Common CMS-HCC Diagnosis Codes*

Information for Physicians/Allied Health Providers (AHP's)

*Not an exhaustive list. This list contains frequently seen diagnoses that are relevant for CMS-HCC Risk Adjustment

Overview

Per the ICD-10-CM Official Guidelines for Coding and Reporting[1]:

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.

Coding Uncertain Diagnoses for Outpatient Encounters[2]

Do not code diagnoses documented as "probable", "suspected", "questionable", "rule out", "appears to be", "consistent with", or "working diagnosis" or other similar terms indicating uncertainty. However, "evidence of" a particular condition is not considered an uncertain diagnosis, and should be appropriately coded and reported in the outpatient setting.

A diagnosis can be used for the Risk Adjustment methodology if the following criteria are met:

1. A diagnosis must be **documented** and **coded** in a face-to-face encounter
2. The documentation and coding must be done to the **highest degree of specificity**
3. Documentation must support MEAT criteria - must show the condition is being **Managed, Evaluated, Assessed or Treated**

Instructions on how to interpret this card.

The codes listed in blue below will fall into onto one of two categories:

- **Codes in bold blue font indicate a higher weighted Risk Adjustment score for CMS-HCC model version 22.**
- Codes in regular blue font are considered Rx CMS-HCCs, model version V05, and have a lower Risk Adjustment score.

However, because Rx HCC conditions are frequently treated they do have a significant impact on the overall Risk Adjustment score. All other codes listed that are not in blue font will have no impact on the Risk Adjustment score.

[1] *ICD-10-CM Official Guidelines for Coding and Reporting, FY 2016, page 102*

[2] *AHA Coding Clinic, Third Quarter 2009, page 7*

Certain Infectious & Parasitic Diseases (A00 - B99)

Human Immunodeficiency Virus (HIV) Infectious Coding Tips

Code only confirmed cases of HIV infection/illness.

Z21 - assigned for asymptomatic human immunodeficiency virus [HIV] infection.

B20 - assigned when a patient has/had any known prior diagnosis of an HIV-related illness. If a patient had been previously diagnosed with any HIV illness B20 will always be assigned.

Other Common Infectious Diseases

ICD-10 Code	Description
A40.3	Pneumococcal Septicemia
A41.50	Gram-Neg Septicemia NOS
A41.51	E Coli Septicemia
A41.52	Pseudomonas Septicemia
A41.9	Septicemia NOS
B02.23	Postherpetic Polyneuropathy
B02.29	PostHerpetic Neuralgia
B18.1	Chronic Hep B without Coma
B18.2	Chronic Hep C without Coma
B37.81	Candidal Esophagitis

Neoplasms (C00 - D49)

Neoplasm Coding Tips

A code for the neoplasm is assigned until the treatment is complete. Treatment means surgery, chemotherapy and/or radiation. Once treatment is completed assign a code from category Z85, Personal history of malignant neoplasm.

Any metastasis to another site is coded as a secondary malignant neoplasm to that site. See example below.

Examples

75 y/o patient s/p mastectomy two years ago for T2N0 breast cancer on Arimidex. It is appropriate to code **Malignant neoplasm of unspecified site of unspecified female breast, C50.919,** as the patient is still receiving treatment.

75 y/o patient s/p hemicolectomy for colon cancer 1 year ago now presents for CEA check. Assign code Z85.038, Personal history of other malignant neoplasm of large intestine.

75 y/o patient s/p lobectomy for lung cancer 5 years ago now presents for radiation treatments of metastatic lung cancer to the brain. Assign codes **C79.31, Secondary malignant neoplasm of brain,** and Z85.118, Personal history of other malignant neoplasm of bronchus and lung.

