Optum

2024 coding guidelines included

Expert

ICD-10-CM Expert for Home Health and Hospice

The complete official code set

Codes valid from October 1, 2023 through September 30, 2024

2024

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Contents

How to Use ICD-10-CM Expert for Home Health and Hospice 2024

Introduction

ICD-10-CM Expert for Home Health and Hospice: The Complete Official Code Set is your definitive coding resource, combining the work of the National Center for Health Statistics (NCHS), Centers for Medicare and Medicaid Services (CMS), American Hospital Association (AHA), and Optum experts to provide the information you need for coding accuracy.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), is an adaptation of ICD-10, copyrighted by the World Health Organization (WHO). The development and maintenance of this clinical modification (CM) is the responsibility of the NCHS as authorized by WHO. Any new concepts added to ICD-10-CM are based on an established update process through the collaboration of WHO's Update and Revision Committee and the ICD-10-CM Coordination and Maintenance Committee.

In addition to the ICD-10-CM classification, other official government source information has been included in this manual. Depending on the source, updates to information may be annual or quarterly. This manual provides the most current information that was available at the time of publication. For updates to the source documents that may have occurred after this manual was published, please refer to the following:

- **NCHS, International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)**

  https://www.cms.gov/medicare/icd-10/2023-icd-10-cm

- **CMS Integrated Outpatient Code Editor (IOCE), version 23.2**

  https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/OCEQtrReleaseSpecs.html

- **CMS Home Health Patient-Driven Groupings Model (PDGM)**

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/HH-PDGM.html

- **CMS Hospice Quality Reporting Requirements**

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices

- **AHA Coding Clinics**

  https://www.codingclinicadvisor.com/

The official NCHS ICD-10-CM classification includes three main sections: the guidelines, the indexes, and the tabular list, all of which make up the bulk of this coding manual. To complement the classification, Optum's coding experts have incorporated Medicare-related coding edits and proprietary features, such as supplementary notations, coding tools, and appendixes, into a comprehensive and easy-to-use reference. This publication is organized as follows:

What's New for 2024

This section provides a high-level overview of the code changes made for fiscal 2023. The list of codes provided identify new, revised, and deleted codes. Asterisked codes identify prior midyear changes that were made to the classification, effective April 1, 2022. All changes are based on official addendum, provided by the National Center for Health Statistics (NCHS), the agency charged with maintaining and updating ICD-10-CM. NCHS is part of the Centers for Disease Control and Prevention (CDC).

Conversion Table

The conversion table was developed by National Center for Healthcare Statistics (NCHS) to help facilitate data retrieval as new codes are added to the ICD-10-CM classification. This table provides a crosswalk from each fiscal 2023 new code to the equivalent code(s) assigned, prior to October 1, 2022, for that diagnosis or condition. Asterisked codes identify prior midyear additions, effective April 1, 2022. For the full conversion table, refer to the Conversion Table zip file at https://www.cms.gov/medicare/icd-10/2023-icd-10-cm.

10 Steps to Correct Coding

This step-by-step tutorial walks the coder through the process of finding the correct code — from locating the code in the official indexes to verifying the code in the tabular section — while following applicable conventions, guidelines, and instructional notes. Specific examples are provided with detailed explanations of each coding step along with advice for proper sequencing.

Official ICD-10-CM Guidelines for Coding and Reporting

This section provides the full official conventions and guidelines regulating the appropriate assignment and reporting of ICD-10-CM codes. These conventions and guidelines are published by the U.S. Department of Health and Human Services (DHHS) and approved by the cooperating parties (American Health Information Management Association [AHIMA], National Center for Health Statistics [NCHS], Centers for Disease Control and Prevention [CDC], and the American Hospital Association [AHA]).

Indexes

Index to Diseases and Injuries

The Index to Diseases and Injuries is arranged in alphabetic order by terms specific to a disease, condition, illness, injury, eponym, or abbreviation as well as terms that describe circumstances other than a disease or injury that may require attention from a health care professional.

Neoplasm Table

The Neoplasm Table is arranged in alphabetic order by anatomical site. Codes are then listed in individual columns based upon the histological behavior (malignant, in situ, benign, uncertain, or unspecified) of the neoplasm.

Sex Edits

Codes intended for a specific sex based on CMS IOCE designations, v22.2.

♂ **Male diagnosis only**

Q98.Ø Klinefelter syndrome karyotype 47, XXY ♂

♀ **Female diagnosis only**

N35.12 Postinfective urethral stricture, not elsewhere classified, female ♀

CL **Comorbidity Low**

This symbol identifies secondary diagnosis codes that are considered a low comorbidity relative to the primary diagnosis. When at least one comorbidity-low diagnosis is reported on a home health claim, the period of care receives a low comorbidity payment adjustment. For a comprehensive list of all comorbidity-low diagnosis codes, refer to appendix G, "Patient-Driven Groupings Model (PDGM) Comorbid Conditions," at the back of this book.

CØØ.8 Malignant neoplasm of overlapping sites of lip CL

CH **Comorbidity High**

This symbol identifies secondary diagnosis codes that are considered a high comorbidity relative to the primary diagnosis. When at least two comorbidity-high diagnoses are reported on a home health claim, the period of care receives a high comorbidity payment adjustment. For a comprehensive list of all comorbidity-high diagnosis codes, refer to appendix G, "Patient-Driven Groupings Model (PDGM) Comorbid Conditions," at the back of this book.

F33.Ø Major depressive disorder, recurrent, mild CH

RP **Return to Provider**

This symbol identifies diagnosis codes that are considered to be vague, unspecified, or, based on the ICD-10-CM coding guidelines and conventions, inappropriate for reporting as the principal diagnosis. If one of these diagnosis codes is reported as a principal diagnosis on the home health claim, the claim will be returned to the home health agency for a more definitive diagnosis code. For a comprehensive list of all return-to-provider codes, refer to appendix H, "Patient-Driven Groupings Model (PDGM) Return-to-Provider Code List," at the back of this book.

A18.1Ø Tuberculosis of genitourinary system, unspecified RP

NC **Noncancer Diagnosis**

This symbol indicates a noncancer diagnosis that may satisfy the medical necessity criteria for Medicare coverage of hospice care. The diagnosis alone does not support medical necessity but represents one of the many factors that establish medical necessity. For more detailed explanation of the noncancer diagnosis policies for hospice care, please refer to appendix I, "Hospice Criteria for Medicare Coverage on Noncancer Hospice Care," at the back of this book.

I51.5 Myocardial degeneration NC
Fatty degeneration of heart or myocardium
Myocardial disease
Senile degeneration of heart or myocardium

Color Bars

Manifestation Code

Codes defined as manifestation codes appear in italic type, with a blue color bar over the code description. A manifestation cannot be reported as a first-listed code; it is sequenced as a secondary diagnosis with the underlying disease code listed first.

G32.89 Other specified degenerative disorders of nervous system in diseases classified elsewhere RP
Degenerative encephalopathy in diseases classified elsewhere

Unspecified Diagnosis

Codes that appear with a gray color bar over the alphanumeric code identify unspecified diagnoses. These codes should be used in limited circumstances, when neither the diagnostic statement nor the documentation provides enough information to assign a more specific diagnosis code. The abbreviation NOS, "not otherwise specified," in the tabular list may be interpreted as "unspecified."

