Presented by:
Kim Pollock, RN, MBA, CPC, CMDP

Kim Pollock specializes in streamlining the operations of neurosurgery practices. Kim has thirty years experience in health care as a nurse, administrator and consultant. For almost twenty years, Ms. Pollock has helped large group practices, as well as academic and solo practices, improve collections and efficiency. She is expert at auditing neurosurgery, including all subspecialties, coding and documentation.

Ms. Pollock understands the complexity of coding and reimbursement issues specific to neurosurgical surgeons – both from a clinical perspective and from a payer side. She is an expert in analyzing chart documentation and in reengineering practices to enhance the reimbursement process.

She has presented seminars and workshops for physicians and their staff on behalf of the American Association of Neurological Surgeons, the American Academy of Otolaryngology-Head and Neck Surgery (AAOHNS) and the American Society of Plastic Surgeons (ASPS). Ms. Pollock has also conducted programs for the American Academy of Professional Coders (AAPC), the North American Spine Society (NASS), the America Neurological Society (ANS) and the Congress of Neurological Surgeons (CNS).

Ms. Pollock is the recipient of the prestigious Presidential Citation Award from the Society of Otorhinolaryngology and Head Neck Nurses as well as an Honor Award from the AAOHNS. Ms. Pollock holds a Masters of Business Administration degree as well as a Bachelor of Science Degree in Nursing. She is also a certified coder through the AAPC and a certified medical documentation professional through the American Institute of Healthcare Compliance.

Meet Kim Pollock
RN, MBA, CPC, CMDP

Webinar Policy

Webinars are the property of KarenZupko & Associates, Inc. and are for personal use only. They may not be recorded, rebroadcast, retransmitted, shared, or disseminated without permission from KZA.
Agenda

- Address major changes in code descriptors in ICD-10-CM and how documentation is impacted.
- Focus is on how provider documentation must change so most accurate ICD-10-CM code can be assigned.

ICD-10-CM Implementation 10/1/15

- Claims with date of service 10/1/15 or later must use ICD-10-CM codes
- Pre-certification of services for 10/1/15 must be done using ICD-10-CM codes (e.g., procedures, MRIs)
- Applies to HIPAA covered entities (e.g., physicians, facilities, health insurers)
  - Non-HIPAA covered entities are not mandated to comply.
    - Examples: Work Comp payers, MVA payers
    - Action: Check to see which of your non-HIPAA covered payers will/won’t be allowing ICD-10-CM codes
- Hospitals will be implementing ICD-10-PCS on 10/1/15 (does not apply to physician professional claims)

CMS Announcement on 7/6/15

- Claim denials: For the first year ICD-10 is in place, Medicare claims will not be denied solely based on the specificity of the diagnosis codes as long as they are from the appropriate family of ICD-10 codes.
- Claim audits: Medicare claims will not be audited based on the specificity of the diagnosis codes as long as they are from the appropriate family of codes.
- Quality-reporting penalties: Similar to claim denials, CMS will not subject physicians to penalties for the PQRS, the value-based payment modifier or meaningful use based on the specificity of diagnosis codes as long as they use a code from the correct ICD-10 family of codes. In addition, penalties will not be applied if CMS experiences difficulties calculating quality scores for these programs as a result of ICD-10 implementation.
CMS Announcement on 7/6/15

- Payment disruptions: If Medicare contractors are unable to process claims as a result of problems with ICD-10, CMS will authorize advance payments to physicians.
- Navigating transition problems: CMS has said it will establish a communication center to monitor issues and resolve them as quickly as possible. This will include an “ICD-10 ombudsman” devoted to triaging physician issues.

NOTE: Both Medicare Administrative Contractors (MACs) and Recovery Audit Contractors (RACs) will be required to follow this policy.

Bill Introduced to Allow Dual Coding

Both ICD9 and ICD10 codes cannot be on the same claim; “dual” coding means using either ICD9 OR ICD10 for a 6 month grace period.

