Icd 10 cm 2018 guidelines pdf

I'm not robot!

TABLE LIST OF ROOT OPERATION – Examples

ROOT OPERATION	WHAT OPERATION DOES	OBJECTIVES OF PROCEDURES	PROCEDURE SITE	EXAMPLE
Excision	Takes out some/ all of the body	Cutting out/off without replacement	Some of the body part	Breast Lumpectomy
Drainage	Takes out solids/ fluids/gases from body	Taking/letting out fluids/gases	Within the body part	Incision & drainage
Division	Involved cutting or separation only	Cutting into/ separating a body part	Within the body part	Neurotomy
Transplantation	Puts in/puts back or moves some all of a body part	Putting in a living body part from a person/animal	Some/all of a body part	Kidney Transplant

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Mini-Mental State Examination (MMSE)

Patient's Name:__________ Date:__________

Instructions: Ask the questions in the order listed. Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: ______
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, …) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)
3		"Earlier I told you the names of three things. Can you tell me what those were?"
2		Show the patient two simple objects, such as a wristwatch and a pencil, and ask the patient to name them.
1		"Repeat the phrase: 'No ifs, ands, or buts.'"
3		"Take the paper in your right hand, fold it in half, and put it on the floor." (The examiner gives the patient a piece of blank paper.)
1		"Please read this and do what it says." (Written instruction is "Close your eyes.")
1		"Make up and write a sentence about anything." (This sentence must contain a noun and a verb.)
1		"Please copy this picture." (The examiner gives the patient a blank piece of paper and asks him/her to draw the symbol below. All 10 angles must be present and two must intersect.)
30		TOTAL

SPEECH-LANGUAGE PATHOLOGY
MOST COMMONLY USED ICD-10-CM DIAGNOSTIC CODES

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Fiscal year 2018 icd-10-cm official guidelines for coding and reporting. Icd-10-cm official guidelines.