Disease of the Blood & Blood-Forming Organs & Certain Disorders of Immune Mechanism (D50 - D89)

Common Hematologic Codes

ICD-10 Code	Description
D61.810	Pancytopenia due to chemotherapy
D61.818	Other Pancytopenia
D68.59	Primary and Secondary Hypercoagulable State - includes Protein C Deficiency and Protein S Deficiency
D68.62	Lupus anticoagulant with hypercoagulable state
D69.3	Immune (idiopathic) thrombocytopenic purpura
D69.6	Thrombocytopenia, Unspecified
D70.1	Neutropenia due to chemotherapy
D70.2	Neutropenia due to drugs
D70.9	Neutropenia, Unspecified

Endocrine, Nutritional, and Metabolic Diseases (E00 - E89)

Diabetes Coding Hierarchy: There are three tiers of Diabetes severity in the CMS-HCC Risk Adjustment model. The higher the tier the greater the Risk Adjustment score. Code to the highest Diabetic severity you are treating to accurately portray the patient's risk score.

Highest Severity: Ex. DKA, Hyperosmolar Nonketotic Coma

Moderate Severity (Diabetes with secondary complications): Ex. Diabetic Neuropathy, Diabetic Retinopathy, etc.

Lowest Severity: Diabetes without any complications

Diabetes without complications

E11.9 - Type 2 diabetes mellitus without complications

E10.9 - Type 1 diabetes mellitus without complications

E09.9 - Drug or chemical induced diabetes mellitus without complications

E08.9 - Diabetes mellitus due to underlying condition without complications

Z79.4 - Long-term (current) use of insulin

Diabetes with secondary complications

Document all diabetic complications and ensure that the documentation links the complication to the diabetes (i.e. diabetic neuropathy, diabetic PVD, diabetic nephropathy). The diabetic complication codes in **ICD-10-CM are combination codes** that include the **type of diabetes mellitus, the body system affected, and the complication affecting that body system.** Assign as many codes as necessary to describe all of the complications of the disease. See examples below:

1 Diabetic Complication = 1 Code
(Ex. Type 2 DM with **Diabetic Neuropathy** code **E11.40**)

2 Diabetic Complications = 2 Codes
(Ex. Type 2 DM with **Diabetic Neuropathy** and **Diabetic Retinopathy** code **E11.40** and **E11.319**)

3 Diabetic Complications = 3 Codes
(Ex. Type 2 DM with **Diabetic Neuropathy, Diabetic Retinopathy, and Diabetic Nephropathy** code **E11.40, E11.319, and E11.21**)

Other chronic manifestations of diabetes mellitus may require additional codes to fully describe the complication, in addition to a code from category E08–E13. See example below:

Type 2 DM with Diabetic Foot Ulcer: E11.621, Type 2 diabetes mellitus with foot ulcer, and **L97.509**, Non-pressure chronic ulcer of other part of unspecified foot with unspecified severity

Phrases such as "inadequately controlled", "out of control", "poorly controlled" are coded to **Diabetes, by type with hyperglycemia**. Do not assign diabetes with hypoglycemia for patients using these phrases.

Common Diabetic Complication

ICD-10 Code	Description
E11.22 + N18.9	CKD Unspecified due to Type 2 Diabetes Mellitus
E11.22 + N18.1	CKD Stage 1 due to Type 2 Diabetes Mellitus - GFR > 90, some kidney damage
E11.22 + N18.2	CKD Stage 2 due to Type 2 Diabetes Mellitus- GFR 60 - 89
E11.22 + N18.3	CKD Stage 3 due to Type 2 Diabetes Mellitus - GFR 30 - 59
E11.22 + N18.4	CKD Stage 4 due to Type 2 Diabetes Mellitus - GFR 15 - 29
E11.22 + N18.5	CKD Stage 5 due to Type 2 Diabetes Mellitus - GFR < 15
E11.22 + N18.6	ESRD (CKD requiring chronic dialysis) due to Type 2 Diabetes Mellitus. Code also Z99.2 for Renal Dialysis Status if appropriate.
E11.319	Type 2 Diabetes Mellitus with Diabetic Retinopathy
E11.359	Type 2 Diabetes Mellitus with Diabetic Proliferative Retinopathy
E11.39 + H54.0	Type 2 Diabetes Mellitus with Diabetic Blindness
E11.40	Type 2 Diabetes Mellitus with Diabetic Neuropathy
E11.43 + K31.84	Type 2 Diabetes Mellitus with Diabetic Gastroparesis
E11.42	Type 2 Diabetes Mellitus with Gangrene
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.621 + L97.509	Type 2 Diabetes Mellitus with Diabetic Foot Ulcer (note see also codes from L97.4- and L97.5- for specific foot ulcer codes)
E11.622 + L98.499	Type 2 Diabetes Mellitus with Other Skin Ulcer (note see also codes from L97.1 - L97.9, L98.41 - L98.49 for specific skin ulcer codes)