GØ3.9 Meningitis, unspecified RP
Arachnoiditis (spinal) NOS

Chapter-Level Notations

Chapter-specific Guidelines with Coding Examples

Each chapter begins with the Official Guidelines for Coding and Reporting specific to that chapter, where provided. Coding examples specific to outpatient care settings have been provided to illustrate the coding and/or sequencing guidance in these guidelines.

Muscle and Tendon Table

ICD-10-CM categorizes certain muscles and tendons in the upper and lower extremities by their action (e.g., extension or flexion) as well as their anatomical location. The Muscle/Tendon table is provided at the beginning of chapter 13 and chapter 19 to help users when code selection depends on the action of the muscle and/or tendon.

Note: This table is not all-inclusive, and proper code assignment should be based on the provider's documentation.

Appendixes

The additional resources described below have been included as appendixes for this book. These resources further instruct the professional coder on the appropriate application of the ICD-10-CM code set.

Appendix A: Valid 3-character ICD-10-CM Codes

The user may consult this table to confirm that no further specificity, such as the use of 4th, 5th, 6th or 7th characters or placeholders (X), is necessary. All ICD-10-CM codes that are valid at the three-character level are listed.

Appendix B: Pharmacology List 2023

This reference is a comprehensive but not all-inclusive list of pharmacological agents used to treat acute and/or chronic conditions. Drugs are listed in alphabetical order by their brand and/or generic names along with their drug action and indications for which they may commonly be prescribed. Some drugs have also been mapped to their appropriate Z code for long-term drug use.

Appendix C: Z Codes for Long-Term Drug Use with Associated Drugs

This resource correlates Z codes that are used to identify current long-term drug use with a list of drugs that are typically categorized to that class of drug.

Note: These tables are not all-inclusive but list some of the more commonly used drugs.

Conversion Table of ICD-10-CM Codes

The fiscal 2023 (October 1, 2022–September 30, 2023) Conversion Table for new ICD-10-CM codes is provided to assist users in data retrieval. For each new code the table shows its previously assigned code equivalent. Asterisks identify new codes added to the classification April 1, 2022.

Code Assignment Beginning 10/1/2022	Previous Code(s) Assignment
B37.31	B37.3
B37.32	B37.3
D59.30	D59.3
D59.31	D59.3
D59.32	D59.3
D59.39	D59.3
D68.00	D68.0
D68.01	D68.0
D68.020	D68.0
D68.021	D68.0
D68.022	D68.0
D68.023	D68.0
D68.029	D68.0
D68.03	D68.0
D68.04	D68.0
D68.09	D68.0
D75.821	D75.82
D75.822	D75.82
D75.828	D75.82
D75.829	D75.82
D75.84	D75.89
D81.82	D81.89
E34.30	E34.3
E34.31	E34.3
E34.321	E34.3
E34.322	E34.3
E34.328	E34.3
E34.329	E34.3
E34.39	E34.3
E87.20	E87.2
E87.21	E87.2
E87.22	E87.2
E87.29	E87.2
F01.511	F01.51
F01.518	F01.51
F01.52	F01.51
F01.53	F01.51
F01.54	F01.51
F01.A0	F01.50
F01.A11	F01.51
F01.A18	F01.51
F01.A2	F01.51
F01.A3	F01.51
F01.A4	F01.51
F01.B0	F01.50
F01.B11	F01.51
F01.B18	F01.51
F01.B2	F01.51
F01.B3	F01.51
F01.B4	F01.51
F01.C0	F01.50
F01.C11	F01.51
F01.C18	F01.51
F01.C2	F01.51
F01.C3	F01.51
F01.C4	F01.51
F02.811	F02.81
F02.818	F02.81
F02.82	F02.81
F02.83	F02.81
F02.84	F02.81
F02.A0	F02.80
F02.A11	F02.81
F02.A18	F02.81
F02.A2	F02.81
F02.A3	F02.81
F02.A4	F02.81
F02.B0	F02.80
F02.B11	F02.81
F02.B18	F02.81
F02.B2	F02.81
F02.B3	F02.81
F02.B4	F02.81
F02.C0	F02.80
F02.C11	F02.81
F02.C18	F02.81
F02.C2	F02.81
F02.C3	F02.81
F02.C4	F02.81
F03.911	F03.91
F03.918	F03.91
F03.92	F03.91
F03.93	F03.91
F03.94	F03.91
F03.A0	F03.90
F03.A11	F03.91
F03.A18	F03.91
F03.A2	F03.91
F03.A3	F03.91
F03.A4	F03.91
F03.B0	F03.90
F03.B11	F03.91
F03.B18	F03.91
F03.B2	F03.91
F03.B3	F03.91
F03.B4	F03.91
F03.C0	F03.90
F03.C11	F03.91
F03.C18	F03.91
F03.C2	F03.91
F03.C3	F03.91
F03.C4	F03.91
F06.70	G31.84
F06.71	G31.84
F10.90	Z72.89
F10.91	Z72.89
F11.91	F11.90
F12.91	F12.90
F13.91	F13.90
F14.91	F14.90
F15.91	F15.90
F16.91	F16.90
F18.91	F18.90
F19.91	F19.90
F43.81	F43.8
F43.89	F43.8
G71.031	G71.09
G71.032	G71.09
G71.033	G71.09
G71.0340	G71.09
G71.0341	G71.09
G71.0342	G71.09
G71.0349	G71.09
G71.035	G71.09
G71.038	G71.09
G71.039	G71.09
G90.A	I49.8
G93.31	G93.3
G93.32	G93.3; R53.82
G93.39	G93.3
I20.2	I20.0-I20.1; I20.8
I25.112	I25.110-I25.111; I25.118
I25.702	I25.700-I25.701; I25.708
I25.712	I25.710-I25.711; I25.718
I25.722	I25.720-I25.721; I25.728
I25.732	I25.730-I25.731; I25.738
I25.752	I25.750-I25.751; I25.758
I25.762	I25.760-I25.761; I25.768
I25.792	I25.790-I25.791; I25.798
I31.31	I31.3
I31.39	I31.3
I34.81	I34.8
I34.89	I34.8
I47.20	I47.2
I47.21	I47.2
I47.29	I47.2
I71.010	I71.01
I71.011	I71.01
I71.012	I71.01
I71.019	I71.01
I71.10	I71.1
I71.11	I71.1
I71.12	I71.1
I71.13	I71.1
I71.20	I71.2
I71.21	I71.2
I71.22	I71.2
I71.23	I71.2
I71.30	I71.3
I71.31	I71.3
I71.32	I71.3
I71.33	I71.3
I71.40	I71.4
I71.41	I71.4
I71.42	I71.4
I71.43	I71.4
I71.50	I71.5
I71.51	I71.5
I71.52	I71.5
I71.60	I71.6
I71.61	I71.6
I71.62	I71.6
I77.82	I77.89
J95.87	J95.89
K76.82	K72.90-K72.91
M51.A0	M51.86
M51.A1	M51.86
M51.A2	M51.86
M51.A3	M51.87
M51.A4	M51.87
M51.A5	M51.87
M62.5A0	M62.58
M62.5A1	M62.58
M62.5A2	M62.58
M62.5A9	M62.58
M93.004	M93.001 & M93.002
M93.014	M93.011 & M93.012
M93.024	M93.021 & M93.022
M93.034	M93.031 & M93.032
M93.041	M93.011
M93.042	M93.012
M93.043	M93.013
M93.044	M93.011 & M93.012
M93.051	M93.031
M93.052	M93.032
M93.053	M93.033
M93.054	M93.031 & M93.032
M93.061	M93.011
M93.062	M93.012
M93.063	M93.013
M93.064	M93.011 & M93.012
M93.071	M93.031
M93.072	M93.032
M93.073	M93.033
M93.074	M93.031 & M93.032
M96.A1	M96.89 & Y84.8
M96.A2	M96.89 & Y84.8
M96.A3	M96.89 & Y84.8
M96.A4	M96.89 & Y84.8
M96.A9	M96.89 & Y84.8
N14.11	N14.1
N14.19	N14.1
N76.82	N76.89
N80.00	N80.0
N80.01	N80.0
N80.02	N80.0
N80.03	N80.0
N80.101	N80.1
N80.102	N80.1
N80.103	N80.1
N80.109	N80.1
N80.111	N80.1
N80.112	N80.1
N80.113	N80.1
N80.119	N80.1
N80.121	N80.1
N80.122	N80.1
N80.123	N80.1
N80.129	N80.1
N80.201	N80.2
N80.202	N80.2
N80.203	N80.2
N80.209	N80.2
N80.211	N80.2
N80.212	N80.2
N80.213	N80.2
N80.219	N80.2
N80.221	N80.2
N80.222	N80.2
N80.223	N80.2
N80.229	N80.2
N80.30	N80.3
N80.311	N80.3
N80.312	N80.3
N80.319	N80.3
N80.321	N80.3
N80.322	N80.3
N80.329	N80.3
N80.331	N80.3
N80.332	N80.3
N80.333	N80.3
N80.339	N80.3
N80.341	N80.3
N80.342	N80.3
N80.343	N80.3
N80.349	N80.3
N80.351	N80.3
N80.352	N80.3
N80.353	N80.3
N80.359	N80.3
N80.361	N80.3
N80.362	N80.3
N80.363	N80.3
N80.369	N80.3
N80.371	N80.3
N80.372	N80.3
N80.373	N80.3
N80.379	N80.3
N80.381	N80.3
N80.382	N80.3
N80.383	N80.3
N80.389	N80.3
N80.3A1	N80.3
N80.3A2	N80.3
N80.3A3	N80.3
N80.3A9	N80.3
N80.3B1	N80.3
N80.3B2	N80.3
N80.3B3	N80.3
N80.3B9	N80.3
N80.3C1	N80.3
N80.3C2	N80.3
N80.3C3	N80.3
N80.3C9	N80.3
N80.391	N80.3
N80.392	N80.3
N80.399	N80.3
N80.40	N80.3
N80.41	N80.4
N80.42	N80.4
N80.50	N80.5
N80.511	N80.5
N80.512	N80.5
N80.519	N80.5
N80.521	N80.5
N80.522	N80.5
N80.529	N80.5
N80.531	N80.5
N80.532	N80.5
N80.539	N80.5

