### ICD-10-CM/PCS Structural Code Change Overview

The coding system used to classify diseases and other conditions will transition to the International Classification of Diseases version 10, or ICD-10-CM. Anatomy is the primary axis of classification of ICD-10-CM, or diagnosis. The structure of ICD-10-CM diagnosis codes captures a greater degree of detail than could be captured using the ICD-9-CM classification.

#### ICD-10-CM codes are 3–7 Characters (alphabetic) with all codes starting with an alphabetic character:

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategories:</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Etiology</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anatomic site</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Complication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laterality</td>
<td></td>
</tr>
</tbody>
</table>

#### ICD-10-PCS procedure codes contain 7 alphanumeric characters.

*High Impact Diagnosis  **Low Impact Diagnosis

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
</table>

*High Impact Diagnosis  **Low Impact Diagnosis

### Documentation Best Practices

- Always document the diagnosis(es) that is the reason for admission, rather than just the presenting symptoms, as soon as it is determined.
- Document diagnoses, rather than descriptors (e.g. “metabolic encephalopathy”, not “altered mental status”).
- Indicate acuity/severity of all diagnoses: acute, chronic, acute on chronic, or exacerbation.
- Link all diseases/diagnoses to their underlying causes if known. (For example, “GI bleed due to peptic ulcer with hemorrhage”)
- Indicate “suspected,” “possible,” or “likely” when treating a condition empirically, such as a gram negative pneumonia. Coding guidelines require that uncertain diagnoses are documented as such at the time of discharge.
- Use supporting documentation from dietary and wound care specialists to accurately document nutritional disorders and pressure ulcers.
- Clarify what is present on admission (POA).
- Clearly indicate what has been ruled out (e.g., “post-op infection: ruled out”).
- Avoid use of temporal indicators, unless they are pertinent and are intended to describe complications rather than expected events.
- Consider documenting if systemic inflammatory response syndrome (SIRS) is present in trauma, burn, and pancreatitis cases when VS and labs support this.
- Avoid use of arrows/symbols (e.g., use hyponatremia instead of ↓Na).

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**ICD-10-PCS Changes to Procedural Documentation Requirements**

PCS includes significant changes to how procedures must be captured and coded, with more specificity required for code assignment. As with diagnosis codes, unspecified options are not provided. To avoid excessive queries from your coding staff, ensure that your documentation makes clear the following concepts:

<table>
<thead>
<tr>
<th>If Observing...</th>
<th>Please Consider Documenting... (Higher SOI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protein-Calorie Malnutrition</td>
<td>Acuity</td>
</tr>
<tr>
<td></td>
<td>• Mild Degree*</td>
</tr>
<tr>
<td></td>
<td>• Moderate Degree*</td>
</tr>
<tr>
<td></td>
<td>• Unspecified**</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>Identify the Stage: I-V Stages IV &amp; V**</td>
</tr>
<tr>
<td>BMI 240** or BMI &lt;19**</td>
<td>Provider must document the correlating medical diagnoses:</td>
</tr>
<tr>
<td></td>
<td>• Morbid obesity</td>
</tr>
<tr>
<td></td>
<td>• Obesity</td>
</tr>
<tr>
<td></td>
<td>• Cachexia*</td>
</tr>
</tbody>
</table>

### Documentation Tips

**Obstetrics**

#### Documentation Overview

Your documentation tells a patient’s story.
- H&P = Introduction
- Progress/Op Notes = Body
- Discharge summary = Conclusion

It is critical to paint a clear picture from start to finish and cover the initial situation, changes through the stay, and a clear summary that brings it all together.