Obesity/BMI Coding Tips

A BMI > 40 (Morbid Obesity) contributes to Risk Adjustment. If the patient has a BMI > 40, provide a diagnosis code plus a code for the BMI. Ex. For a patient with a BMI of 45, code **E66.01** (Morbid Obesity) + **Z68.42** (BMI 45-49.9).

The BMI codes that impact Risk Adjustment with obesity are as follows:

Z68.41, BMI 40 - 44.9, adult

Z68.42, BMI 45 - 49.9, adult

Z68.43, BMI 50 - 59.9, adult

Z68.44, BMI 60 - 69.9, adult

Z68.45, BMI 70 and over, adult

It is acceptable to assign the BMI code if known (Z68.41 - Z68.45) with any diagnosis code in subcategory Z66.-.

Common Obesity/BMI Combination Codes

ICD-10 Code	Description
E66.01 + BMI V code	Morbid Obesity - code also the BMI if known **Z68.41** - **Z68.45**
E66.9 + BMI V code	Obesity - code also the BMI if known **Z68.41** - **Z68.45**
E66.3 + BMI V code	Overweight - code also the BMI if known **Z68.41** - **Z68.45**

Other Common Endocrine Codes

ICD-10 Code	Description
E03.9	Hypothyroidism NOS
E04.9	Goiter NOS
E21.0	Primary Hyperparathyroidism
E21.1	Secondary Hyperparathyroidism (non-renal)
E21.3	Hyperparathyroidism NOS
E46	Malnutrition, Unspecified
E78.5	Hyperlipidemia, Unspecified

Mental, Behavioral and Neurodevelopmental Disorders (F01 - F99)

Alcohol and Drug Disorders Coding Tips

Be specific when documenting Alcohol and Drug disorders as the specific words will affect the Risk Adjustment score. Alcohol or Drug "Dependence" contributes to the Risk Adjustment methodology, but the diagnosis of Alcohol or Drug "Abuse" or "Use" does not unless there are related physical complications or psychotic symptoms. Documentation of an Alcohol or Drug dependence "in remission" will also contribute to the Risk Adjustment methodology. See below for common conditions.

Common Alcohol and Drug Disorder Codes

ICD-10 Code	Description
F10.20	Alcohol Dependence NOS Unspecified - includes Alcoholism
F10.21	Alcohol Dependence NOS Remission - includes Alcoholism in Remission
F10.129	Alcohol abuse with intoxication, unspecified
F10.94	Alcohol use, unspecified with alcohol-induced mood disorder
F11.20	Opioid Dependence Unspecified
F11.24	Opioid dependence with opioid-induced mood disorder
F11.21	Opioid Dependence Remission
F12.20	Cannabis Dependence Unspecified
F12.21	Cannabis Dependence Remission
F14.20	Cocaine Dependence Unspecified
F14.21	Cocaine Dependence Remission
F19.20	Drug Dependence NOS Unspecified
F19.21	Drug Dependence NOS Remission

Psychiatric Coding Tips

Be as specific as possible when documenting affective disorders. Major depressive disorder, bipolar disorders, and anxiety disorders are the most common affective disorders.

