z00 Encounter for general examination without complaint, suspected or reported diagnosis
Z01 Encounter for other special examination without complaint, suspected or reported diagnosis
Z02 Encounter for administrative examination
Except: Z02.9, Encounter for administrative examinations, unspecified
Z32.0- Encounter for pregnancy test

Prophylactic Organ Removal
For encounters specifically for prophylactic removal of an organ (such as prophylactic removal of breasts due to a genetic susceptibility to cancer or a family history of cancer), the principal or first listed code should be a code from category Z40, Encounter for prophylactic surgery, followed by the appropriate codes to identify the associated risk factor (such as genetic susceptibility or family history).

If the patient has a malignancy of one site and is having prophylactic removal at another site to prevent either a new primary malignancy or metastatic disease, a code for the malignancy should also be assigned in addition to a code from subcategory Z40.0, Encounter for prophylactic surgery for risk factors related to malignant neoplasms. A Z40.0 code
should not be assigned if the patient is having organ removal for treatment of a malignancy, such as the removal of the testes for the treatment of prostate cancer.

Miscellaneous Z codes/categories:
Z28 Immunization not carried out
**Except: Z28.3, Underimmunization status**
Z40 Encounter for prophylactic surgery
Z41 Encounter for procedures for purposes other than remedying health state
Except: Z41.9, Encounter for procedure for purposes other than remedying health state, unspecified

**Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury**
Z51.0 Encounter for antineoplastic radiation therapy
Z51.1- Encounter for antineoplastic chemotherapy and immunotherapy
Z52 Donors of organs and tissues
Except: Z52.9, Donor of unspecified organ or tissue
Z76.1 Encounter for health supervision and care of foundling
Z76.2 Encounter for health supervision and care of other healthy infant and child
Z99.12 Encounter for respirator [ventilator] dependence during power failure

**G. Complications of surgery and other medical care**
When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

**Admission Following Post-Operative Observation**
When a patient is admitted to an observation unit to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should apply the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis as "that condition established after study to be chiefly
Admission from Outpatient Surgery
When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission:

If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.

If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.

If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.

Outpatient Surgery
When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

Observation Stay
When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.
When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

Patients receiving preoperative evaluations only
For patients receiving preoperative evaluations only, sequence first a code from subcategory Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations. Assign a code for the condition to
describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

**Ambulatory surgery**
For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

**Let's look at some of the most used codes in General Surgery.**
Please understand that this guide does NOT contain all codes used. The top 10 codes used were converted to ICD-10-CM. This guide does not take the place of coding or published coding manuals.

**NUMERICAL ORDER BY ICD-9-CM**

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

**ICD-9-CM**
153.9 Malignant neoplasm of colon

**ICD-10-CM**
- Needs to be more specific
- C18 Malignant neoplasm of colon
- C18.0 Malignant neoplasm of cecum
- C18.2 Malignant neoplasm of ascending colon
- C18.4 Malignant neoplasm of transverse colon
- C18.6 Malignant neoplasm of descending colon
- C18.7 Malignant neoplasm of sigmoid colon
ICD-9-CM
188.9 (Inguinal hernia, without mention of obstruction or gangrene, unspecified)
Inguinal hernia NOS

Icd-10
Needs to be more specific:
K40 Inguinal hernia
Includes:
bubonocele direct inguinal hernia
double inguinal hernia
indirect inguinal hernia
inguinal hernia NOS
oblique inguinal hernia scrotal hernia
K40.90 Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent Inguinal hernia NOS
Unilateral inguinal hernia NOS

ICD-9-CM
447.1 (Stricture of artery)

ICD-10
I77.1 Stricture of artery

ICD-9-CM
550.90 (Malignant neoplasm of other and ill-defined sites, Abdomen)

ICD-10
C76.2 Malignant neoplasm of abdomen
(Needs more info on anatomical body within abdomen affected with neoplasm)
ICD-9-CM
174.9 (Malignant neoplasm of female breast, Breast (female), unspecified)

ICD-10-CM
Needs more information
C43.52 Malignant melanoma of skin of breast
C50 Malignant neoplasm of breast
Includes:
connective tissue of breast
Paget's disease of breast
Paget's disease of nipple
Use additional code to identify estrogen receptor status (Z17.0, Z17.1)
Excludes1: skin of breast (C43.5, C44.5)
C50.0 Malignant neoplasm of nipple and areola
C50.01 Malignant neoplasm of nipple and areola, female
C50.011 Malignant neoplasm of nipple and areola, right female breast
C50.012 Malignant neoplasm of nipple and areola, left female breast
C50.019 Malignant neoplasm of nipple and areola, unspecified female breast
C50.11 Malignant neoplasm of central portion of breast, female
C50.111 Malignant neoplasm of central portion of right female breast
C50.112 Malignant neoplasm of central portion of left female breast
C50.119 Malignant neoplasm of central portion of unspecified female breast
C50.21 Malignant neoplasm of upper-inner quadrant of breast, female
C50.211 Malignant neoplasm of upper-inner quadrant of right female breast
C50.212 Malignant neoplasm of upper-inner quadrant of left female breast
C50.219 Malignant neoplasm of upper-inner quadrant of unspecified female breast
C50.31 Malignant neoplasm of lower-inner quadrant of breast, female
C50.311 Malignant neoplasm of lower-inner quadrant of right female breast
C50.312 Malignant neoplasm of lower-inner quadrant of left female breast
C50.319 Malignant neoplasm of lower-inner quadrant of unspecified female breast
C50.41 Malignant neoplasm of upper-outer quadrant of breast, female
C50.411 Malignant neoplasm of upper-outer quadrant of right female breast
C50.412 Malignant neoplasm of upper-outer quadrant of left female breast
C50.419 Malignant neoplasm of upper-outer quadrant of unspecified female breast
C50.51 Malignant neoplasm of lower-outer quadrant of breast, female
C50.511 Malignant neoplasm of lower-outer quadrant of right female breast
C50.512 Malignant neoplasm of lower-outer quadrant of left female breast
C50.519 Malignant neoplasm of lower-outer quadrant of unspecified female breast
C50.61 Malignant neoplasm of axillary tail of breast, female
  C50.611 Malignant neoplasm of axillary tail of right female breast
C50.612 Malignant neoplasm of axillary tail of left female breast
C50.619 Malignant neoplasm of axillary tail of unspecified female breast
C50.81 Malignant neoplasm of overlapping sites of breast, female
  C50.811 Malignant neoplasm of overlapping sites of right female breast
C50.812 Malignant neoplasm of overlapping sites of left female breast
C50.819 Malignant neoplasm of overlapping
  C50.91 Malignant neoplasm of breast of unspecified site, female
  C50.911 Malignant neoplasm of unspecified site of right female breast
C50.912 Malignant neoplasm of unspecified site of left female breast
C50.919 Malignant neoplasm of unspecified site of unspecified female breast