What’s Different: Format of Codes

ICD-9 Code Structure:
- Numeric or Alpha (E or V)
- Category
- Etiology, Anatomic Site, Severity

ICD-10 Code Structure:
- Numeric or Alpha (every letter except U)
- Category
- Etiology, Anatomic Site, Severity
- Extension
What’s Different: Format of Codes

<table>
<thead>
<tr>
<th>First Character</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C, D</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>E</td>
<td>Endocrine System</td>
</tr>
<tr>
<td>G</td>
<td>Nervous System</td>
</tr>
<tr>
<td>I</td>
<td>Circulatory System</td>
</tr>
<tr>
<td>M</td>
<td>Musculoskeletal System</td>
</tr>
<tr>
<td>Q</td>
<td>Congenital Malformations</td>
</tr>
<tr>
<td>S</td>
<td>Injury</td>
</tr>
<tr>
<td>T</td>
<td>Malfunction</td>
</tr>
<tr>
<td>V, W</td>
<td>External Cause Codes</td>
</tr>
<tr>
<td>Z</td>
<td>Other Reasons for Health Care (non-illness such as surveillance)</td>
</tr>
</tbody>
</table>

What’s Different: Use of “X” Placeholder

- ICD-10-CM uses the letter “X” as a placeholder
- There are 2 applications:

1. Used as a 5th character placeholder at certain 6-character codes to allow for future expansion without disturbing the 6th character structure
   - Example:
     - M53.2X1 Spinal instabilities, occipito-atlanto-axial region
     - M53.2X2 Spinal instabilities, cervical region
     - M53.2X3 Spinal instabilities, cervicothoracic region
     - M53.2X4 Spinal instabilities, thoracic region
     - M53.2X5 Spinal instabilities, thoracolumbar region
     - M53.2X6 Spinal instabilities, lumbar region
     - M53.2X7 Spinal instabilities, lumbosacral region
     - M53.2X8 Spinal instabilities, sacral and sacrococcygeal region

2. Certain categories of codes (e.g., pathological fractures, injuries, mechanical complications) require a 7th character extension
   - The 7th character extension must always be in the 7th position
   - If the code provided is not full 6 characters in length, then a placeholder “X” must be used to fill in the empty positions to keep the 7th character extension in the 7th position

   Example:
   - M80.08 Age-related osteoporosis with current pathological fracture, vertebra(e)
     - Incorrect code assignment: M80.08A
     - Correct code assignment: M80.08XA

What’s Different: 7th Character Extension for Pathological Fractures (e.g., M80, M84)

<table>
<thead>
<tr>
<th>Extension</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Initial encounter for fracture</td>
</tr>
<tr>
<td>D</td>
<td>Subsequent encounter for fracture with routine healing</td>
</tr>
<tr>
<td>G</td>
<td>Subsequent encounter for fracture with delayed healing</td>
</tr>
<tr>
<td>E</td>
<td>Subsequent encounter for fracture with nonunion</td>
</tr>
<tr>
<td>P</td>
<td>Subsequent encounter for fracture with malunion</td>
</tr>
<tr>
<td>S</td>
<td>Sequela</td>
</tr>
</tbody>
</table>

While the patient may be seen by a new or different provider over the course of treatment for a pathological fracture, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.
What’s Different 7th Character Extension for
Pathological Fractures (e.g., M80, M84)

Initial – Use for encounters when the patient is receiving active treatment for the fracture; a patient who delayed seeking treatment for the fracture or nonunion. Examples: Surgical treatment, emergency department encounter, evaluation and continuing treatment by the same or a different physician.

Subsequent – Use 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. Examples: follow-up visits even in the global period, x-ray to check healing status, removal of fixation device.

There are no definitions of terms for problems such as nonunion, malunion, or delayed healing.

Sequela – Use for conditions that arise as a direct result of a condition. A sequela is not a complication. There must be a causal relationship documented to support using the “S” extension.