Common Psychiatric Codes

ICD-10 Code	Description
F01.50	Vascular Dementia, Uncomplicated
F03.90	Senile Dementia, Uncomplicated Presenile Dementia Dementia NOS without Behavioral Disturbance
F03.91	Dementia NOS with Behavioral Disturbance
F20.0	Paranoid Schizophrenia, Unspecified
F20.89	Simple Schizophrenia, Unspecified
F20.9	Schizophrenia, NOS
F31.9	Bipolar Disorder, Unspecified
F32.0	Major depressive disorder, single episode, mild
F32.9	Major Depression, Unspecified - includes Depression NOS
F33.0	Major depressive disorder, recurrent, mild
F41.1	Generalized Anxiety Disorder
F42	Obsessive-Compulsive Disorder
F79	Mental Retardation NOS

Diseases of the Nervous System (G00 - G99)

Common Neurologic Codes

ICD-10 Code	Description
G20	Parkinson's Disease
G21.9	Secondary Parkinsonism
G30.9 + F02.80	Alzheimer's Disease
G35	Multiple sclerosis
G40.409	Petit Mal Status
G40.109	Partial Epilepsy NOS
G40.909	Epilepsy NOS w/o Intractable Epilepsy
G43.909	Migraine Unspecified
G54.6	Phantom limb syndrome with pain
G54.7	Phantom limb syndrome without pain
G81.90	Unspecified Hemiplegia, Unspecified side - do not assign for late effect of CVA
G81.91	Hemiplegia, unspecified affecting right dominant side - do not assign for late effect of CVA
G81.92	Hemiplegia, unspecified affecting left dominant side - do not assign for late effect of CVA
G81.93	Hemiplegia, unspecified affecting right nondominant side - do not assign for late effect of CVA
G81.94	Hemiplegia, unspecified affecting left nondominant side - do not assign for late effect of CVA
G82.20	Paraplegia NOS - do not assign for late effect of CVA
G83.30	Monoplegia NOS - do not assign for late effect of CVA

Diseases of the Eye and Adnexa (H00 - H59)

Common Ophthalmic Codes

ICD-10 Code	Description
H40.10X0	Unspecified open-angle glaucoma, stage unspecified
H43.11	Vitreous hemorrhage, right eye
H43.12	Vitreous hemorrhage, left eye

Diseases of the Circulatory Systems (I00 - I99)

Hypertension Coding Tips

Code to the highest level of specificity. If hypertensive heart disease or hypertensive kidney disease is present code per the instructions below.

Common Hypertension Codes

ICD-10 Code	Description
I10	HTN, not otherwise specified
I11.9	Hypertensive Heart Disease, without Heart Failure
I11.0 + code from **I50.1** - **I50.9**	Hypertensive Heart Disease, with Heart Failure
I12.9 + code from N18.1 - **N18.4**, N18.9	Hypertensive Chronic Kidney Disease, Unspecified, with CKD Stage 1-4 or Unspecified
I12.0 + code from **N18.5** or **N18.6**	Hypertensive Chronic Kidney Disease, Unspecified, with CKD Stage 5 or ESRD

Acute Myocardial Infarction Coding Tips

Document the site of the myocardial infarction

Codes for AMI are based on the following criteria:

Acute or with a duration of four weeks or less - assign code from category I21

New myocardial infarction within four weeks of an acute myocardial infarction - assign code from category I22. Use in conjunction with a code from category I21.

Healed or old MI - any MI that is greater than 4 weeks old.

Common Myocardial Infarction Codes

ICD-10 Code	Description
I21.3	Acute MI NOS - for a more complete list of specific location of the MI codes refer to the ICD-10-CM classification
I21.4	Acute Subendo MI 4 weeks or less
I22.2 + I21.4	New Subendo MI within 4 weeks of a previous Subendo MI
I25.2	Old Myocardial Infarction > 8 weeks old

Common Angina/CAD Codes

ICD-10 Code	Description
I20.9	Angina Decubitus
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris (includes CAD NOS)
I25.119	Coronary Atherosclerosis of Native Coronary Artery with Angina

Heart Failure Coding Tips

Use the most specific code and documentation to support the treatment of the heart failure.

