McKESSON

Condition	ICD-9-CM	ICD-10-CM	Additional Requirements
Fracture	• Location (hip fracture) • Open or Closed • Late Effect	• Location -**include** Specific site of the fracture (hip fracture – subtrochantericfx of right femur) • Open or Closed • Late Effect • Documentation of the type of fracture as displaced or non displaced • Documentation supporting laterality • Gustilo classification system for further classification of open fractures	• A, Initial encounter for closed fracture • B, Initial encounter for open fracture • D, Subsequent encounter with routine healing • G, Subsequent encounter with delayed healing • K, Subsequent encounter with nonunion • P, Subsequent encounter with malunion • S, Sequela

Injury	• Injury
	• Type
		• Type of injury (specify)
		• Codes are organized by the general site of the injury:
		  • Head
		  • Neck
		  • Thorax
		  • Abdomen
		  • Shoulder and upper arm
		  • Elbow and forearm
		  • Wrist and hand
		  • Hip and thigh
		  • Knee and lower leg
		  • Ankle and foot
			• ICD-10-CM features an expanded category for injuries:
			• A – Initial encounter
			• D – Subsequent with routine healing
			• G – Subsequent with delayed healing
			• S – Sequela
			• How & Where the injury occurred

Pain	• Location • Site	• Location • Site • Type – acute or chronic	• Multiple options for reporting pain • Pain codes may be used to provide further detail regarding acute or chronic pain (G89.XX) • These codes are used in conjunction with codes that identify site specific pain

Neoplasms	• Anatomical site
	Histological behavior
	  • Benign
	  • Malignant
	  • In situ
	  • Uncertain behavior
		• Anatomical Site
		• **Histological behavior**
		  • Benign
		  • Malignant
		  • In situ
		  • Uncertain behavior
		  • Primary site
		  • Secondary (metastatic) site(s)
			• Additional classifications that are now grouped by morphology (histologic type)
			• Must document the histologic type of the neoplasm

Condition	ICD-9-CM	ICD-10-CM	Additional Requirements
Circulatory	Specify Condition • **Hypertension (HTN):** ▪ Benign ▪ Malignant ▪ Unspecified • **Coronary Artery Disease (CAD)** (Atherosclerosis/Ischemia): • Native Coronary Artery • Graft type • Nonautologous • **Acute Myocardial Infarction (AMI)** defined as duration of 8 weeks or less. • **Cerebral Infarction / Cerebrovascular Accident (CVA):** • Occlusion • Thrombosis • Embolism	**General Documentation:** • Site specificity, when applicable • Laterality (right, left, bilateral), when applicable **HTN** (no distinction of status/type), document if: • With heart involvement (and with heart failure, if applicable) • With kidney involvement, specify: o Stage 1 thru 5, or ESRD • Secondary **CAD**, document: • Specific artery (default is native artery) • With angina (specify: stable or unstable) or without angina **AMI** (redefined as duration of 4 weeks {28 days} or less), document: • Location: o anterior wall (left main, left anterior descending or other coronary artery) o inferior wall (right or other coronary artery) o other sites (left circumflex coronary artery or other site) • ST elevation (STEMI) or Non-ST elevation (NSTEMI) **CVA**, document: • Location: o Precerebral artery (vertebral, basilar, carotid) o Cerebral artery (right/left…middle, anterior, posterior, cerebellar) • Due to: thrombosis, embolism, occlusion or stenosis **Heart Failure/CHF**, document: • Left ventricle, systolic, diastolic, combined • Acute, chronic, acute on chronic (decompensated) **Atrial fibrillation**, **specify:** Paroxysmal, persistent or chronic **Cardiomyopathy**, document: • Dilated • Hypertrophic (obstructive, other) • Endomyocardial • Endocardial fibroelastosis • Other restrictive • Due to: alcohol, drug or external agent	• No distinction of HTN status/type. • CAD with or without angina inclusive in one code. • AMI redefined as duration of 4 weeks (28 days) or less.