Note: The list below gives the code number for neoplasms by anatomical site. For each site there are six possible code numbers according to whether the neoplasm in question is malignant, benign, in situ, of uncertain behavior, or of unspecified nature. The description of the neoplasm will often indicate which of the six columns is appropriate; e.g., malignant melanoma of skin, benign fibroadenoma of breast, carcinoma in situ of cervix uteri. Where such descriptors are not present, the remainder of the Index should be consulted where guidance is given to the appropriate column for each morphological (histological) variety listed; e.g., Mesonephroma – see Neoplasm, malignant; Embryoma — see also Neoplasm, uncertain behavior; Disease, Bowen's – see Neoplasm, skin, in situ. However, the guidance in the Index can be overridden if one of the descriptors mentioned above is present; e.g., malignant adenoma of colon is coded to C18.9 and not to D12.6 as the adjective "malignant" overrides the Index entry "Adenoma — *see also* Neoplasm, benign, by site." Codes listed with a dash -, following the code have a required additional character for laterality. The tabular list must be reviewed for the complete code.

	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavior	Unspecified Behavior
Neoplasm, neoplastic	C80.1	C79.9	D09.9	D36.9	D48.9	D49.9
abdomen, abdominal	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
cavity	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
organ	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
viscera	C76.2	C79.8-☑	D09.8	D36.7	D48.7	D49.89
wall — *see also* Neoplasm, abdomen, wall, skin	C44.509	C79.2	D04.5	D23.5	D48.5	D49.2
connective tissue	C49.4	C79.8-☑	—	D21.4	D48.1	D49.2
skin	C44.509	—	—	—	—	—
basal cell carcinoma	C44.519	—	—	—	—	—
specified type NEC	C44.599	—	—	—	—	—
squamous cell carcinoma	C44.529	—	—	—	—	—
abdominopelvic	C76.8	C79.8-☑	—	D36.7	D48.7	D49.89
accessory sinus — *see* Neoplasm, sinus						
acoustic nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
adenoid (pharynx) (tissue)	C11.1	C79.89	D00.08	D10.6	D37.05	D49.0
adipose tissue — *see also* Neoplasm, connective tissue	C49.4	C79.89	—	D21.9	D48.1	D49.2
adnexa (uterine)	C57.4	C79.89	D07.39	D28.7	D39.8	D49.59
adrenal	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
capsule	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
cortex	C74.0-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
gland	C74.9-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
medulla	C74.1-☑	C79.7-☑	D09.3	D35.0-☑	D44.1-☑	D49.7
ala nasi (external) — *see also* Neoplasm, skin, nose	C44.301	C79.2	D04.39	D23.39	D48.5	D49.2
alimentary canal or tract NEC	C26.9	C78.80	D01.9	D13.9	D37.9	D49.0
alveolar	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ridge or process	C41.1	C79.51	—	D16.5	D48.0	D49.2
carcinoma	C03.9	C79.8-☑	—	—	—	—
lower	C03.1	C79.8-☑	—	—	—	—
upper	C03.0	C79.8-☑	—	—	—	—
lower	C41.1	C79.51	—	D16.5	D48.0	D49.2
mucosa	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C41.0	C79.51	—	D16.4	D48.0	D49.2
sulcus	C06.1	C79.89	D00.02	D10.39	D37.09	D49.0
alveolus	C03.9	C79.89	D00.03	D10.39	D37.09	D49.0
lower	C03.1	C79.89	D00.03	D10.39	D37.09	D49.0
upper	C03.0	C79.89	D00.03	D10.39	D37.09	D49.0
ampulla of Vater	C24.1	C78.89	D01.5	D13.5	D37.6	D49.0
ankle NEC	C76.5-☑	C79.89	D04.7-☑	D36.7	D48.7	D49.89
anorectum, anorectal (junction)	C21.8	C78.5	D01.3	D12.9	D37.8	D49.0
antecubital fossa or space	C76.4-☑	C79.89	D04.6-☑	D36.7	D48.7	D49.89
antrum (Highmore) (maxillary)	C31.0	C78.39	D02.3	D14.0	D38.5	D49.1
pyloric	C16.3	C78.89	D00.2	D13.1	D37.1	D49.0
tympanicum	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
anus, anal	C21.0	C78.5	D01.3	D12.9	D37.8	D49.0
canal	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
cloacogenic zone	C21.2	C78.5	D01.3	D12.9	D37.8	D49.0
margin — *see also* Neoplasm, anus, skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
overlapping lesion with rectosigmoid junction or rectum	C21.8	—	—	—	—	—
skin	C44.500	C79.2	D04.5	D23.5	D48.5	D49.2
basal cell carcinoma	C44.510	—	—	—	—	—
specified type NEC	C44.590	—	—	—	—	—
squamous cell carcinoma	C44.520	—	—	—	—	—
sphincter	C21.1	C78.5	D01.3	D12.9	D37.8	D49.0
aorta (thoracic)	C49.3	C79.89	—	D21.3	D48.1	D49.2
abdominal	C49.4	C79.89	—	D21.4	D48.1	D49.2
aortic body	C75.5	C79.89	—	D35.6	D44.7	D49.7
aponeurosis	C49.9	C79.89	—	D21.9	D48.1	D49.2
palmar	C49.1-☑	C79.89	—	D21.1-☑	D48.1	D49.2
plantar	C49.2-☑	C79.89	—	D21.2-☑	D48.1	D49.2
appendix	C18.1	C78.5	D01.0	D12.1	D37.3	D49.0
arachnoid	C70.9	C79.49	—	D32.9	D42.9	D49.7
cerebral	C70.0	C79.32	—	D32.0	D42.0	D49.7
spinal	C70.1	C79.49	—	D32.1	D42.1	D49.7
areola	C50.0-☑	C79.81	D05-☑	D24-☑	D48.6-☑	D49.3
arm NEC	C76.4-☑	C79.89	D04.6-☑	D36.7	D48.7	D49.89
artery — *see* Neoplasm, connective tissue						
aryepiglottic fold	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
hypopharyngeal aspect	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
laryngeal aspect	C32.1	C78.39	D02.0	D14.1	D38.0	D49.1
marginal zone	C13.1	C79.89	D00.08	D10.7	D37.05	D49.0
arytenoid (cartilage)	C32.3	C78.39	D02.0	D14.1	D38.0	D49.1
fold — *see* Neoplasm, aryepiglottic						
associated with transplanted organ	C80.2	—	—	—	—	—
atlas	C41.2	C79.51	—	D16.6	D48.0	D49.2
atrium, cardiac	C38.0	C79.89	—	D15.1	D48.7	D49.89