Common Heart Failure Codes

ICD-10 Code	Description
I50.21	Acute Systolic Heart Failure
I50.22	Chronic Systolic Heart Failure
I50.23	Acute on Chronic Systolic Heart Failure
I50.31	Acute Diastolic Heart Failure
I50.32	Chronic Diastolic Heart Failure
I50.33	Acute on Chronic Diastolic Heart Failure
I50.9	CHF NOS

Cerebral Infarction/Stroke/CVA Coding Tips

Acute stroke or TIA can only be coded during the acute episode. After the patient is discharged from the acute event assign code Z86.73, TIA and CVA without Residual Deficits. However, if there are any residual neurological deficits assigned a code from category I69.-, ex. history of CVA with hemiplegia/hemiparesis is assigned I69.359, Hemiplegia and hemiparesis following cerebral infarction affecting unspecified side. **Weakness associated with a previous cerebral infarction will also be assigned to category I69.-.**

Common Atherosclerosis Codes

ICD-10 Code	Description
I65.29	Occluded Carotid Artery
I66.9	Cerebral Artery Occlusion NOS
I70.0	Aortic Atherosclerosis
I70.1	Renal Atherosclerosis
I70.211	Atherosclerosis of native arteries of extremities with intermittent claudication, right leg

Common Atherosclerosis Codes

ICD-10 Code	Description
I70.212	Atherosclerosis of native arteries of extremities with intermittent claudication, left leg
I71.2	Thoracic Aortic Aneurysm
I71.4	Abdominal Aortic Aneurysm
I73.9	Peripheral vascular disease, unspecified - excludes arteriosclerotic vascular disease. If present report a code from I70.- instead.

Common Residual Complication Stroke Codes

ICD-10 Code	Description
I69.359	Hemiplegia and hemiparesis following cerebral infarction affecting unspecified side (includes weakness associated with a previous CVA)
I69.339	Monoplegia of upper limb following cerebral infarction affecting unspecified side
I69.349	Monoplegia of lower limb following cerebral infarction affecting unspecified side
I69.369	Other paralytic syndrome following cerebral infarction affecting unspecified side

Other Common Cardiac/ Circulatory Codes

ICD-10 Code	Description
I26.99	Acute Pulmonary Embolism
I27.82	Chronic Pulmonary Embolism
I27.0	Primary pulmonary hypertension
I27.2	Pulmonary HTN NOS
I27.81	Chronic Cor Pulmonale
I42.1	Hypertrophic Obstructive Cardiomyopathy
I42.9	Idiopathic Cardiomyopathy Secondary Cardiomyopathy, Unspecified
I47.1	Paroxysmal Atrial Tachycardia (PAT) Paroxysmal Ventricular Tachycardia NOS (PSVT)
I48.91	Atrial Fibrillation
I48.92	Atrial Flutter
I82.4Y1	Acute embolism and thrombosis of unspecified deep veins of right proximal lower extremity
I82.4Y2	Acute embolism and thrombosis of unspecified deep veins of left proximal lower extremity
I82.4Z1	Acute embolism and thrombosis of unspecified deep veins of right distal lower extremity
I82.4Z2	Acute embolism and thrombosis of unspecified deep veins of left distal lower extremity
I82.431	Acute embolism and thrombosis of right popliteal vein
I82.432	Acute embolism and thrombosis of left popliteal vein
I82.531	Chronic embolism and thrombosis of right popliteal vein
I82.532	Chronic embolism and thrombosis of left popliteal vein

Common Circulatory Combination Codes

ICD-10 Code	Description
I70.239 or **I70.249** + code from **L97**.-	Atherosclerosis of Native Extremities with Ulceration (see I70.23- , I70.24- and I70.25- for specific codes)
I70.261 or **I70.262** + code from **L97.-**, **L98.49-**	Atherosclerosis of Native Extremities with Gangrene (refer to ICD-10-CM for more specific codes, including ones for bypass grafts)

