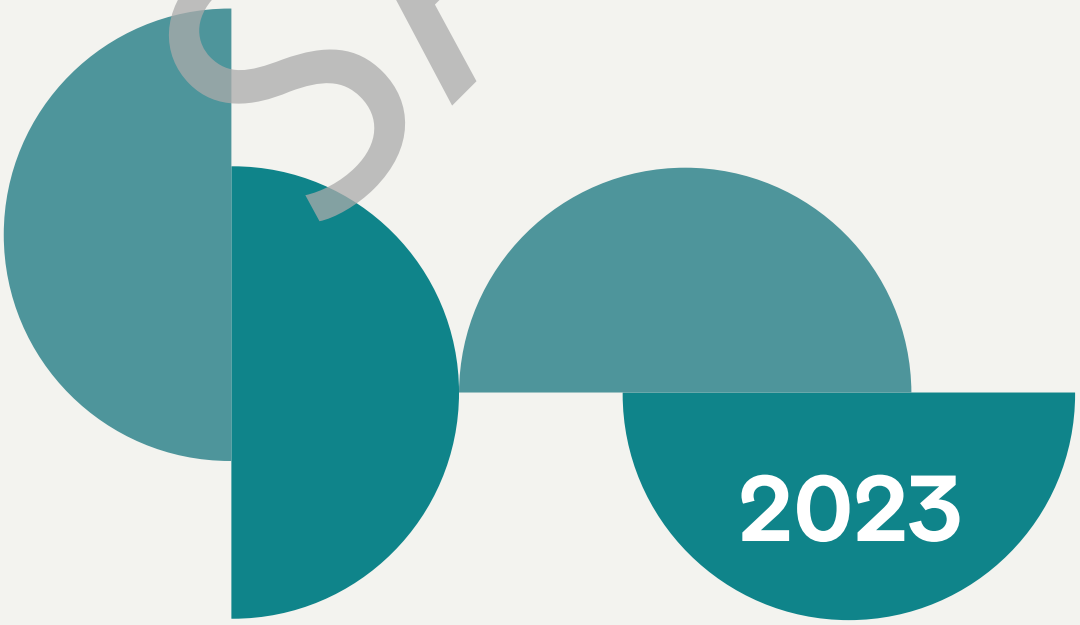
Optum

Expert

ICD-10-CM Expert for Skilled Nursing Facilities and Inpatient Rehabilitation Facilities

The complete official code set

Codes valid from October 1, 2022
through September 30, 2023



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Contents

Note
The term "NOTE" appears as an icon and precedes the instructional information. These notes function as alerts to highlight coding instructions within the text.

Code First/Use additional code
These instructional notes provide sequencing instruction. They may appear independently of each other or to designate certain etiology/manifestation paired codes. These instructions signal the coder that an additional code should be reported to provide a more complete picture of that diagnosis.

In etiology/manifestation coding, ICD-10-CM requires the underlying condition to be sequenced first, followed by the manifestation. In these situations, codes with "In diseases classified elsewhere" in the code description are never permitted as a first-listed or principal diagnosis code and must be sequenced following the underlying condition code.

Code Also
A "code also" note alerts the coder that more than one code may be required to fully describe the condition. The sequencing depends on the circumstances of the encounter. Factors that may determine sequencing include severity and reason for the encounter.

Revised Text
The revised text ▶◀ "bow ties" alert the user to changes in official notations for the current year. Revised text may include the following:

- A change in a current parenthetical description
- A change in the code(s) associated with a current parenthetical note
- A change in how a current parenthetical note is classified (e.g., an Excludes 1 note that changed to an Excludes 2 note)
- Addition of a new parenthetical note(s) to a code

Deleted Text
~~Strikethrough~~ on official notations indicate a deletion from the classification for the current year.

Optum360 Notations

AHA Coding Clinic Citations
Coding Clinics are official American Hospital Association (AHA) publications that provide coding advice specific to ICD-10-CM and ICD-10-PCS.

Coding Clinic citations included in this manual are current up to the second quarter of 2021.

These citations identify the year, quarter, and page number of one or more *Coding Clinic* publications that may have coding advice relevant to a particular code or group of codes. With the most current citation listed first, these notations are preceded by the symbol **AHA:** and appear in purple type.