#### Documentation Best Practices

- Always document the diagnosis(es) that is the reason for admission, rather than just the presenting symptoms, as soon as it is determined.
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- Consider documenting if systemic inflammatory response syndrome (SIRS) is present in trauma, burn, and pancreatitis cases when VS and labs support this.
- Avoid use of arrows/symbols (e.g., use hyponatremia instead of ↓Na).
If documenting Signs/Symptoms… Please Consider Documenting... (Higher SOI)

<table>
<thead>
<tr>
<th>Fever</th>
<th>Clarify underlying condition (due to infection – e.g. sepsis*, pneumonia*)</th>
</tr>
</thead>
</table>
| Early versus late vomiting | Clarify weeks of gestation  
| | Early is defined as < 20 weeks now instead of 22 weeks as in ICD-9-CM  
| | Clarify any associated secondary conditions  
| | (e.g. dehydration, acute kidney injury*, hypovolemia)  
| Maternal care: | The reason for observation, hospitalization, other obstetric care, or C-section delivery before onset of care  

<table>
<thead>
<tr>
<th>Trimester</th>
<th>Counted from the first day of the LMP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trimester 1</td>
<td>LMP to less than 14 weeks 0 days</td>
</tr>
<tr>
<td>Trimester 2</td>
<td>14 weeks 0 days to less than 28 weeks 0 days</td>
</tr>
<tr>
<td>Trimester 3</td>
<td>≥ 28 weeks 0 days to delivery</td>
</tr>
</tbody>
</table>

**Note:** The Coder cannot assume or identify trimester based on LMP documentation

<table>
<thead>
<tr>
<th>Fetus</th>
<th>Identify</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trimester when the complication occurred</td>
</tr>
<tr>
<td></td>
<td>If pre-existing condition, then utilize the trimester of the encounter</td>
</tr>
<tr>
<td></td>
<td>If spanning more than one trimester, utilize the trimester in which the condition occurred</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Causes</th>
<th>Identify</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fetus, single or multiple</td>
</tr>
<tr>
<td></td>
<td>Fetus to which the complication occurred/affected</td>
</tr>
</tbody>
</table>

**Abortion versus Fetal Death**

<table>
<thead>
<tr>
<th>Abortion: Up to 20 weeks of gestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal Death: After 20 weeks of gestation</td>
</tr>
</tbody>
</table>

**Gravidity Status**

<table>
<thead>
<tr>
<th>Young</th>
<th>Less than 16 years of age at the expected date of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elderly</td>
<td>35 years or older at the expected date of delivery</td>
</tr>
</tbody>
</table>

**Definitions**

<table>
<thead>
<tr>
<th>Peripartum</th>
<th>Last month of pregnancy to 5 months post partum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post partum</td>
<td>From delivery to 6 weeks after delivery</td>
</tr>
<tr>
<td>Preterm Gestation</td>
<td>Before 37 weeks completed</td>
</tr>
<tr>
<td>Post term</td>
<td>Pregnancy between 40-42 weeks gestation</td>
</tr>
<tr>
<td>Prolonged pregnancy completed gestation</td>
<td>Pregnancy that has advanced beyond 42 weeks</td>
</tr>
</tbody>
</table>

**Labor**

<table>
<thead>
<tr>
<th>False Labor</th>
<th>Before 37 weeks completed gestation</th>
</tr>
</thead>
</table>
| Late pregnancy | Post term  
| | Prolonged pregnancy |
| Preterm | Identify trimester  
| | Identify if  
| | With delivery, preterm (add trimester and fetus)  
| | With delivery, term  
| | Without delivery  
| | Asthma with chronic obstructive pulmonary diseases** |
| Obstructed | Cause: maternal (deformity of maternal pelvic bones, inlet or outlet contracture, fetopelvic disproportion, abnormality of pelvic organs)  
| | Cause: Fetal (Presentation – incomplete rotation, breech, face, brow, shoulder; identify which specific fetus) |

**Cord Conditions**

<table>
<thead>
<tr>
<th>Prolapse of the cord</th>
</tr>
</thead>
</table>
| Cord around the neck | With compression  
| | Without compression |
| Cord entanglement | With compression  
| | Without compression |
| Short cord |
| Vascular malformations |
| Other cord conditions |

**Capturing Severity of Illness (SOI) in ICD-10-CM Terms**

A patient’s SOI is conveyed to CMS and quality organizations via ICD-10-CM codes, assigned by a coder reading the medical record. Document known or suspected relationships between concomitant conditions wherever possible to ensure accurate capture of the patient’s true risk of mortality and/or readmission.