All pathological fracture documentation must support the following so the correct 7th character extension can be applied:

1) Type of encounter: 1) Healing status

What’s Different: 7th Character Extension for
Traumatic Fractures (S02, S12, S22, S32)

Initial Fractures, the appropriate 7th character is to be added to each code:

A Initial encounter for closed fracture
B Initial encounter for open fracture
D Subsequent encounter for fracture with routine healing
G Subsequent encounter for fracture with delayed healing
S Sequela

While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

What’s Different 7th Character Extension for
Pathological Fractures (e.g., M80, M84)
For non-fractures (e.g., lacerations, nerve injuries, intracranial injuries), the appropriate 7th character is to be added to each code: (3 options)

- A: Initial encounter
- D: Subsequent encounter
- S: Sequela

While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

**What's Different: 7th Character Extension for Non-Fracture Injuries (e.g., S06, S14, S24, S34)**

<table>
<thead>
<tr>
<th>Character</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Initial encounter</td>
</tr>
<tr>
<td>D</td>
<td>Subsequent encounter</td>
</tr>
<tr>
<td>S</td>
<td>Sequela</td>
</tr>
</tbody>
</table>

Initial = Use for encounters when the patient is receiving active treatment for the injury. Examples: Surgical treatment, emergency department encounter, evaluation and continuing treatment by the same or a different physician.

Subsequent = Use for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples: follow-up visits even in the global period, x-ray to check healing status.

Sequela = Use for conditions that arise as a direct result of a condition. A sequela is not a complication. There must be a causal relationship documented to support using the “S” extension.

All non-fracture injury documentation must support the following so the correct 7th character extension can be applied:

1. Type of encounter
2. Healing status

**What's Different: Use of Codes for External Cause of Morbidity**

- ICD-9-CM has “E” codes for supplementary classification of external causes; payer dependent.
- ICD-10-CM uses “V” and “Y” codes – also payer dependent.
- Reporting of external causes of morbidity codes are secondary codes (not primary codes) intended to provide data for injury research and evaluation of injury prevention strategies.
- There is no national requirement for mandatory ICD-10-CM external cause code reporting.
  - Some states or payers may require the codes.
  - The World Health Organization encourages voluntary reporting.
- May be used with any primary code (e.g., infection caused by an external source) but most applicable to injuries.
- Use on claim for initial encounter only.
Example: External Cause of Morbidity

At least 5 diagnosis codes on claim for initial encounter only:
1) Primary diagnosis/injury: medical condition
2) External cause: how it happened (V-)
3) Place of occurrence: where it happened (Y92.-)
4) Activity performed: what the patient was doing at the time the injury occurred (Y93.-)
5) Patient status: whether event occurred during military activity, non-military person was at work, non-work activity (Y99.-)

Example: A 25-year-old female ice skating instructor fell while teaching ice skating at work on an outdoor rink and sustained a frontal bone fracture. She was taken by ambulance to the local hospital. You see the patient in consultation in the emergency department.

The appropriate diagnosis codes for this case are based on injury and external cause coding guidelines and billed to Work Comp because the codes were required by the specific payer.

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-10-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Primary Diagnosis/Injury</td>
<td>S02.0XXA</td>
</tr>
<tr>
<td>2) External Cause</td>
<td>V90.211A</td>
</tr>
<tr>
<td>3) Place of Occurrence</td>
<td>Y92.33D</td>
</tr>
<tr>
<td>4) Activity Performed</td>
<td>Y90.21</td>
</tr>
<tr>
<td>5) Patient Status</td>
<td>Y99.0</td>
</tr>
</tbody>
</table>

Musculoskeletal Conditions (M Codes): New Concepts

- Radiculopathy added as combination code for disc disorders (M50, M51)
- Radiculopathy is now a primary diagnosis code (M54.1-)
- Sciatica is now right or left (M54.3-); combined code for lumbar with sciatica (M54.4-)
- No combined code for stenosis with neurogenic claudication like in ICD-9-CM
- Spondylolisthesis in “multiple sites” is a separate code (M43.19)
  - Example: L4-5 (lumbar, M43.14) and L5-S1 (lumbosacral, M43.17) – one code for multiple sites (M43.20)
- For only cervical disc disorders (M520); code to the most superior level of disorder
  - Example: herniated disc with myelopathy at C5-C6, C6-C7 and C7-T1 is only M50.03 (not M50.02 and M50.05)
- Otherwise code for all levels of disorder
  - Example: Spinal stenosis at L4-5
    - M48.06 Lumbosacral (L4-5) + M48.07 Lumbosacral (L5-S1)
Musculoskeletal Conditions (M Codes): CDI Tips