I15.1 Hypertension secondary to other renal disorders
AHA: 2Ø16, 3Q, 22

Definitions
Definitions explain a specific term, condition, or disease process in layman's terms. These notations are preceded by the symbol **DEF:** and appear in purple type.

✓5th **M51.4 Schmorl's nodes**
DEF: Irregular bone defect in the margin of the vertebral body that causes herniation into the end plate of the vertebral body.

Coding Tips
The tips in the tabular list offer coding advice that is not readily available within the ICD-10-CM classification. They may relate to official coding guidelines, indexing nuances, or advice from *AHA's Coding Clinic for ICD-10-CM/PCS*. These notations are preceded by the symbol **TIP:** and appear in brown type.

✓5th **B97.2 Coronavirus as the cause of diseases classified elsewhere**
TIP: Do not report a code from this subcategory for COVID-19; refer to U07.1.

RIC Excl
Rehabilitation impairment categories (RIC) may qualify for a payment adjustment when certain conditions, considered comorbid conditions (CC), are assigned as secondary diagnoses. However, there are certain CCs that are excluded from specific RIC categories. This reference identifies those RIC categories to which the CC is excluded. These notations are preceded by the symbol **RIC Excl:** and appear in blue type.

I40.8 Other acute myocarditis CC
RIC Excl: 14 Cardiac

If no RIC exclusion reference is listed, the CC may qualify a case for payment adjustment regardless of the RIC category assigned. For a comprehensive list of all RIC CCs and the RIC categories from which they may be excluded, please refer to appendix K, "RIC Comorbid Conditions," at the back of this book.

Icons
Note: The following icons are placed to the left of the code.

● **New Code**
Codes that have been added to the classification effective October 1, 2022.

● **New Code – Mid-year**
Codes that have been added to the classification effective April 1, 2022.

New for 2023

▲ **Revised Code**
Codes that have had a change to their description or validity effective October 1, 2022. For additional information on codes with validity changes, see the "What's New" section.

▲ **Revised Code – Mid-year**
Codes that have had a change to their description or validity effective April 1, 2022.

New for 2023

☑ **Additional Characters Required**
✓4th This symbol indicates that the code requires a 4th character.
✓5th This symbol indicates that the code requires a 5th character.
✓6th This symbol indicates that the code requires a 6th character.
✓7th This symbol indicates that the code requires a 7th character.

✓5th **H60.3 Other infective otitis externa**
✓6th **H60.31 Diffuse otitis externa**
H60.311 Diffuse otitis externa, right ear RP
H60.312 Diffuse otitis externa, left ear RP
H60.313 Diffuse otitis externa, bilateral RP
H60.319 Diffuse otitis externa, unspecified ear RP

✓x7th **Placeholder Alert**
This symbol indicates that the code requires a 7th character following the placeholder "X". Codes with fewer than six characters that require a 7th character must contain placeholder "X" to fill in the empty character(s).

✓x7th **T16.1 Foreign body in right ear** RP

Note: The following icons are placed at the end of the code description.

10 Steps to Correct Coding

Follow the 10 steps below to correctly code encounters for health care services.

Step 1: Identify the reason for the visit or encounter (i.e., a sign, symptom, diagnosis and/or condition).

The medical record documentation should accurately reflect the patient's condition, using terminology that includes specific diagnoses and symptoms or clearly states the reasons for the encounter.

Choosing the main term that best describes the reason chiefly responsible for the service provided is the most important step in coding. If symptoms are present and documented but a definitive diagnosis has not yet been determined, code the symptoms. *For outpatient cases, do not code conditions that are referred to as "rule out," "suspected," "probable," or "questionable."* Diagnoses often are not established at the time of the initial encounter/visit and may require two or more visits to be established. Code only what is documented in the available outpatient records and only to the highest degree of certainty known at the time of the patient's visit. For inpatient medical records, uncertain diagnoses may be reported if documented at the time of discharge.

Step 2: After selecting the reason for the encounter, consult the alphabetic index.

The most critical rule is to begin code selection in the alphabetic index. Never turn first to the tabular list. The index provides cross-references, essential and nonessential modifiers, and other instructional notations that may not be found in the tabular list.

Step 3: Locate the main term entry.