auditory canal (external) (skin)	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
nerve	C72.4-☑	C79.49	—	D33.3	D43.3	D49.7
tube	C30.1	C78.39	D02.3	D14.0	D38.5	D49.1
opening	C11.2	C79.89	D00.08	D10.6	D37.05	D49.0
auricle, ear — *see also* Neoplasm, skin, ear	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
auricular canal (external) — *see also* Neoplasm, skin, ear	C44.20-☑	C79.2	D04.2-☑	D23.2-☑	D48.5	D49.2
internal	C30.1	C78.39	D02.3	D14.0	D38.5	D49.2
autonomic nerve or nervous system NEC (see Neoplasm, nerve, peripheral)						
axilla, axillary	C76.1	C79.89	D09.8	D36.7	D48.7	D49.89
fold — *see also* Neoplasm, skin, trunk	C44.509	C79.2	D04.5	D23.5	D48.5	D49.2
back NEC	C76.8	C79.89	D04.5	D36.7	D48.7	D49.89
Bartholin's gland	C51.0	C79.82	D07.1	D28.0	D39.8	D49.59
basal ganglia	C71.0	C79.31	—	D33.0	D43.0	D49.6
basis pedunculi	C71.7	C79.31	—	D33.1	D43.1	D49.6
bile or biliary (tract)	C24.9	C78.89	D01.5	D13.5	D37.6	D49.0

Chapter 2. Neoplasms (C00–D49)

Chapter-specific Guidelines with Coding Examples

The chapter-specific guidelines from the ICD-10-CM Official Guidelines for Coding and Reporting have been provided below. Along with these guidelines are coding examples, contained in the shaded boxes, that have been developed to help illustrate the coding and/or sequencing guidance found in these guidelines.

General guidelines

Chapter 2 of the ICD-10-CM contains the codes for most benign and all malignant neoplasms. Certain benign neoplasms, such as prostatic adenomas, may be found in the specific body system chapters. To properly code a neoplasm, it is necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior. If malignant, any secondary (metastatic) sites should also be determined.

Primary malignant neoplasms overlapping site boundaries

A primary malignant neoplasm that overlaps two or more contiguous (next to each other) sites should be classified to the subcategory/code .8 ('overlapping lesion'), unless the combination is specifically indexed elsewhere. For multiple neoplasms of the same site that are not contiguous such as tumors in different quadrants of the same breast, codes for each site should be assigned.

A 73-year-old white female with a large rapidly growing malignant tumor in the left breast extending from the upper outer quadrant into the axillary tail.

C50.812 **Malignant neoplasm of overlapping sites of left female breast**

Explanation: Because this is a single large tumor that overlaps two contiguous sites, a single code for overlapping sites is assigned.

A 52-year old white female with two distinct lesions of the right breast, one (0.5 cm) in the upper outer quadrant and a second (1.5 cm) in the lower outer quadrant; path report indicates both lesions are malignant

C50.411 **Malignant neoplasm of upper-outer quadrant of right female breast**

C50.511 **Malignant neoplasm of lower-outer quadrant of right female breast**

Explanation: This patient has two distinct malignant lesions of right breast in adjacent quadrants. Because the lesions are not contiguous, two codes are reported.

Malignant neoplasm of ectopic tissue

Malignant neoplasms of ectopic tissue are to be coded to the site of origin mentioned, e.g., ectopic pancreatic malignant neoplasms involving the stomach are coded to malignant neoplasm of pancreas, unspecified (C25.9).

The neoplasm table in the Alphabetic Index should be referenced first. However, if the histological term is documented, that term should be referenced first, rather than going immediately to the Neoplasm Table, in order to determine which column in the Neoplasm Table is appropriate. For example, if the documentation indicates "adenoma," refer to the term in the Alphabetic Index to review the entries under this term and the instructional note to "see also neoplasm, by site, benign." The table provides the proper code based on the type of neoplasm and the site. It is important to select the proper column in the table that corresponds to the type of neoplasm. The Tabular List should then be referenced to verify that the correct code has been selected from the table and that a more specific site code does not exist.

See Section I.C.21. Factors influencing health status and contact with health services, Status, for information regarding Z15.0, codes for genetic susceptibility to cancer.

a. *Admission/Encounter for* treatment of primary site

If the malignancy **is chiefly responsible for occasioning the patient admission/encounter and treatment is directed at the primary site**, designate the **primary** malignancy as the principal/**first-listed** diagnosis.

The only exception to this guideline is if the administration of chemotherapy, immunotherapy or external beam radiation therapy **is chiefly responsible for occasioning the admission/encounter. In that case**, assign the appropriate Z51.-- code as the first-listed or principal diagnosis, and the **underlying** diagnosis or problem for which the service is being performed as a secondary diagnosis.

b. *Admission/Encounter for* treatment of secondary site

When a patient is admitted because of a primary neoplasm with metastasis and treatment is directed toward the secondary site only, the secondary neoplasm is designated as the principal diagnosis even though the primary malignancy is still present.