Diseases of the Respiratory System (J00 - J99)

Respiratory Helpful Tip

Document and code chronic respiratory failure for patient's who require continuous home oxygen

Common Respiratory Codes

ICD-10 Code	Description
J41.0	Smoker's Cough
J42	Chronic Bronchitis
J43.9	Emphysema NOS
J44.0	COPD with Acute Bronchitis
J44.1	COPD with Acute Exacerbation
J44.1 + J45.901	Chronic Obstructive Asthma with Acute Exacerbation
J44.9 + J45.909	Chronic Obstructive Asthma NOS
J44.9	Chronic Obstructive Pulmonary Disease (COPD) NOS
J45.909	Asthma NOS
J47.1	Bronchiectasis with acute exacerbation
J47.9	Bronchiectasis w/o acute exacerbation
J96.00	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.10	Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.20	Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia

Diseases of the Digestive System (K00 - K95)

Common Digestive Disorder Codes

ICD-10 Code	Description
K21.9	Esophageal Reflux
K22.70	Barrett's esophagus without dysplasia
K50.90	Regional Enteritis NOS (Crohn's)
K51.90	Ulcerative Colitis NOS
K56.41	Fecal Impaction
K70.30	Alcoholic Cirrhosis Liver
K74.60	Unspecified cirrhosis of liver, or, Cirrhosis, Non-Alcoholic
K73.9	Chronic Hepatitis, Unspecified
K75.4	Autoimmune Hepatitis
K86.1	Chronic Pancreatitis
K90.0	Celiac Disease

Diseases of the Skin and Subcutaneous Tissue (L00 - L99)

Skin Ulcer Coding Tips

Most of the chronic ulcers of the skin are classified as:

Pressure Ulcer (Decubitus Ulcers) - are assigned to category L89 - specify the site and stage of the ulcer. Pressure ulcers that are stage 3, stage 4 and unstageable contribute to Risk Adjustment.

Nonpressure Ulcer of lower limbs - are assigned to category L97 - specify the site and severity of the ulcer, such as limited to breakdown of skin, fat layer exposed, necrosis of muscle, or necrosis of bone. A causal condition should be assumed when a lower extremity ulcer is documented with the following conditions: atherosclerosis of the lower extremities, chronic venous hypertension, diabetic ulcers, postphlebitic syndrome, postthrombotic syndrome, and varicose ulcer.

Pressure Ulcer Coding Tips

Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.

Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the current stage of the pressure ulcer stage. Ex. Pressure ulcer of the right heel originally was a stage 4, is now improved to a stage 3, code as a stage 3 pressure ulcer of the right heel, **L89.613, Pressure ulcer of right heel, stage 3**.

Common Pressure Ulcer Codes

ICD-10 Code	Description
L89.010	Pressure ulcer of right elbow, unstageable
L89.020	Pressure ulcer of left elbow, unstageable
L89.110	Pressure ulcer of right upper back, unstageable
L89.120	Pressure ulcer of left upper back, unstageable
L89.130	Pressure ulcer of right lower back, unstageable
L89.140	Pressure ulcer of left lower back, unstageable
L89.150	Pressure ulcer of sacral region, unstageable
L89.210	Pressure ulcer of right hip, unstageable
L89.220	Pressure ulcer of left hip, unstageable
L89.310	Pressure ulcer of right buttock, unstageable
L89.320	Pressure ulcer of left buttock, unstageable
L89.510	Pressure ulcer of right ankle, unstageable
L89.520	Pressure ulcer of left ankle, unstageable
L89.610	Pressure ulcer of right heel, unstageable
L89.620	Pressure ulcer of left heel, unstageable
L89.890	Pressure ulcer of other site, unstageable