The alphabetic index lists conditions, which may be expressed as nouns or eponyms, with critical use of adjectives. Some conditions known by several names have multiple main entries. Reasons for encounters may be located under general terms such as admission, encounter, and examination. Other general terms such as history, status (post), or presence (of) can be used to locate other factors influencing health.

Step 4: Scan subterm entries.

Scan the subterm entries, as appropriate, being sure to review continued lines and additional subterms that may appear in the next column or on the next page. Shaded vertical guidelines in the index indicate the indentation level for each subterm in relation to the main terms.

Step 5: Pay close attention to index instructions.

- Parentheses ( ) enclose nonessential modifiers, terms that are supplementary words or explanatory information that may or may not appear in the diagnostic statement and do not affect code selection.
- Brackets [ ] enclose manifestation codes that can be used only as secondary codes to the underlying condition code immediately preceding it. If used, manifestation codes must be reported with the appropriate etiology codes.
- Default codes are listed next to the main term and represent the condition most commonly associated with the main term or the unspecified code for the main term.
- "*See*" cross-references, identified by italicized type and "code by" cross-references indicate that another term *must be referenced* to locate the correct code.
- "*See also*" cross-references, identified by italicized type, provide alternative terms that may be useful to look up but *are not mandatory*.
- "Omit code" cross-references identify instances when a code is not applicable depending on the condition being coded.
- "With" subterms are listed out of alphabetic order and identify a presumed causal relationship between the two conditions they link.
- "Due to" subterms identify a relationship between the two conditions they link.
- "NEC," abbreviation for "not elsewhere classified," follows some main terms or subterms and indicates that there is no specific code for the condition even though the medical documentation may be very specific.
- "NOS," abbreviation for "not otherwise specified," follows some main terms or subterms and is the equivalent of unspecified; NOS signifies that the information in the medical record is insufficient for assigning a more specific code.
- *Following* references help coders locate alphanumeric codes that are out of sequence in the tabular section.
- Check-additional-character symbols flag codes that require additional characters to make the code valid; the characters available to complete the code should be verified in the tabular section.

Step 6: Choose a potential code and locate it in the tabular list.

To prevent coding errors, always use both the alphabetic index (to identify a code) and the tabular list (to verify a code), as the index does not include the important instructional notes found in the tabular list. An added benefit of using the tabular list, which groups like things together, is that while looking at one code in the list, a coder might see a more specific one that would have been missed had the coder relied solely on the alphabetic index. Additionally, many of the codes require a fourth, fifth, sixth, or seventh character to be valid, and many of these characters can be found only in the tabular list.

Step 7: Read all instructional material in the tabular section.

The coder must follow any Includes, Excludes 1 and Excludes 2 notes, and other instructional notes, such as "Code first" and "Use additional code," listed in the tabular list for the chapter, category, subcategory, and subclassification levels of code selection that direct the coder to use a different or additional code. Any codes in the tabular range A00.0- through T88.9- may be used to identify the diagnostic reason for the encounter. The tabular list encompasses many codes describing disease and injury classifications (e.g., infectious and parasitic diseases, neoplasms, symptoms, nervous and circulatory system etc.).

Codes that describe symptoms and signs, as opposed to definitive diagnoses, should be reported when an established diagnosis has not been made (confirmed) by the physician. Chapter 18 of the ICD-10-CM code book, "Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified" (codes R00.---R99), contains many, but not all, codes for symptoms.

ICD-10-CM classifies encounters with health care providers for circumstances other than a disease or injury in chapter 21, "Factors Influencing Health Status and Contact with Health Services" (codes Z00–Z99). Circumstances other than a disease or injury often are recorded as chiefly responsible for the encounter.

A code is invalid if it does not include the full number of characters (greatest level of specificity) required. Codes in ICD-10-CM can contain from three to seven alphanumeric characters. A three-character code is to be used only if the category is not further subdivided into four-, five-, six-, or seven-character codes. Placeholder character X is used as part of an alphanumeric code to allow for future expansion and as a placeholder for empty characters in a code that requires a seventh character but has no fourth, fifth, or sixth character. Note that certain categories require seventh characters that apply to all codes in that category. Always check the category level for applicable seventh characters for that category.

Step 8: Consult the official ICD-10-CM conventions and guidelines.

The *ICD-10-CM Official Guidelines for Coding and Reporting* govern the use of certain codes. These guidelines provide both general and chapter-specific coding guidance.