Patient with unresolved primary prostate cancer is admitted for respiratory care and rehabilitation related to new diagnosis of right lung metastasis.

C78.01 **Secondary malignant neoplasm of right lung**

C61 **Malignant neoplasm of prostate**

Explanation: The patient was admitted for treatment of the secondary neoplastic disease of the right lung with respiratory care. The code for the secondary lung metastasis is sequenced before the code for primary prostate cancer.

c. Coding and sequencing of complications

Coding and sequencing of complications associated with the malignancies or with the therapy thereof are subject to the following guidelines:

1) Anemia associated with malignancy

When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease).

Patient is admitted for treatment of anemia in advanced colon cancer.

C18.9 **Malignant neoplasm of colon, unspecified**

D63.0 **Anemia in neoplastic disease**

Explanation: Even though the admission was solely to treat the anemia, this guideline indicates that the code for the malignancy is sequenced first.

2) Anemia associated with chemotherapy, immunotherapy and radiation therapy

When the admission/encounter is for management of an anemia associated with an adverse effect of the administration of chemotherapy or immunotherapy and the only treatment is for the anemia, the anemia code is sequenced first followed by the appropriate codes for the neoplasm and the adverse effect (T45.1X5, Adverse effect of antineoplastic and immunosuppressive drugs).

When the admission/encounter is for management of an anemia associated with an adverse effect of radiotherapy, the anemia code should be sequenced first, followed by the appropriate neoplasm code and code Y84.2, Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure.

A 65-year-old female is admitted following hospitalization for multiple blood transfusions to treat anemia secondary to radiation therapy. She has been receiving radiation treatments for right breast cancer.

D64.89 **Other specified anemias**

C50.911 **Malignant neoplasm of unspecified site of right female breast**

Y84.2 **Radiological procedure and radiotherapy as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure**

Explanation: The code for the anemia is sequenced first, followed by the code for the malignancy, and last the code for the abnormal reaction due to radiotherapy.

3) Management of dehydration due to the malignancy

When the admission/encounter is for management of dehydration due to the malignancy and only the dehydration is being treated (intravenous rehydration), the dehydration is sequenced first, followed by the code(s) for the malignancy.

E08.3 Diabetes mellitus due to underlying condition with ophthalmic complications

AHA: 2016,4Q,11-13

One of the following 7th characters is to be assigned to codes in subcategories E08.32, E08.33, E08.34, E08.35, and E08.37 to designate laterality of the disease:
1 right eye
2 left eye
3 bilateral
9 unspecified eye

E08.31 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy

DEF: Diabetic retinopathy: Diabetic complication from damage to the retinal vessels resulting in vision problems that can progress to blindness.

E08.311 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema RP CH CL

E08.319 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema RP

E08.32 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy

Diabetes mellitus due to underlying condition with nonproliferative diabetic retinopathy NOS

E08.321 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema RP CH CL

E08.329 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema RP

E08.33 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy

E08.331 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema RP CH CL

E08.339 Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema RP

E08.34 Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy

E08.341 Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema RP CH CL

E08.349 Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema RP

E08.35 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy

E08.351 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema RP CH CL

E08.352 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment involving the macula RP

E08.353 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with traction retinal detachment not involving the macula RP

E08.354 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with combined traction retinal detachment and rhegmatogenous retinal detachment RP

E08.355 Diabetes mellitus due to underlying condition with stable proliferative diabetic retinopathy RP

E08.359 Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema RP

E08.36 Diabetes mellitus due to underlying condition with diabetic cataract RP

AHA: 2019,2Q,30-31; 2016,4Q,142

E08.37 Diabetes mellitus due to underlying condition with diabetic macular edema, resolved following treatment RP

E08.39 Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication RP

Use additional code to identify manifestation, such as:
diabetic glaucoma (H40-H42)

E08.4 Diabetes mellitus due to underlying condition with neurological complications

E08.40 Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified RP CH CL

E08.41 Diabetes mellitus due to underlying condition with diabetic mononeuropathy RP

E08.42 Diabetes mellitus due to underlying condition with diabetic polyneuropathy RP CH CL

Diabetes mellitus due to underlying condition with diabetic neuralgia

E08.43 Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy RP CH CL

Diabetes mellitus due to underlying condition with diabetic gastroparesis

AHA: 2013,4Q,114

E08.44 Diabetes mellitus due to underlying condition with diabetic amyotrophy RP

E08.49 Diabetes mellitus due to underlying condition with other diabetic neurological complication RP

E08.5 Diabetes mellitus due to underlying condition with circulatory complications

E08.51 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene RP

AHA: 2018,3Q,3-4; 2018,2Q,7

E08.52 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene RP

Diabetes mellitus due to underlying condition with diabetic gangrene

AHA: 2020,2Q,18; 2018,3Q,3; 2018,2Q,7; 2017,4Q,102

E08.59 Diabetes mellitus due to underlying condition with other circulatory complications RP

E08.6 Diabetes mellitus due to underlying condition with other specified complications

E08.61 Diabetes mellitus due to underlying condition with diabetic arthropathy

E08.610 Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy RP

Diabetes mellitus due to underlying condition with Charcôt's joints

DEF: Charcot's joint: Progressive neurologic arthropathy in which chronic degeneration of joints in the weight-bearing areas with peripheral hypertrophy occurs as a complication of a neuropathy disorder. Supporting structures relax from a loss of sensation resulting in chronic joint instability.

E08.618 Diabetes mellitus due to underlying condition with other diabetic arthropathy RP

AHA: 2018,2Q,6

E08.62 Diabetes mellitus due to underlying condition with skin complications

E08.620 Diabetes mellitus due to underlying condition with diabetic dermatitis RP

Diabetes mellitus due to underlying condition with diabetic necrobiosis lipoidica

✓6th **G40.11 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable**
G40.111 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, with status epilepticus
G40.119 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus

✓5th **G40.2 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures**
Attacks with alteration of consciousness, often with automatisms
Complex partial seizures developing into secondarily generalized seizures

✓6th **G40.20 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable**
Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures without intractability
G40.201 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, with status epilepticus
G40.209 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus
Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures NOS

✓6th **G40.21 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable**
G40.211 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, with status epilepticus
G40.219 Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus

✓5th **G40.3 Generalized idiopathic epilepsy and epileptic syndromes**
Code also MERRF syndrome, if applicable (E88.42)

✓6th **G40.30 Generalized idiopathic epilepsy and epileptic syndromes, not intractable**
Generalized idiopathic epilepsy and epileptic syndromes without intractability
G40.301 Generalized idiopathic epilepsy and epileptic syndromes, not intractable, with status epilepticus
G40.309 Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus
Generalized idiopathic epilepsy and epileptic syndromes NOS

✓6th **G40.31 Generalized idiopathic epilepsy and epileptic syndromes, intractable**
G40.311 Generalized idiopathic epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.319 Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus

✓5th **G40.A Absence epileptic syndrome**
Childhood absence epilepsy [pyknolepsy]
Juvenile absence epilepsy
Absence epileptic syndrome, NOS

✓6th **G40.A0 Absence epileptic syndrome, not intractable**
G40.A01 Absence epileptic syndrome, not intractable, with status epilepticus
G40.A09 Absence epileptic syndrome, not intractable, without status epilepticus