Clinical Documentation Improvement Tips

1. Accurate coding of spine disorders requires documentation of the EXACT LEVEL of disease or condition.

Example: C5-6 vs C5-5

2. Always document presence of MYELOPATHY and/or RADICULOPATHY.

For example, a cervical herniated disc with myelopathy has 3 specific codes:

- M43.01: high cervical region (C2-3, C3-4)
- M43.02: mid-cervical region (C4-5, C5-6, C6-7)
- M43.03: low cervical region (C7-T1)

A cervical herniated disc with radiculopathy has 3 specific codes:

- M43.11: high cervical region (C2-3)
- M43.12: mid-cervical region (C4-5, C5-6, C6-7)
- M43.13: low cervical region (C7-T1)

3. Always document the TYPE/CAUSE of disorder:

- Degenerative vs. traumatic vs. post-surgical
- Infectious
- For pathologic fractures – osteoporosis, neoplastic related, steroid induced, infarction, etc.

4. Always document LATERALITY – right vs. left

Do NOT Say: T12 pathologic fracture

DO Say: T12 pathologic fracture due to osteoporosis

Injuries (S Codes): New Concepts

- 7th character extension for healing status

  - Initial encounter
  - Subsequent encounter
  - Sequela

- A fracture not indicated as open or closed should be coded to closed (same as ICD-9-CM). A fracture not indicated whether displaced or not displaced should be coded to displaced (new in ICD-10-CM)

Head Injuries: Scalp Wounds (S01 Code)

Clinical Documentation Improvement Tips

1. State TYPE of injury

  - Laceration
  - Puncture
  - Open bite

2. State presence of FOREIGN BODY

  - WITH FB (describe it)
  - WITHOUT FB (will assume no FB unless stated)

3. State (or imply) phase of HEALING PROCESS (defines the 7th character)

  - Initial encounter
  - Subsequent encounter
  - Sequela

4. For CPT coding of laceration repair: state LENGTH of wound repair in centimeters and TYPE of repair

  - Simple – non-layered closure
  - Intermediate – layered closure OR non-layered closure with extensive debridement of particulate matter (describe it)
  - Complex – extensive undermining, extensive OR layered closure with extensive debridement of particulate matter (describe it)
Head Injuries: Skull Fractures (S02 Codes)

Clinical Documentation Improvement Tips

1. State name of BONE or area of fracture
   - Vault
   - Frontal bone
   - Parietal bone
   - Base of skull
   - Occiput
   - Other area – anterior/middle/posterior fossa, base of skull, temporal bone, ethmoid/frontal/sphenoid sinuses

2. If occipital condyle fracture, then state TYPE
   - Type 1
   - Type 2
   - Type 3

3. State (or imply) phase of HEALING PROCESS (directs the 7th character)
   - Initial encounter – open vs. closed fracture
   - Subsequent encounter – routine healing, delayed healing, nonunion

Note: A fracture not indicated as open or closed should be coded as closed. Closed means not associated with further injury at site of fracture (e.g., laceration, hematoma). Open means site is broken and the fracture communicates to/with the air (external environment).

Head Injuries: Intracranial Injuries (S06 Codes) – Slide 1 of 2

Clinical Documentation Improvement Tips

1. State TYPE of injury
   - Contusion
   - Diffuse traumatic brain injury
   - Contusion, laceration
   - Hemorrhage
   - Traumatic cerebral edema
   - Focal traumatic brain injury

2. State LOCATION of injury
   - Cerebrum
   - Cerebellum
   - Epidural
   - Subdural
   - Subarachnoid
   - Internal carotid artery

3. State LATERNALITY
   - Right
   - Left

4. State LOSS of CONSCIOUSNESS and patient OUTCOME
   - Without loss of consciousness
   - 30 minutes or less
   - 31 minutes to 59 minutes
   - 1 hour to 5 hours 59 minutes
   - 6 hours to 24 hours
   - Greater than 24 hours with return to pre-existing conscious level
   - Greater than 24 hours without return to pre-existing conscious level with patient surviving
   - Any duration with death prior to retaining consciousness
   - Any duration with death due to brain injury prior to retaining consciousness