Please note: This booklet correlates with 2018 Code sets, it does not encompass 2019 guidelines. The ICD-10-CM Official Guidelines for Coding and Reporting provide coding conventions and guidelines needed to accurately assign ICD-10-CM diagnosis codes. The official guidelines and conventions are used in conjunction with instructions contained in the ICD-10-CM code set to ensure accurate coding of diseases, injuries, consequences of other external causes and other reasons for health care encounters. Use this separate guideline booklet together with your ICD-10-CM codebook to correctly assign and sequence diagnosis codes in all health care settings.Key Features and BenefitsOptum360 Edge Complete up-to-date 2018 ICD-10-CM conventions and guidelines. This handy booklet is designed to be used with your 2018 ICD-10-CM codebook.Optum360 Edge Guideline changes clearly identified. Changes from the 2017 version of the guidelines are identified as follows:Bold text identifies narrative changes Underlined text identifies text that has been moved within the guidelines since the 2017 version.Italics are used to identify revisions to heading text. Unchanged headings are displayed in bold. Increased efficiency Use a separate guideline booklet to eliminate the need to flip back-and-forth between the guideline section in your codebook and the index and tabular sections. Keep your codebook open to the referenced index entry or code while reviewing the relevant guidelines affecting code assignment. The 2018 ICD-10-CM diagnosis code files contain information on code updates for FY 2018. These 2018 ICD-10-CM diagnosis codes are to be used for discharges and patient encounters occurring from October 1, 2017 through September 30, 2018. Radiology practices should review these files to determine the 2018 additions, deletions, expanded code sets, as well as updated inclusionary terms and exclusionary notes to ensure that proper selection of a final diagnosis code(s) is made. The ICD-10-CM Official Guidelines for Coding and Reporting FY 2018 have also been posted and are available for review. Also reference the Centers for Medicare and Medicaid Services updated ICD-10 Q&As and be sure to keep up-to-date with ICD-10 Resource on the ACR website. Customer Reviews, including Product Star Ratings help customers to learn more about the product and decide whether it is the right product for them. To calculate the overall star rating and percentage breakdown by star, we donâ€™t use a simple average. Instead, our system considers things like how recent a review is and if the reviewer bought the item on Amazon. It also analyzed reviews to verify trustworthiness. Learn more how customers reviews work on Amazon The 2018 ICD-10-CM Official Guidelines for Coding and Reporting includes a dozen substantive changes in Section I, and one important change in Section II. Here are those changes. Section I Key Changes 1. Information has been added to clarify the meaning of "with" (new text is bold): The word "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions (e.g., sepsis guideline for "acute organ dysfunction that is not clearly associated with the sepsis"). For conditions not specifically linked by these relational terms in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, provider documentation must link the conditions to code them as related. 2. "Code also" guidelines are clarified. When two codes may be required to fully describe a condition, a "code also" note is indicated. The note does not provide sequencing direction. The new guidelines explain, "The sequencing depends on the circumstances of the encounter." 3. Information is added for brachytherapy, within admissions/encounters involving chemotherapy, immunotherapy, and radiation therapy: If a patient admission/encounter is solely for the administration of chemotherapy, immunotherapy or external beam radiation therapy, assign code Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy as the first-listed or principal diagnosis. If a patient receives more than one of these therapies during the same admission more than one of these codes may be assigned, in any sequence. The malignancy for which the therapy is being administered should be assigned as a secondary diagnosis. If a patient admission/encounter is for the insertion or implantation of radioactive elements (e.g., brachytherapy) the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis. Code Z51.0 should not be assigned. 3) Patient admitted for radiation therapy, chemotherapy or immunotherapy and develops complications When a patient is admitted for the purpose of external beam radiotherapy, immunotherapy or chemotherapy and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is Z51.0, Encounter for antineoplastic radiation therapy, or Z51.11, Encounter for antineoplastic chemotherapy, or Z51.12, Encounter for antineoplastic immunotherapy followed by any codes for the complications. When a patient is admitted for the purpose of insertion or implantation of radioactive elements (e.g., brachytherapy) and develops complications such as uncontrolled nausea and vomiting or dehydration, the principal or first-listed diagnosis is the appropriate code for the malignancy followed by any codes for the complications. 4. Coding for diabetes with the use of insulin or oral diabetic medication is clarified: Diabetes mellitus and the use of insulin and oral hypoglycemics 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. An additional code should be assigned from category Z79 to identify the long-term (current) use of insulin or oral hypoglycemic drugs. If the patient is treated with both oral medications and insulin, only the code for long-term (current) use of insulin should be assigned. 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 categories E08, Diabetes mellitus due to underlying condition, E09, Drug or chemical induced diabetes mellitus, and E13, Other specified 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). (a) Secondary diabetes mellitus and the use of insulin or oral hypoglycemic drugs For patients with secondary diabetes mellitus who routinely use insulin or oral hypoglycemic drugs, an additional code from category Z79 should be assigned to identify the long-term (current) use of insulin or oral hypoglycemic drugs. If the patient is treated with both oral medications and insulin, only the code for long-term (current) use of insulin should be assigned. 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. 5. Guidelines are added for mental and behavioral disorders due to psychoactive substance use, in remission: Selection of codes for "in remission" for categories F10-F19, Mental and behavioral disorders due to psychoactive substance use (categories F10-F19 with -11, -.21) requires the provider's clinical judgment. The appropriate codes for "in remission" are assigned only on the basis of provider documentation (as defined in the Official Guidelines for Coding and Reporting), unless otherwise instructed by the classification. Mild substance use disorders in early or sustained remission are classified to the appropriate codes for substance abuse in remission, and moderate or severe substance use disorders in early or sustained remission are classified to the appropriate codes for substance dependence in remission. 