Chapter 4. Endocrine, Nutritional and Metabolic Diseases (EØØ–E89)

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.

a. Diabetes mellitus

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used. They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories EØ8–E13 as needed to identify all of the associated conditions that the patient has.

Patient is admitted with reported diagnoses of uncontrolled diabetes, type 2, with diabetic polyneuropathy and diabetic retinopathy with macular edema. Endocrinology clinical notes indicate a current HgA1c of 12.4 and "persistent blood glucose elevations over 300."

E11.65 **Type 2 diabetes mellitus with hyperglycemia**

E11.311 **Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema**

E11.42 **Type 2 diabetes mellitus with diabetic polyneuropathy**

Explanation: Use as many codes to describe the diabetic complications as needed. Many are combination codes that describe more than one condition. "Uncontrolled" may reference hypo- or hyperglycemia, based upon available provider documentation.

1) Type of diabetes

The age of a patient is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason, type 1 diabetes mellitus is also referred to as juvenile diabetes.

A 45-year-old patient is diagnosed with type 1 diabetes.

E1Ø.9 **Type 1 diabetes mellitus without complications**

Explanation: Although most type 1 diabetics are diagnosed in childhood or adolescence, it can also begin in adults.

2) Type of diabetes mellitus not documented

If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2 diabetes mellitus.

Patient is referred with new diagnoses reported in provider clinical notes as diabetes and hypertension.

E11.9 **Type 2 diabetes mellitus without complications**

I1Ø **Essential (primary) hypertension**

Explanation: Since the type of diabetes was not documented and no complications were noted, the default code is E11.9.

3) Diabetes mellitus and the use of insulin, oral hypoglycemics, and injectable non-insulin drugs

If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11-, Type 2 diabetes mellitus, should be assigned. **Additional** code**(s)** should be assigned from category Z79 to identify the long-term (current) use of insulin, oral hypoglycemic drugs, **or injectable non-insulin antidiabetic, as follows:**

If the patient is treated with both oral medications and insulin, **both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs,** should be assigned.

If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long term (current) use of insulin, and Z79.899, Other long term (current) drug therapy.

If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long term (current) use of oral hypoglycemic drugs, and Z79.899, Other long term (current) drug therapy.

Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

Patient is referred with documented provider notes reporting 10-year history of diabetes requiring daily insulin use.

E11.9 **Type 2 diabetes mellitus without complications**

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

Explanation: Do not assume that a patient requiring insulin use must have type 1 diabetes. The default for diabetes without further specification defaults to type 2. Add the code for long-term use of insulin.

4) Diabetes mellitus in pregnancy and gestational diabetes

See Section I.C.15. Diabetes mellitus in pregnancy.

See Section I.C.15. Gestational (pregnancy induced) diabetes

5) Complications due to insulin pump malfunction

(a) Underdose of insulin due to insulin pump failure

An underdose of insulin due to an insulin pump failure should be assigned to a code from subcategory T85.6, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, that specifies the type of pump malfunction, as the principal or first-listed code, followed by code T38.3X6-, Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs. Additional codes for the type of diabetes mellitus and any associated complications due to the underdosing should also be assigned.

A 76-year-old male with diabetic ESRD is admitted for rehabilitation and develops hyperglycemia. He has had an insulin pump for 14 years and after returning from the ER, is noted to have experienced hyperglycemia due to a pump malfunction that caused too little insulin to be administered. On return, the blood sugars are resolving.

T85.614D **Breakdown (mechanical) of insulin pump, subsequent encounter**

T38.3X6D **Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, subsequent encounter**

E11.65 **Type 2 diabetes mellitus with hyperglycemia**

E11.22 **Type 2 diabetes mellitus with diabetic chronic kidney disease**

N18.6 **End stage renal disease**

Explanation: The complication code for the mechanical breakdown of the pump is sequenced first, followed by the underdosing code and code for the type of diabetes with complication. If other diabetic complications are present, assign all codes needed to capture each complication. The seventh character D is used for a subsequent encounter.

(b) Overdose of insulin due to insulin pump failure

The principal or first-listed code for an encounter due to an insulin pump malfunction resulting in an overdose of insulin, should also be T85.6-, Mechanical complication of other specified internal and external prosthetic devices, implants and grafts, followed by code T38.3X1-, Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional).