✓6th **G40.A1 Absence epileptic syndrome, intractable**
G40.A11 Absence epileptic syndrome, intractable, with status epilepticus
G40.A19 Absence epileptic syndrome, intractable, without status epilepticus

✓5th **G40.B Juvenile myoclonic epilepsy [impulsive petit mal]**

✓6th **G40.B0 Juvenile myoclonic epilepsy, not intractable**
G40.B01 Juvenile myoclonic epilepsy, not intractable, with status epilepticus
G40.B09 Juvenile myoclonic epilepsy, not intractable, without status epilepticus

✓6th **G40.B1 Juvenile myoclonic epilepsy, intractable**
G40.B11 Juvenile myoclonic epilepsy, intractable, with status epilepticus
G40.B19 Juvenile myoclonic epilepsy, intractable, without status epilepticus

✓5th **G40.4 Other generalized epilepsy and epileptic syndromes**
Epilepsy with grand mal seizures on awakening
Epilepsy with myoclonic absences
Epilepsy with myoclonic-astatic seizures
Grand mal seizure NOS
Nonspecific atonic epileptic seizures
Nonspecific clonic epileptic seizures
Nonspecific myoclonic epileptic seizures
Nonspecific tonic epileptic seizures
Nonspecific tonic-clonic epileptic seizures
Symptomatic early myoclonic encephalopathy

✓6th **G40.40 Other generalized epilepsy and epileptic syndromes, not intractable**
Other generalized epilepsy and epileptic syndromes without intractability
Other generalized epilepsy and epileptic syndromes NOS
G40.401 Other generalized epilepsy and epileptic syndromes, not intractable, with status epilepticus
G40.409 Other generalized epilepsy and epileptic syndromes, not intractable, without status epilepticus

✓6th **G40.41 Other generalized epilepsy and epileptic syndromes, intractable**
G40.411 Other generalized epilepsy and epileptic syndromes, intractable, with status epilepticus
G40.419 Other generalized epilepsy and epileptic syndromes, intractable, without status epilepticus

G40.42 Cyclin-Dependent Kinase-Like 5 Deficiency Disorder
CDKL5
Use additional code, if known, to identify associated manifestations, such as:
cortical blindness (H47.61-)
global development delay (F88)
AHA: 2020,4Q,18-19

✓5th **G40.5 Epileptic seizures related to external causes**
Epileptic seizures related to alcohol
Epileptic seizures related to drugs
Epileptic seizures related to hormonal changes
Epileptic seizures related to sleep deprivation
Epileptic seizures related to stress
Code also, if applicable, associated epilepsy and recurrent seizures (G40.-)
Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)

✓6th **G40.50 Epileptic seizures related to external causes, not intractable**
G40.501 Epileptic seizures related to external causes, not intractable, with status epilepticus
G40.509 Epileptic seizures related to external causes, not intractable, without status epilepticus
Epileptic seizures related to external causes, NOS

Y92 Place of occurrence of the external cause

The following category is for use, when relevant, to identify the place of occurrence of the external cause. Use in conjunction with an activity code.

Place of occurrence should be recorded only at the initial encounter for treatment

Y92.0 Non-institutional (private) residence as the place of occurrence of the external cause

EXCLUDES 1 *abandoned or derelict house (Y92.89)*
home under construction but not yet occupied (Y92.6-)
institutional place of residence (Y92.1-)

Y92.00 Unspecified non-institutional (private) residence as the place of occurrence of the external cause

Y92.000 Kitchen of unspecified non-institutional (private) residence as the place of occurrence of the external cause

Y92.001 Dining room of unspecified non-institutional (private) residence as the place of occurrence of the external cause

Y92.002 Bathroom of unspecified non-institutional (private) residence as the place of occurrence of the external cause

Y92.003 Bedroom of unspecified non-institutional (private) residence as the place of occurrence of the external cause

Y92.007 Garden or yard of unspecified non-institutional (private) residence as the place of occurrence of the external cause

Y92.008 Other place in unspecified non-institutional (private) residence as the place of occurrence of the external cause

Y92.009 Unspecified place in unspecified non-institutional (private) residence as the place of occurrence of the external cause

Home (NOS) as the place of occurrence of the external cause

Y92.01 Single-family non-institutional (private) house as the place of occurrence of the external cause

Farmhouse as the place of occurrence of the external cause

EXCLUDES 1 *barn (Y92.71)*
chicken coop or hen house (Y92.72)
farm field (Y92.73)
orchard (Y92.74)
single family mobile home or trailer (Y92.02-)
slaughter house (Y92.86)

Y92.010 Kitchen of single-family (private) house as the place of occurrence of the external cause

Y92.011 Dining room of single-family (private) house as the place of occurrence of the external cause

Y92.012 Bathroom of single-family (private) house as the place of occurrence of the external cause

Y92.013 Bedroom of single-family (private) house as the place of occurrence of the external cause

Y92.014 Private driveway to single-family (private) house as the place of occurrence of the external cause

Y92.015 Private garage of single-family (private) house as the place of occurrence of the external cause

Y92.016 Swimming-pool in single-family (private) house or garden as the place of occurrence of the external cause

Y92.017 Garden or yard in single-family (private) house as the place of occurrence of the external cause

Y92.018 Other place in single-family (private) house as the place of occurrence of the external cause

Y92.019 Unspecified place in single-family (private) house as the place of occurrence of the external cause

Y92.02 Mobile home as the place of occurrence of the external cause

Y92.020 Kitchen in mobile home as the place of occurrence of the external cause

Y92.021 Dining room in mobile home as the place of occurrence of the external cause

Y92.022 Bathroom in mobile home as the place of occurrence of the external cause

Y92.023 Bedroom in mobile home as the place of occurrence of the external cause

Y92.024 Driveway of mobile home as the place of occurrence of the external cause

Y92.025 Garage of mobile home as the place of occurrence of the external cause

Y92.026 Swimming-pool of mobile home as the place of occurrence of the external cause

Y92.027 Garden or yard of mobile home as the place of occurrence of the external cause

Y92.028 Other place in mobile home as the place of occurrence of the external cause

Y92.029 Unspecified place in mobile home as the place of occurrence of the external cause

Y92.03 Apartment as the place of occurrence of the external cause

Condominium as the place of occurrence of the external cause

Co-op apartment as the place of occurrence of the external cause

Y92.030 Kitchen in apartment as the place of occurrence of the external cause

Y92.031 Bathroom in apartment as the place of occurrence of the external cause

Y92.032 Bedroom in apartment as the place of occurrence of the external cause

Y92.038 Other place in apartment as the place of occurrence of the external cause

Y92.039 Unspecified place in apartment as the place of occurrence of the external cause

Y92.04 Boarding-house as the place of occurrence of the external cause

Y92.040 Kitchen in boarding-house as the place of occurrence of the external cause

Y92.041 Bathroom in boarding-house as the place of occurrence of the external cause

Y92.042 Bedroom in boarding-house as the place of occurrence of the external cause

Y92.043 Driveway of boarding-house as the place of occurrence of the external cause

Y92.044 Garage of boarding-house as the place of occurrence of the external cause

Y92.045 Swimming-pool of boarding-house as the place of occurrence of the external cause

Y92.046 Garden or yard of boarding-house as the place of occurrence of the external cause

Y92.048 Other place in boarding-house as the place of occurrence of the external cause

Y92.049 Unspecified place in boarding-house as the place of occurrence of the external cause

Y92.09 Other non-institutional residence as the place of occurrence of the external cause

AHA: 2017,2Q,10

Y92.090 Kitchen in other non-institutional residence as the place of occurrence of the external cause

Y92.091 Bathroom in other non-institutional residence as the place of occurrence of the external cause

Y92.092 Bedroom in other non-institutional residence as the place of occurrence of the external cause

Y92.093 Driveway of other non-institutional residence as the place of occurrence of the external cause

Y92.094 Garage of other non-institutional residence as the place of occurrence of the external cause

Y92.095 Swimming-pool of other non-institutional residence as the place of occurrence of the external cause

Y92.096 Garden or yard of other non-institutional residence as the place of occurrence of the external cause

Appendix D: Qualifications for Medicare Coverage of Home Health Services

The criteria that must be met by the patient to qualify for Medicare coverage of home health services are specified in the following sections of the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 7 - Home Health Services.