6. There are new guidelines for blindness. When "blindness" or "low vision" in both eyes is documented, but the visual impairment category is not documented, use code H54.3 Unqualified visual loss, both eyes. When "blindness" or "low vision" is documented in one eye, but the visual impairment category is not documented, report a code from H54.6- Unqualified visual loss, one eye. When "blindness" or "visual loss" is documented without information specifying one or both eyes are affected, choose code H54.7 Unspecified visual loss. 7. New guidelines are added for pulmonary hypertension. Pulmonary hypertension is classified to category I27 Other pulmonary heart diseases. For secondary pulmonary hypertension (I27.1 Kyphoscoliotic heart disease, I27.2- Other secondary pulmonary hypertension), code also associated conditions or adverse effects of drugs or toxins. Base sequencing on the reason for the encounter. 8. Guidelines for acute myocardial infarction (AMI) are revised, specifying "type 1" AMI, where required and guidelines are added for other types of MI: 1) Type 1 ST elevation myocardial infarction (STEMI) and non-ST elevation myocardial infarction (NSTEMI) The ICD-10-CM codes for type 1 acute myocardial infarction (AMI) identify the site, such as anterolateral wall or true posterior wall. Subcategories I21.0-I21.2 and code I21.3 are used for type 1 ST elevation myocardial infarction (STEMI). Code I21.4, Non-ST elevation (NSTEMI) myocardial infarction, is used for type 1 non ST elevation myocardial infarction (NSTEMI) and nontransmural MIs. If a type 1 NSTEMI evolves to STEMI, assign the STEMI code. If a type 1 STEMI converts to NSTEMI due to thrombolytic therapy, it is still coded as STEMI. 2) Acute myocardial infarction, unspecified Code I21.9, Acute myocardial infarction, unspecified, is the default for unspecified acute myocardial infarction or unspecified type. If only type 1 STEMI or transmural MI without the site is documented, assign code I21.3, ST elevation (STEMI) myocardial infarction of unspecified site. 3) AMI documented as nontransmural or subendocardial but site provided If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI. See Section I.C.21.3 for information on coding status post administration of tPA in a different facility within the last 24 hours. 4) Subsequent acute myocardial infarction A code from category I22, Subsequent ST elevation (STEMI) and non-ST elevation (NSTEMI) myocardial infarction, is to be used when a patient who has suffered a type 1 or unspecified AMI has a new AMI within the 4 week time frame of the initial AMI. A code from category I22 must be used in conjunction with a code from category I21. The sequencing of the I22 and I21 codes depends on the circumstances of the encounter. Do not assign code I22 for subsequent myocardial infarctions other than type 1 or unspecified. For subsequent type 2 AMI assign only code I21.A1. For subsequent type 4 or type 5 AMI, assign only code I21.A9. 5) Other Types of Myocardial Infarction The ICD-10-CM provides codes for different types of myocardial infarction. Type 1 myocardial infarctions are assigned to codes I21.0-I21.4. Type 2 myocardial infarction, and myocardial infarction due to demand ischemia or secondary to ischemic balance, is assigned to code I21.A1, Myocardial infarction type 2 with a code for the underlying cause. Do not assign code I24.8, Other forms of acute ischemic heart disease for the demand ischemia. Sequencing of type 2 AMI or the underlying cause is dependent on the circumstances of admission. When a type 2 AMI code is described as NSTEMI or STEMI, only assign code I21.A1. Codes I21.01-I21.4 should only be assigned for type 1 AMIs. Acute myocardial infarctions type 3, 4a, 4b, 4c and 5 are assigned to code I21.A9, Other myocardial infarction type. The "Code also" and "Code first" notes should be followed related to complications, and for coding of postprocedural myocardial infarctions during or following cardiac surgery. 9. New guidelines are introduced for non-pressure chronic ulcers. For admitted patients with non-pressure ulcers, do not assign a code if the documentation says the non-pressure ulcer is completely "healed." For admitted patients with non-pressure ulcers documented as "healing," new guidelines say: Non-pressure ulcers described as healing should be assigned the appropriate non-pressure ulcer code based on the documentation in the medical record. If the documentation does not provide information about the severity of the healing non-pressure ulcer, assign the appropriate code for unspecified severity. If the documentation is unclear as to whether the patient has a current (new) non-pressure ulcer or if the patient is being treated for a healing non-pressure ulcer, query the provider. For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and severity of the non-pressure ulcer at the time of admission. For admitted patients with a non-pressure ulcer that progresses to a higher severity level during the admission, use two separate codes, "one code for the site and severity level of the ulcer on admission and a second code for the same ulcer site and the highest severity level reported during the stay." 10. New and revised instruction are introduced regarding retained products of conception following an abortion: Subsequent encounters for retained products of conception following a spontaneous abortion or elective termination of pregnancy, without complications are assigned O03.4, Incomplete spontaneous, abortion without complication, or codes O07.4, Failed attempted termination of pregnancy without complication. This advice is appropriate even when the patient was discharged previously with a discharge diagnosis of complete abortion. If the patient has a specific complication associated with the spontaneous abortion or elective termination of pregnancy in addition to retained products of conception, assign the appropriate complication in category O03 or O07 instead of code O03.4 or O07.4. 11. Under the heading "Coding of Pathologic Fractures," language is added to clarify "Active Treatment." The new language says the seventh character D is reported for encounters after the patient has completed active treatment "for the fracture and is receiving routine care for the fracture during the healing or recovery phase." Use the other seventh characters, listed under each subcategory in the Tabular List for subsequent treatment encounters for healing problems, such as malunions, nonunions, and sequelae. 12. Guidelines for functional quadriplegia are deleted, effective Oct. 1, 2017. Section II Key Changes In Section II, changes occur to admissions/encounters for rehabilitation. When an admission/encounter is for

rehabilitation, sequence first the condition for the service performed. The guidelines state, “For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.” If the condition that required the rehabilitation service is no longer present: … report the appropriate aftercare code as the first-listed or principal diagnosis, unless the rehabilitation service is being provided following an injury. For rehabilitation services following active treatment of an injury, assign the injury code with the appropriate seventh character for subsequent encounter as the first-listed or principal diagnosis. For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis. If the patient requires rehabilitation post hip replacement for right intertrochanteric femur fracture, report code S72.141D, Displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, as the first-listed or principal diagnosis. To ensure proper diagnosis coding, review all sections of the ICD-10 guidelines for 2018, not just Sections I and II. John Verhovshek, MA, CPC, is a contributing editor at AAPC. He has been covering medical coding and billing, healthcare policy, and the business of medicine since 1999. He is an alumnus of York College of Pennsylvania and Clemson University. Take Note of the 2018 ICD-10-CM Official Guidelines was last modified: October 1st, 2017 by John Verhovshek

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