A 70-year-old female with type 2 diabetes is found on the floor and sent to the ER. On her return from the hospital, it is noted that a failure of her insulin pump that caused excess insulin administration was the cause of hypoglycemia, resulting in her condition.

T85.614D **Breakdown (mechanical) of insulin pump, subsequent encounter**

T38.3X1D **Poisoning by insulin and oral hypoglycemic [antidiabetic] drugs, accidental (unintentional), subsequent encounter**

E11.649 **Type 2 diabetes mellitus with hypoglycemia without coma**

Explanation: The complication code for the mechanical breakdown of the pump is sequenced first, followed by the code for poisoning and type of diabetes with any associated complications. The seventh character D is used for subsequent encounter.

I82.602 Acute embolism and thrombosis of unspecified veins of left upper extremity RIC
I82.603 Acute embolism and thrombosis of unspecified veins of upper extremity, bilateral RIC
I82.609 Acute embolism and thrombosis of unspecified veins of unspecified upper extremity RP RIC

✓6th I82.61 Acute embolism and thrombosis of superficial veins of upper extremity
Acute embolism and thrombosis of antecubital vein
Acute embolism and thrombosis of basilic vein
Acute embolism and thrombosis of cephalic vein
I82.611 Acute embolism and thrombosis of superficial veins of right upper extremity RIC
I82.612 Acute embolism and thrombosis of superficial veins of left upper extremity RIC
I82.613 Acute embolism and thrombosis of superficial veins of upper extremity, bilateral RIC
I82.619 Acute embolism and thrombosis of superficial veins of unspecified upper extremity RP RIC

✓6th I82.62 Acute embolism and thrombosis of deep veins of upper extremity
Acute embolism and thrombosis of brachial vein
Acute embolism and thrombosis of radial vein
Acute embolism and thrombosis of ulnar vein
I82.621 Acute embolism and thrombosis of deep veins of right upper extremity RIC
I82.622 Acute embolism and thrombosis of deep veins of left upper extremity RIC
I82.623 Acute embolism and thrombosis of deep veins of upper extremity, bilateral RIC
I82.629 Acute embolism and thrombosis of deep veins of unspecified upper extremity RP RIC

✓5th I82.7 Chronic embolism and thrombosis of veins of upper extremity
Use additional code, if applicable, for associated long-term (current) use of anticoagulants (Z79.01)
EXCLUDES 1 *personal history of venous embolism and thrombosis (Z86.718)*

✓6th I82.70 Chronic embolism and thrombosis of unspecified veins of upper extremity
I82.701 Chronic embolism and thrombosis of unspecified veins of right upper extremity RIC
I82.702 Chronic embolism and thrombosis of unspecified veins of left upper extremity RIC
I82.703 Chronic embolism and thrombosis of unspecified veins of upper extremity, bilateral RIC
I82.709 Chronic embolism and thrombosis of unspecified veins of unspecified upper extremity RP RIC

✓6th I82.71 Chronic embolism and thrombosis of superficial veins of upper extremity
Chronic embolism and thrombosis of antecubital vein
Chronic embolism and thrombosis of basilic vein
Chronic embolism and thrombosis of cephalic vein
I82.711 Chronic embolism and thrombosis of superficial veins of right upper extremity RIC
I82.712 Chronic embolism and thrombosis of superficial veins of left upper extremity RIC
I82.713 Chronic embolism and thrombosis of superficial veins of upper extremity, bilateral RIC
I82.719 Chronic embolism and thrombosis of superficial veins of unspecified upper extremity RP RIC

✓6th I82.72 Chronic embolism and thrombosis of deep veins of upper extremity
Chronic embolism and thrombosis of brachial vein
Chronic embolism and thrombosis of radial vein
Chronic embolism and thrombosis of ulnar vein
I82.721 Chronic embolism and thrombosis of deep veins of right upper extremity RIC
I82.722 Chronic embolism and thrombosis of deep veins of left upper extremity RIC
I82.723 Chronic embolism and thrombosis of deep veins of upper extremity, bilateral RIC
I82.729 Chronic embolism and thrombosis of deep veins of unspecified upper extremity RP RIC