ICD-9-CM
540.0 (Acute appendicitis, With generalized peritonitis)

ICD-10-CM
K35.0 Acute appendicitis with generalized peritonitis
Appendicitis (acute) with perforation
Appendicitis (acute) with peritonitis (generalized) (localized) following rupture or perforation
Appendicitis (acute) with peritonitis with peritoneal abscess
Appendicitis (acute) with rupture
Acute appendicitis

ICD-9-CM
540.9 (Acute appendicitis, Without mention of peritonitis)

ICD-10-CM
K35.9 Acute appendicitis, unspecified
Acute appendicitis NOS
Acute appendicitis with peritonitis, localized without rupture or NOS
Acute appendicitis without generalized peritonitis
Acute appendicitis without perforation
Acute appendicitis without peritoneal abscess
Acute appendicitis without rupture

ICD-9-CM
233.0 (Carcinoma in situ of breast and genitourinary system, Breast)

ICD-10-CM
D05 Carcinoma in situ of breast
Excludes1: carcinoma in situ of skin of breast (D04.5) melanoma in situ of breast (skin) (D03.5) Paget's disease of breast or nipple (C50.-)
D05.0 Lobular carcinoma in situ of breast  
D05.01 Lobular carcinoma in situ of right breast  
D05.02 Lobular carcinoma in situ of left breast  
D05.09 Lobular carcinoma in situ of unspecified breast  
D05.1 Intraductal carcinoma in situ of breast  
D05.11 Intraductal carcinoma in situ of right breast  
D05.12 Intraductal carcinoma in situ of left breast  
D05.19 Intraductal carcinoma in situ of unspecified breast  
D05.7 Other carcinoma in situ of breast  
D05.71 Other carcinoma in situ of right breast  
D05.72 Other carcinoma in situ of left breast  
D05.79 Other carcinoma in situ of unspecified breast  
D05.9 Unspecified carcinoma in situ of breast  
D05.91 Unspecified carcinoma in situ of right breast  
D05.92 Unspecified carcinoma in situ of left breast  
D05.99 Unspecified carcinoma in situ of unspecified breast  
C56 Malignant neoplasm of ovary  
Use additional code to identify any functional activity  
C56.0 Malignant neoplasm of right ovary  
C56.1 Malignant neoplasm of left ovary  
C56.9 Malignant neoplasm of ovary, unspecified side  

**ICD-9-CM**  
217 *(217)* Benign neoplasm of breast  
   Breast (male) (female):  
     connective tissue  
     glandular tissue  
     soft parts  
     *Excludes:* adenofibrosis *(610.2)*  
     benign cyst of breast *(610.0)*  
     fibrocystic disease *(610.1)*  
     skin of breast *(216.5)*  

**ICD-10-CM**  
D24 Benign neoplasm of breast  
Includes: benign neoplasm of connective tissue of breast  
benign neoplasm of soft parts of breast  
fibroadenoma of breast
Excludes2: adenofibrosis of breast (N60.2)
benign cyst of breast (N60.-)
benign mammary dysplasia (N60.-)
benign neoplasm of skin of breast (D22.5, D23.5)
fibrocystic disease of breast (N60.-)
D24.0 Benign neoplasm of female breast
D24.00 Benign neoplasm of female breast, unspecified side
D24.01 Benign neoplasm of right female breast
D24.02 Benign neoplasm of left female breast
D24.1 Benign neoplasm of male breast
D24.10 Benign neoplasm of male breast, unspecified side
D24.11 Benign neoplasm of right male breast
D24.12 Benign neoplasm of left male breast
574.10 (Calculus of gallbladder with other cholecystitis, without mention of obstruction)
Any condition listed in K80.2 with acute cholecystitis
K80.00 Calculus of gallbladder with acute cholecystitis without obstruction

**ICD-9-CM**
575.11 (Chronic cholecystitis)

**ICD-10-CM**
K81.1 Chronic cholecystitis

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.

- 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 (520-57)
- 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.
The proposed effective date for ICD-10 is October 1, 2014.

So, what do we have to do?

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).

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