Common Nonpressure Ulcer Codes

ICD-10 Code	Description
L97.919	Non-pressure chronic ulcer of unspecified part of right lower leg with unspecified severity
L97.929	Non-pressure chronic ulcer of unspecified part of left lower leg with unspecified severity
L97.119	Non-pressure chronic ulcer of right thigh with unspecified severity
L97.129	Non-pressure chronic ulcer of left thigh with unspecified severity
L97.219	Non-pressure chronic ulcer of right calf with unspecified severity
L97.229	Non-pressure chronic ulcer of left calf with unspecified severity
L97.319	Non-pressure chronic ulcer of right ankle with unspecified severity
L97.329	Non-pressure chronic ulcer of left ankle with unspecified severity
L97.419	Non-pressure chronic ulcer of right heel and midfoot with unspecified severity
L97.429	Non-pressure chronic ulcer of left heel and midfoot with unspecified severity
L97.519	Non-pressure chronic ulcer of other part of right foot with unspecified severity - includes the toes
L97.529	Non-pressure chronic ulcer of other part of left foot with unspecified severity - includes the toes
L97.819	Non-pressure chronic ulcer of other part of right lower leg with unspecified severity
L97.829	Non-pressure chronic ulcer of other part of left lower leg with unspecified severity

Other Common Skin Ulcer Combination Codes

ICD-10 Code	Description
E11.621 + L97.519	Type 2 Diabetes Mellitus with Diabetic Right Foot Ulcer
E11.621 + L97.529	Type 2 Diabetes Mellitus with Diabetic Left Foot Ulcer
I70.235 + L97.519	Atherosclerosis of native arteries of right leg with ulceration of other part of foot
I70.245 + L97.529	Atherosclerosis of native arteries of left leg with ulceration of other part of foot
I70.261 + L97.519	Atherosclerosis of native arteries of extremities with gangrene, right leg
I70.262 + L97.529	Atherosclerosis of native arteries of extremities with gangrene, left leg

Diseases of the Musculoskeletal System and Connective Tissue (M00 - M99)

Common Rheumatologic/Musculoskeletal Codes

ICD-10 Code	Description
M06.4	Inflammatory Polyarthropathy NOS
M06.9	Rheumatoid Arthritis
M32.9	Systemic Lupus Erythematosus
M34.1	CR(E)ST syndrome
M35.3	Polymyalgia Rheumatica
M81.0	Osteoporosis
M86.179	Other acute osteomyelitis, unspecified ankle and foot - for complete list of osteomyelitis codes see M86.-.

Diseases of Genitourinary System (N00 - N99)

Common Genitourinary Codes

ICD-10 Code	Description
N17.9	Acute Renal Failure/Acute Kidney Injury
N18.1	Chronic Kidney Disease, Stage I - GFR > 90, some kidney damage
N18.2	Chronic Kidney Disease, Stage II - GFR 69 - 89
N18.3	Chronic Kidney Disease, Stage III - GFR 30 - 59
N18.4	Chronic Kidney Disease, Stage IV - GFR 15 - 29
N18.5	Chronic Kidney Disease, Stage V - GFR < 15
N18.6	ESRD or CKD Requiring Chronic Dialysis
N18.9	Chronic Kidney Disease, Unspecified

Congenital Malformation, Deformations, and Chromosomal Abnormalities (Q00 - Q99)

Common Congenital Codes

ICD-10 Code	Description
Q05.9	Spina bifida, unspecified
Q07.00	Arnold-Chiari syndrome without spina bifida or hydrocephalus

Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00 - R99)

Common Signs & Symptoms Codes

ICD-10 Code	Description
R64	Cachexia

Injury, Poisoning, and Certain Other Consequences of External Causes (S00 - T88)

Acute Fractures versus Aftercare Coding Tips

ICD-10-CM makes extensive use of seventh-character values for fractures. While most categories in chapter 19 have three seventh-character values - "A," initial encounter; "D," subsequent encounter; and "S," sequela - the seventh-character values vary depending on the bones affected. Review the Tabular List at each category level to determine the appropriate code value.

The seventh-character value for **initial encounter** is assigned while the patient is receiving active treatment for the fracture. Examples of active treatment are surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.