✓5th I82.A Embolism and thrombosis of axillary vein

✓6th I82.A1 Acute embolism and thrombosis of axillary vein
I82.A11 Acute embolism and thrombosis of right axillary vein RIC
I82.A12 Acute embolism and thrombosis of left axillary vein RIC
I82.A13 Acute embolism and thrombosis of axillary vein, bilateral RIC
I82.A19 Acute embolism and thrombosis of unspecified axillary vein RP RIC

✓6th I82.A2 Chronic embolism and thrombosis of axillary vein
I82.A21 Chronic embolism and thrombosis of right axillary vein RIC
I82.A22 Chronic embolism and thrombosis of left axillary vein RIC
I82.A23 Chronic embolism and thrombosis of axillary vein, bilateral RIC
I82.A29 Chronic embolism and thrombosis of unspecified axillary vein RP RIC

✓5th I82.B Embolism and thrombosis of subclavian vein

✓6th I82.B1 Acute embolism and thrombosis of subclavian vein
I82.B11 Acute embolism and thrombosis of right subclavian vein RIC
I82.B12 Acute embolism and thrombosis of left subclavian vein RIC
I82.B13 Acute embolism and thrombosis of subclavian vein, bilateral RIC
I82.B19 Acute embolism and thrombosis of unspecified subclavian vein RP RIC

✓6th I82.B2 Chronic embolism and thrombosis of subclavian vein
I82.B21 Chronic embolism and thrombosis of right subclavian vein RIC
I82.B22 Chronic embolism and thrombosis of left subclavian vein RIC
I82.B23 Chronic embolism and thrombosis of subclavian vein, bilateral RIC
I82.B29 Chronic embolism and thrombosis of unspecified subclavian vein RP RIC

✓5th I82.C Embolism and thrombosis of internal jugular vein

✓6th I82.C1 Acute embolism and thrombosis of internal jugular vein
I82.C11 Acute embolism and thrombosis of right internal jugular vein RIC
I82.C12 Acute embolism and thrombosis of left internal jugular vein RIC
I82.C13 Acute embolism and thrombosis of internal jugular vein, bilateral RIC
I82.C19 Acute embolism and thrombosis of unspecified internal jugular vein RP RIC

✓6th I82.C2 Chronic embolism and thrombosis of internal jugular vein
I82.C21 Chronic embolism and thrombosis of right internal jugular vein RIC
I82.C22 Chronic embolism and thrombosis of left internal jugular vein RIC
I82.C23 Chronic embolism and thrombosis of internal jugular vein, bilateral RIC
I82.C29 Chronic embolism and thrombosis of unspecified internal jugular vein RP RIC