5. State (or imply) phase of HEALING PROCESS (directs the 7th character)
   - Initial encounter
   - Subsequent encounter
   - Sequela

Note: A fracture not indicated as open or closed should be coded as closed. Closed means not associated with further injury at site of fracture (e.g., laceration, hematoma). Open means site is broken and the fracture communicates to/with the air (external environment).
Neck Injuries: Cervical Fractures (S12 Codes) – Slide 1 of 2
Clinical Documentation Improvement Tips

1. State specific VERTEBRA
   - C1
   - C2
   - C3
   - C4

2. State TYPE of fracture
   - Displaced vs non-displaced
   - Presence of spondylolisthesis
     - Type III or Other
     - Displaced or non-displaced
   
Note: A fracture not indicated as nondisplaced or displaced should be classified as displaced.

3. State presence of SPINAL CORD INJURY, if applicable
   - C1
   - C2
   - C3
   - C4
   - C5
   - C6
   - C7

4. State (or imply) phase of HEALING PROCESS
   (directs the 7th character)
   - Initial encounter – open vs. closed fracture
   - Subsequent encounter – routine healing, delayed healing, resolution
   - Sequela
   
Note: A fracture not indicated as open or closed should be coded to closed. Closed means not associated with another injury at site of fracture (e.g., contusion, hemorrhage). Open means skin is broken and the fracture communicates to the air (external environment).

5. Specific to C1 and C2 fractures
   - Type II dens fracture (anterior displaced, posterior displaced, nondisplaced)
   
Clinical Documentation Improvement Tips

Do NOT Say: C6 fracture
DO Say: C6 nondisplaced fracture

Neck Injuries: Cervical Fractures (S12 Codes) – Slide 2 of 2

Do NOT Say: C6 spinal cord injury
DO Say: C6 spinal cord injury with complete lesion

Neck Injuries: Spinal Cord Injuries (S14 Codes)

1. State specific LEVEL of spinal cord
   - C1
   - C2
   - C3
   - C4
   - C5
   - C6
   - C7

2. State TYPE of injury
   - Concussion and/or edema
   - Complete lesion
   - Central cord syndrome
   - Anterior cord syndrome
   - Brown-Sequard syndrome
   - Incomplete lesion, posterior cord syndrome

3. State presence of vertebra FRACTURE, if applicable

4. State (or imply) phase of HEALING PROCESS
   (directs the 7th character)
   - Initial encounter
   - Subsequent encounter
   - Sequela

Do NOT Say: C6 spinal cord injury
DO Say: C6 spinal cord injury with complete lesion
Sacral Spine Injuries: Fractures (S32.1- Codes)
Clinical Documentation Improvement Tips
1. State specific ZONE of sacrum:
   - Zone 1: posterior sacral region
   - Zone 2: anterior sacral region
   - Zone 3: sacral cornua
   - Zone 4: sacral ala
And, state DISPLACEMENT of fracture
   - Nondisplaced
   - Severely displaced
Note: A fracture not indicated as nondisplaced or displaced should be coded as displaced.

2. State TYPE of fracture:
   - Type 1: transverse fracture of sacrum without displacement
   - Type 2: transverse fracture of sacrum with posterior displacement
   - Type 3: transverse extension fracture of sacrum with anterior displacement
   - Type 4: transverse segmental compression of upper sacrum

3. State (or imply) phase of HEALING PROCESS (directs the 7th character)
   - Initial encounter
   - Subsequent encounter
   - Sequela

Tips:
- Classification of fractures, unless nondisplaced or displaced:
  - Zone 1: anterior sacral region
  - Zone 2: posterior sacral region
  - Zone 3: sacral cornua
  - Zone 4: sacral ala

Lumbar and Sacral Spine Injuries: Spinal Cord Injuries (S34 Codes)
Clinical Documentation Improvement Tips
1. State specific LEVEL of spinal cord
   - L1
   - L2
   - L3
   - L4
   - L5
   - S1
   - S2
   - S3
   - S4
   - S5
   - Conus medullaris