The seventh-character value for **subsequent care** are for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase. Examples of fracture aftercare are cast change or removal, an X-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment, and follow-up visits following fracture treatment.

The seventh-character value "S," **sequela**, is used for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn; the scars are sequela of the burn. Code also the specific type of sequela (e.g., scar) first, followed by the injury code.

Aftercare for traumatic fractures is coded to the acute fracture with the appropriate seventh-character value for subsequent care. **The aftercare Z codes should not be used for aftercare of injuries**. For aftercare of an injury, the acute injury code is assigned, with the appropriate seventh-character value for subsequent encounter.

Examples

75 y/o patient seen in the ED for a right distal radial fracture and was referred to orthopedic surgery for possible surgery. The orthopedic surgeon evaluated the patient in the office and recommended surgery. Assign code S52.501A, Unspecified fracture of the lower end of right radius, initial encounter for closed fracture, for the ED and office visit as the patient is receiving active treatment for the fracture.

75 y/o patient seen by orthopedic surgery for post-op examination following ORIF of a right trochanteric hip fracture. Assign code S72.101D, Unspecified trochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing.

Factors Influencing Health Status and Contact with Health Services (Z00 - Z99)

Classification of Factors Influencing Health Status Coding Tips

These are conditions that are known to influence the patient's health status. Document if any of these conditions are present for your patient.

Common Status Codes

ICD-10 Code	Description
Z21	Asymptomatic HIV infection
Z43.0	Tracheostomy Status
Z43.1	Gastrostomy Status
Z43.2	Ileostomy Status
Z43.3	Colostomy Status
Z43.4	Enterostomy Status
Z43.5	Cystostomy Status, NOS
Z43.6	Encounter for attention to other artificial openings of urinary tract - includes nephrostomy, ureterostomy and urethrostomy
Z68.41	Body mass index (BMI) 40.0-44.9, adult
Z68.42	Body mass index (BMI) 45.0-49.9, adult
Z68.43	Body mass index (BMI) 50-59.9 , adult
Z68.44	Body mass index (BMI) 60.0-69.9, adult
Z68.45	Body mass index (BMI) 70 or greater, adult
Z79.4	Long-term Use of Insulin
Z89.411	S/P Amputation - Acquired absence of right great toe
Z89.412	S/P Amputation - Acquired absence of left great toe
Z89.421	S/P Amputation - Acquired absence of other right toe(s)
Z89.422	S/P Amputation - Acquired absence of other left toe(s)
Z89.431	S/P Amputation - Acquired absence of right foot
Z89.432	S/P Amputation - Acquired absence of left foot
Z89.441	S/P Amputation - Acquired absence of right ankle

Common Status Codes

ICD-10 Code	Description
Z89.442	S/P Amputation - Acquired absence of left ankle
Z89.511	S/P Amputation - Acquired absence of right leg below knee
Z89.512	S/P Amputation - Acquired absence of left leg below knee
Z89.611	S/P Amputation - Acquired absence of right leg above knee
Z89.612	S/P Amputation - Acquired absence of left leg above knee
Z94.0	Kidney Transplant Status
Z94.1	Heart Transplant Status
Z94.2	Lung Transplant Status
Z94.3	Heart and lungs transplant status
Z94.4	Liver Transplant Status
Z94.81	Bone Marrow Transplant Status
Z94.84	Stem cells transplant status
Z94.83	Pancreas Transplant Status
Z94.82	Intestinal Transplant Status
Z49.31	Encounter for adequacy testing for hemodialysis
Z49.32	Encounter for adequacy testing for peritoneal dialysis
Z99.2	Renal Dialysis Status
Z91.15	Patient's noncompliance with renal dialysis
Z99.11	Respirator Dependent Status

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All conditions affecting the care, treatment or management of the patient should be documented with their status and treatment and coded to the highest level of specificity. It is always the responsibility of the clinician to document accurate and complete information relating to the patient's encounter. If clinician documentation does not support a diagnosis code, that code cannot be used or submitted for reimbursement.

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