Conditions to be Met for Coverage of Home Health Services

Medicare covers HHA services when the following criteria are met:

1. The person to whom the services are provided is an eligible Medicare beneficiary;
2. The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the Medicare program;
3. The beneficiary qualifies for coverage of home health services as described in §30;
4. The services for which payment is claimed are covered as described in §§40 and 50;
5. Medicare is the appropriate payer; and
6. The services for which payment is claimed are not otherwise excluded from payment.

Reasonable and Necessary Services

Background: In enacting the Medicare program, Congress recognized that the physician or allowed practitioner would play an important role in determining utilization of services. The law requires that payment can be made only if a physician or allowed practitioner certifies the need for services and establishes a plan of care. The Secretary is responsible for ensuring that Medicare covers the claimed services, including determining whether they are "reasonable and necessary."

Determination of Coverage: The Medicare contractor's decision on whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR 484.55 or a medical record of the individual patient. Medicare does not deny coverage solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally, but bases it upon objective clinical evidence regarding the patient's individual need for care.

Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on presence or absence of a patient's potential for improvement from nursing care or therapy, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services

Where the Medicare criteria for coverage of home health services are met, patients are entitled by law to coverage of reasonable and necessary home health services. Therefore, a patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services. However, where a family member or other person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for HHA personnel to furnish such services. Ordinarily it can be presumed that there is no able and willing person in the home to provide the services being rendered by the HHA unless the patient or family indicates otherwise and objects to the provision of the services by the HHA, or unless the HHA has first hand knowledge to the contrary.

Similarly, a patient is entitled to reasonable and necessary Medicare home health services even if the patient would qualify for institutional care (e.g., hospital care or skilled nursing facility care) and Medicare payment should be made for reasonable and necessary home health services where the patient is also receiving supplemental services that do not meet Medicare's definition of skilled nursing care or home health aide services.

Example 1: A patient who lives with an adult daughter and otherwise qualifies for Medicare coverage of home health services, requires the assistance of a home health aide for bathing and assistance with an exercise program to improve endurance. The daughter is unwilling to bathe her elderly father and assist him with the exercise program. Home health aide services would be reasonable and necessary.

Example 2: A patient who is being discharged from a hospital with a diagnosis of osteomyelitis and requires continuation of the I.V. antibiotic therapy that was begun in the hospital was found to meet the criteria for Medicare coverage of skilled nursing facility services. If the patient also meets the qualifying criteria for coverage of home health services, payment may be made for the reasonable and necessary home health services the patient needs, notwithstanding the availability of coverage in a skilled nursing facility.

Example 3: A patient who needs skilled nursing care on an intermittent basis also hires a licensed practical (vocational) nurse to provide nighttime assistance while family members sleep. The care provided by the nurse, as respite to the family members, does not require the skills of a licensed nurse (as defined in §40.1) and therefore has no impact on the beneficiary's eligibility for Medicare payment of home health services even though another third party insurer may pay for that nursing care.

Use of Utilization Screens and "Rules of Thumb"

Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate.

Conditions Patient Must Meet to Qualify for Coverage of Home Health Services

To qualify for the Medicare home health benefit a Medicare beneficiary must meet the following requirements:

- Be confined to the home;
- Under the care of a physician or allowed practitioner;
- Receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner;
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

For purposes of benefit eligibility, "intermittent" means skilled nursing care that is either provided or needed on fewer than seven days each week or less than eight hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

A patient must meet each of the criteria specified in this section. Patients who meet each of these criteria are eligible to have payment made on their behalf for services discussed in §§40 and 50.

Confined to the Home

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician or allowed practitioner certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

1. Criterion-One:

   The patient must either:

   - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

   OR

   - Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the criterion-one conditions, then the patient must *also* meet two additional requirements defined in criterion two below.

2. Criterion-Two:

   - There must exist a normal inability to leave home;

   AND

   - Leaving home must require a considerable and taxing effort.

To clarify, in determining whether the patient meets criterion two of the homebound definition, the clinician needs to take into account the illness or injury for which the patient met criterion one and consider the illness or injury in the context of the patient's overall condition. The clinician is not required to include

Appendix F: OASIS Diagnosis Guidance

A draft version of the new Outcome and Assessment Information Set data set (OASIS-E) was made available on the Centers for Medicare and Medicaid Services (CMS) OASIS Data Sets webpage on March 18, 2020. OASIS-E was scheduled to replace OASIS-D effective January 01, 2023. Please note this version of the OASIS is not yet final; approval is expected later this year. The release of the updated version of the OASIS will be delayed until January 1st of the year that is at least one full calendar year after the end of the COVID-19 PHE.

In order to provide maximum flexibilities for home health agencies (HHAs) to respond to the COVID-19 public health emergency (PHE), CMS is delaying the release of the OASIS-E data set needed to support the Transfer of Health (TOH) Information Quality Measures and new or revised Standardized Patient Assessment Data Elements (SPADEs).

The following information outlines diagnosis reporting on the OASIS-D data set.

The Outcome and Assessment Information Set (OASIS-D) includes three OASIS M-items related to ICD-10-CM codes. These items are:

M1021 Primary Diagnosis

M1023 Other Diagnoses

M1028 Active Diagnoses-Comorbidities and Co-existing Conditions

The last item listed, M1028 Active Diagnoses-Comorbidities and Co-existing Conditions, while tied to specific ICD-10-CM related diagnostic conditions, does not require the assignment of ICD-10-CM codes.

For the purpose of payment and compliance, ICD-10-CM diagnoses assigned for a given episode will be represented on:

- OASIS-D comprehensive assessment
- Plan of care (POC), which is reviewed and signed by the certifying physician
- Home health claim submitted for period of care

Diagnoses listed on the claim should follow the OASIS definitions for primary and secondary diagnosis found in the OASIS Guidance Manual. Only current diagnoses actively addressed in the plan of care (POC) or that have the potential to affect the patient's responsiveness to treatment and rehabilitative prognosis even if not the focus of any home health treatment itself. Exclude resolved diagnoses or those that do not have the potential to impact the skilled services provided by the HHA, even if they are known/documented diagnoses. It is expected that more secondary diagnoses would be reported on the home health claim given the increased number of secondary diagnosis fields compared to the OASIS item set.

For case-mix adjustment purposes, the principal diagnosis reported on the home health claim will determine the clinical group for each 30-day period of care. CMS has updated billing instructions to clarify that there will be no need for the HHA to complete a follow up assessment just to make the diagnoses on the claim and the OASIS form match.