2. Or other LOCATION
   - Cord vs nerve root
   - Lumbosacral plexus
   - Cauda equina
   - Lumbar, sacral and pelvic sympathetic nerves
   - Peripheral nerves

3. State TYPE of injury
   - Extension and/or external
   - Complete vs incomplete lesion

4. State presence of vertebra FRACTURE, if applicable

5. State (or imply) phase of HEALING PROCESS (directs the 7th character)
   - Initial encounter
   - Subsequent encounter
   - Sequela

Diseases of the Nervous System: Epilepsy (G40)
Clinical Documentation Improvement Tips
1. State TYPE
   - Localized vs generalized
   - Simple partial vs complex partial
   - Absence epileptic syndrome
   - Juvenile myoclonic
   - Due to external causes (alcohol, drugs, hormonal changes, sleep deprivation, stress)

2. State whether INTRACTABLE or NOT intractable
   - The following terms are to be considered equivalent to intractable: pharmacoresistant (pharmacologically resistant), treatment resistant, refractory (medically) and poor controlled.

3. State whether with STATUS EPILEPTICUS or WITHOUT status epilepticus
Diseases of the Nervous System:
Carpal Tunnel Syndrome (G56.0-)

- Laterality must be documented
- Right: G56.01
- Left: G56.02

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>354.0 Carpal tunnel syndrome</td>
<td>G56.01 Carpal tunnel, right upper limb</td>
</tr>
<tr>
<td></td>
<td>G56.02 left upper limb</td>
</tr>
</tbody>
</table>

Diseases of the Nervous System:
Ulnar Nerve Lesion (G56.2-)

- Laterality must be documented
- Right: G56.21
- Left: G56.22

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>354.2 Lesion of ulnar nerve</td>
<td>G56.21 Carpal tunnel, right upper limb</td>
</tr>
<tr>
<td></td>
<td>G56.22 left upper limb</td>
</tr>
</tbody>
</table>

Circulatory System:
Cerebrovascular Disease (I60-I69) New Concepts

- Use additional code to identify presence of:
  - Alcohol abuse and dependence (F10.-)
  - Exposure to environmental tobacco smoke (Z77.22)
  - History of tobacco use (Z87.891)
  - Hypertension (I10-I15)
  - Occupational exposure to environmental tobacco smoke (Z57.31)
  - Tobacco dependence (F17.-)
  - Tobacco use (Z72.0)

- The concept of laterality exists for many codes:
  - Right = 1 I66.01 Occlusion and stenosis of right middle cerebral artery
  - Left = 2 I66.02 Occlusion and stenosis of left middle cerebral artery
Circulatory System: Nontraumatic Subarachnoid Hemorrhage (I60 Codes)

Clinical Documentation Improvement Tips
(Includes ruptured aneurysm, ruptured AVM)

1. State LOCATION
   - Carotid siphon and bifurcation
   - Middle cerebral artery
   - Anterior communicating artery
   - Posterior communicating artery
   - Basilar artery
   - Vertebral artery
   - Other intracranial arteries

2. State LATERALITY
   - Right
   - Left

ICD-9-CM (1) ICD-10-CM (now 19 codes!)

430 Subarachnoid hemorrhage
   - I60.0 Carotid siphon and bifurcation
   - I60.1 ACA
   - I60.2 MCA
   - I60.3 ACOM
   - I60.4 Posterior communicating artery
   - I60.5 Basilar
   - I60.6 Vertebral
   - I60.6 Other intracranial arteries

All the above codes have variations for laterality (right, left)

- I60.8 Other nontraumatic subarachnoid hemorrhage
  (use for ruptured AVM)

Cerebrovascular Disease: Nontraumatic Intracerebral Hemorrhage (I61 Codes)

Clinical Documentation Improvement Tips

State LOCATION
   - Hemisphere, subcortical
   - Hemisphere, cortical (cerebral lobe, superficial intracerebral)
   - Brain stem
   - Cerebellum
   - Intraventricular
   - Multiple localized