Condition	ICD-9-CM	ICD-10-CM	Additional Requirements

Factors Influencing Health	• ICD-9 V-codes:
	  • Screening
	  • History of
	  • Contact/Exposure
	  • Follow-up
	  • Pre-Operative
		• ICD-10 Reported with Z-codes
		• **Screening** for patient without sign or symptom (e.g. Z12.31 – encounter of screening mammogram for malignant neoplasm of breast)
		• **History** of (condition no longer exists but being monitored) (e.g. Z85.3 – personal history of malignant neoplasm of breast)
		• **Follow-up** continued surveillance following completed treatment (e.g. Z39.2 – Encounter for routine postpartum follow-up)
		• **Pre-operative** for patients receiving preoperative evaluation only (e.g. Z01.81x – Encounter for pre-procedural exam [Specify – Cardio/Resp./ lab/other])
			Z Codes
			• Used to describe a specific purpose for receiving services, or circumstances that affects the patient's health status but is not a current illness or injury.
			• Z-codes may be either primary or secondary
			• Key Terms include: Examination, History, Fitting, Status, Screening, etc…

Obstetrics	• Pregnancy/Episode of Care documented by Trimester • Missed abortion defined as fetal death (before 22 weeks) • Weeks of pregnancy (not reported) • Incidental pregnancy (not reported)	• **Episode of Care**: Majority of codes have a final character indicating the trimester (number of weeks) of pregnancy, for the current encounter. • **Missed abortion** classified as before **20** weeks • **Weeks of Pregnancy** document number weeks gestation (i.e. use Z3A.xx; in addition to the primary obstetric code). • **Document Incidental pregnancy** (Z33.1) when pregnancy is **incidental** to the encounter (i.e. not the reason for encounter).	• Where applicable, a 7th character is to be assigned for certain categories to identify the fetus for which a complication code applies. • Use add'l code from category Z37.- to identify outcome of delivery. • Distinguish between conditions of the mother that existed prior to pregnancy (pre-existing) & those that are a direct result of pregnancy (gestational). • Specific documentation for cesarean delivery (reason): ~ Malposition, ~ Disproportion, ~ Maternal condition, ~ Planned w/ onset of labor

Vascular	Cerebral Infarction / Cerebrovascular Accident (CVA):
	• Occlusion
	• Thrombosis
	• Embolism
		CVA, document:
		• **Location:**
		• **Precerebral artery**
		  ○ **(vertebral, basilar, carotid)**
		• **Cerebral artery**
		  ○ **(right/left…middle, anterior, posterior, cerebellar)**
		• Due to:
		  ○ Thrombosis, embolism, occlusion or stenosis
			• Terminology used to describe several cardiovascular conditions has been revised to reflect more current medical practice

Condition	ICD-9-CM	ICD-10-CM	Additional Requirements
GI	Gastric Ulcer • With/without obstruction • Hemorrhage • Perforation • Location: small, large, both (Intestine) Type Location Hemorrhoids • Location (Internal/External) • Complication Hernia • Site (Inguinal /Femoral) • Type (internal/external)	**Crohn's** disease and **Diverticular** disease, document: • Site: o Small intestine o Large intestine o Both small & large intestine • Complication (specify) or w/o complication **Ulcerative Colitis**, document: • Type: o Pancolitis o Proctitis o Rectosigmoiditis o Left sided o Other • Complication (specify) or w/o complication **Hemorrhoids**, document: • Internal o specify degree, grade, state • External **Hernia**, document: • Site (Inguinal/Femoral) • Type (Internal/External)	• No documentation changes from ICD-9-CM to ICD-10-CM. Column to the left are common documentation pitfalls that may have been missed while documenting I-9. Emphasizing the importance of documenting for I-10. • Utilize combination codes when appropriate.
Neurology	• Type • Site	**General Documentation:** • Type of pain: o Acute or chronic o Post-procedural (specify procedure) o Due to trauma o Neoplasm related (specify neoplasm and site) • Site specificity, when applicable • Laterality (right, left, bilateral), when applicable • Dominant or Non-dominant side, when applicable **Chronic Pain:** • **Central pain syndrome** and **Chronic pain syndrome** are different than the term 'chronic pain' and will be coded based on your specific documentation. **Migraine, document:** • With or without aura • Intractable or not intractable • With or without status migrainosus **Epilepsy, document:** • Localization related or generalized • Intractable or not intractable • With or w/o status epilepticus	*"Pain" is also included in other chapters based on specific documentation (site, not specified as acute or chronic).*

Source: American Academy of Professional Coders. (2014) *ICD-9-CM Volume 1-2* and *ICD-10-CM.* Salt Lake City, UT. AAPC.