However, for both the claim and the OASIS, the ICD-10-CM diagnoses should be listed in the order that best reflects the seriousness of the patient's condition and justifies the disciplines and services provided and in accordance with the Official ICD-10-CM Guidelines for Coding and Reporting. The sequence of codes should follow ICD-10-CM guidelines for reporting manifestation codes. Therefore, if a manifestation code is part of the primary diagnosis, the first two diagnoses should match and appear in the same sequence on both forms.

The ICD-10-CM diagnoses entered onto the OASIS and claim form must be the full diagnosis code, all seven characters, where applicable. If the complete, valid code has fewer than the maximum number of characters, allowed on the form, it is not appropriate to fill it with zeros or other characters.

CMS has clarified "Active Diagnoses" for the purpose of assignment to M1021, M1023 and responses to M1028 with the following taken from Quarterly Q&As:

- Diagnoses that are the chief reason for home health services
- Comorbid condition that is addressed in the plan of care
- Conditions felt to have potential to affect the patient's responsiveness to treatment

Diagnoses felt to have the potential to affect the patient's responsiveness to treatment means that they have a direct relationship to the patient's current functional, cognitive mood, or behavior status; medical treatments; nurse monitoring; or risk of death at the time of assessment.

The following information can be found in the Outcome and Assessment Information Set OASIS-D Guidance Manual, effective January 1, 2019, chapter 3, section 3-C, "OASIS Item Guidance — Patient History and Diagnoses."

Chapter 3 contains item-by-item guidance for all OASIS items. Included here are *only* the items which pertain to assigning an ICD-10-CM diagnosis code, item M1021, M1023 and M1028.

Note: CY 2023 updates to the OASIS Guidance Manual were not available at the time this book was printed. Updated versions can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html.

For each item, guidance is provided on the following topics:

ITEM INTENT: Describes the rationale for collecting the information, in the context of outcome and process quality measurement, care planning, outcome risk adjustment, or prospective payment rate adjustment.

TIME POINTS: Describes when the information is to be collected during the patient's home health episode of care.

RESPONSE-SPECIFIC INSTRUCTIONS: Describes how the clinician should decide which of the possible responses should apply. These instructions may not always provide definitive guidance for selecting responses in every case, because clinical judgement is often required to determine the most accurate response to a specific item.

DATA SOURCES/RESOURCES: Describes the potential sources of information that should be accessed during the assessment to determine the most accurate response to this specific item. May include other clinicians, administrative records, online guidance regarding coding or other assessment guidelines, or standards promulgated by professional or accrediting organizations.

In addition to the information provided in the tables, items M1021 and M1023 also have specific instructions related to reporting diagnoses in the various columns on the form which are as follows.

M1021/M1023

Diagnoses and Symptom Control:
List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only—no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-C M sequencing requirements must be followed if multiple coding is indicated for any diagnoses.

Code each row according to the following directions for each column:
Column 1: Enter the description of the diagnosis. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 2: Enter the ICD-10-CM code for the condition described in Column 1 - no surgical or procedure codes allowed. Codes must be entered at the level of highest specificity and ICD-10-CM coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) may not be reported in M1021 (Primary Diagnosis) but may be reported in M1023 (Secondary Diagnoses). Also note that when a Z-code is reported in Column 2, the code for the underlying condition can often be entered in Column 2, as long as it is an active on-going condition impacting home health care.

Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:

0—Asymptomatic, no treatment needed at this time

1—Symptoms well controlled with current therapy

2—Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring

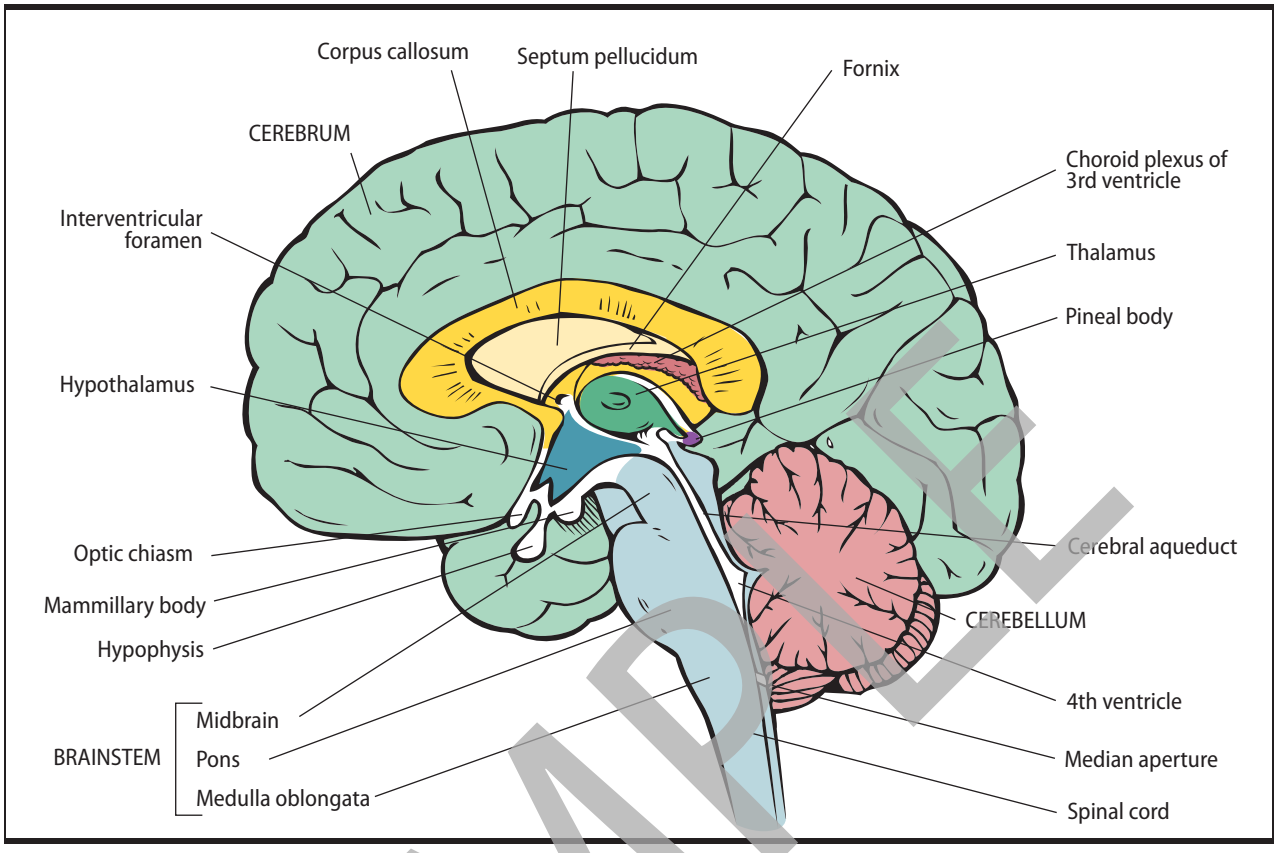
3—Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring

4—Symptoms poorly controlled; history of re-hospitalizations

Note that the rating for symptom control in Column 2 should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.

Chapter 6. Diseases of the Nervous System (GØØ–G99)

Brain



Cranial Nerves