ICD-9-CM (1) ICD-10-CM (9)

431 Intracerebral hemorrhage
   - I61.0 In hemisphere, subcortical
   - I61.1 In hemisphere, cortical
   - I61.2 In hemisphere, unspecified
   - I61.3 In brain stem
   - I61.4 In cerebellum
   - I61.5 Intraventricular
   - I61.6 Multiple locations
   - I61.7 Other
   - I61.9 Unspecified

Cerebrovascular Disease: Nontraumatic Subdural Hemorrhage (I62 Codes)

Clinical Documentation Improvement Tips

State TYPE
   - Acute
   - Chronic

If both acute and chronic (or subacute) are present, code acute first.

ICD-9-CM (1) ICD-10-CM (4)

432.1 Subdural hemorrhage
   - I82.00 Unspecified
   - I82.01 Acute
   - I82.02 Subacute
   - I82.03 Chronic

Do NOT Say: Subdural hematoma
DO Say: Nontraumatic right subacute subdural hematoma
Left nontraumatic chronic subdural hematoma
Cerebrovascular Diseases: Cerebral Infarction (I63 Codes)

Clinical Documentation Improvement Tips

1. **State CAUSE**
   - Thrombosis
   - Embolism
   - Occlusion or stenosis

2. **State specific CEREBRAL or PRE-CEREBRAL ARTERY**
   - Pre-cerebral
     - Vertebral
     - Basilar
     - Carotid
   - Cerebral
     - Middle cerebral
     - Anterior cerebral
     - Posterior cerebral
     - Cerebellar
     - Other

3. **State LATERALITY**
   - Right
   - Left

<table>
<thead>
<tr>
<th>ICD-9-CM (1)</th>
<th>ICD-10-CM (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>433.xx</td>
<td>Occlusion and stenosis of precerebral arteries with infarction</td>
</tr>
<tr>
<td>I63.0</td>
<td>Due to thrombosis (precerebral)</td>
</tr>
<tr>
<td>I63.1</td>
<td>Due to embolism (precerebral)</td>
</tr>
<tr>
<td>I63.2</td>
<td>Unspecified occlusion or stenosis (precerebral)</td>
</tr>
</tbody>
</table>

Above codes are specific for vessel (e.g., carotid, MCA) and laterality (right, left). Use both right and left codes when bilateral disease exists.

Cerebrovascular Disease: Occlusion and Stenosis without Infarction (I65 and I66 Codes)

Clinical Documentation Improvement Tips

1. **State specific ARTERY**
   - Vertebral
   - Basilar
   - Carotid

2. **State LATERALITY**
   - Right
   - Left
   - Bilateral

<table>
<thead>
<tr>
<th>ICD-9-CM (1)</th>
<th>ICD-10-CM (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>435.9</td>
<td>Unspecified transient cerebral ischemia</td>
</tr>
<tr>
<td>I67.841</td>
<td>Reversible cerebrovascular vasoconstriction syndrome</td>
</tr>
<tr>
<td>I67.848</td>
<td>Other cerebrovascular vasospasm and vasoconstriction</td>
</tr>
</tbody>
</table>

Cerebrovascular Disease: Vasospasm

New in ICD-10-CM

<table>
<thead>
<tr>
<th>ICD-9-CM (1)</th>
<th>ICD-10-CM (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>435.9</td>
<td>Unspecified transient cerebral ischemia</td>
</tr>
<tr>
<td>I67.841</td>
<td>Reversible cerebrovascular vasoconstriction syndrome</td>
</tr>
<tr>
<td>I67.848</td>
<td>Other cerebrovascular vasospasm and vasoconstriction</td>
</tr>
</tbody>
</table>
Neoplasms: What’s New in ICD-10-CM

- SAME categories for:
  - Malignant, primary
  - Malignant, secondary (metastatic)
  - Benign
  - Uncertain
  - Unspecified behavior (means you don’t know)

- NEW: Code for overlapping sites of brain tumors only
  - Example: Frontoparietal glioblastoma C71.8 (malignant neoplasm of overlapping sites of brain)