- M12.1 Kaschin-Beck disease
  - Osteochondroarthrosis deformans endemica
  - M12.10 Kaschin-Beck disease, unspecified site
  - M12.11 Kaschin-Beck disease, shoulder
    - M12.111 Kaschin-Beck disease, right shoulder
    - M12.112 Kaschin-Beck disease, left shoulder
    - M12.119 Kaschin-Beck disease, unspecified shoulder
  - M12.12 Kaschin-Beck disease, elbow
    - M12.121 Kaschin-Beck disease, right elbow
    - M12.122 Kaschin-Beck disease, left elbow
    - M12.129 Kaschin-Beck disease, unspecified elbow
  - M12.13 Kaschin-Beck disease, wrist
    - M12.131 Kaschin-Beck disease, right wrist
    - M12.132 Kaschin-Beck disease, left wrist
    - M12.139 Kaschin-Beck disease, unspecified wrist
  - M12.14 Kaschin-Beck disease, hand
    - M12.141 Kaschin-Beck disease, right hand
    - M12.142 Kaschin-Beck disease, left hand
    - M12.149 Kaschin-Beck disease, unspecified hand
  - M12.15 Kaschin-Beck disease, hip
    - M12.151 Kaschin-Beck disease, right hip
    - M12.152 Kaschin-Beck disease, left hip
    - M12.159 Kaschin-Beck disease, unspecified hip
  - M12.16 Kaschin-Beck disease, knee
    - M12.161 Kaschin-Beck disease, right knee
    - M12.162 Kaschin-Beck disease, left knee
    - M12.169 Kaschin-Beck disease, unspecified knee
  - M12.17 Kaschin-Beck disease, ankle and foot
    - M12.171 Kaschin-Beck disease, right ankle and foot
    - M12.172 Kaschin-Beck disease, left ankle and foot
    - M12.179 Kaschin-Beck disease, unspecified ankle and foot
  - M12.18 Kaschin-Beck disease, vertebrae
  - M12.19 Kaschin-Beck disease, multiple sites
- M12.2 Villonodular synovitis (pigmented)
  - M12.20 Villonodular synovitis (pigmented), unspecified site
  - M12.21 Villonodular synovitis (pigmented), shoulder
    - M12.211 Villonodular synovitis (pigmented), right shoulder
    - M12.212 Villonodular synovitis (pigmented), left shoulder
    - M12.219 Villonodular synovitis (pigmented), unspecified shoulder
  - M12.22 Villonodular synovitis (pigmented), elbow
    - M12.221 Villonodular synovitis (pigmented), right elbow
    - M12.222 Villonodular synovitis (pigmented), left elbow
    - M12.229 Villonodular synovitis (pigmented), unspecified elbow
  - M12.23 Villonodular synovitis (pigmented), wrist
    - M12.231 Villonodular synovitis (pigmented), right wrist
    - M12.232 Villonodular synovitis (pigmented), left wrist
    - M12.239 Villonodular synovitis (pigmented), unspecified wrist
  - M12.24 Villonodular synovitis (pigmented), hand
    - M12.241 Villonodular synovitis (pigmented), right hand
    - M12.242 Villonodular synovitis (pigmented), left hand
    - M12.249 Villonodular synovitis (pigmented), unspecified hand
  - M12.25 Villonodular synovitis (pigmented), hip
    - M12.251 Villonodular synovitis (pigmented), right hip
    - M12.252 Villonodular synovitis (pigmented), left hip
    - M12.259 Villonodular synovitis (pigmented), unspecified hip
  - M12.26 Villonodular synovitis (pigmented), knee
    - M12.261 Villonodular synovitis (pigmented), right knee
    - M12.262 Villonodular synovitis (pigmented), left knee
    - M12.269 Villonodular synovitis (pigmented), unspecified knee
  - M12.27 Villonodular synovitis (pigmented), ankle and foot
    - M12.271 Villonodular synovitis (pigmented), right ankle and foot
    - M12.272 Villonodular synovitis (pigmented), left ankle and foot
    - M12.279 Villonodular synovitis (pigmented), unspecified ankle and foot
  - M12.28 Villonodular synovitis (pigmented), other specified site
    - Villonodular synovitis (pigmented), vertebrae
  - M12.29 Villonodular synovitis (pigmented), multiple sites
- M12.3 Palindromic rheumatism
  - DEF: Sudden and recurring attacks of moderate to severe joint pain and swelling generally occurring in the hands or feet of unknown etiology. After the attack subsides, the joints appear normal again.
  - M12.30 Palindromic rheumatism, unspecified site
  - M12.31 Palindromic rheumatism, shoulder
    - M12.311 Palindromic rheumatism, right shoulder
    - M12.312 Palindromic rheumatism, left shoulder
    - M12.319 Palindromic rheumatism, unspecified shoulder
  - M12.32 Palindromic rheumatism, elbow
    - M12.321 Palindromic rheumatism, right elbow
    - M12.322 Palindromic rheumatism, left elbow
    - M12.329 Palindromic rheumatism, unspecified elbow
  - M12.33 Palindromic rheumatism, wrist
    - M12.331 Palindromic rheumatism, right wrist
    - M12.332 Palindromic rheumatism, left wrist
    - M12.339 Palindromic rheumatism, unspecified wrist
  - M12.34 Palindromic rheumatism, hand
    - M12.341 Palindromic rheumatism, right hand
    - M12.342 Palindromic rheumatism, left hand
    - M12.349 Palindromic rheumatism, unspecified hand
  - M12.35 Palindromic rheumatism, hip
    - M12.351 Palindromic rheumatism, right hip
    - M12.352 Palindromic rheumatism, left hip
    - M12.359 Palindromic rheumatism, unspecified hip
  - M12.36 Palindromic rheumatism, knee
    - M12.361 Palindromic rheumatism, right knee
    - M12.362 Palindromic rheumatism, left knee
    - M12.369 Palindromic rheumatism, unspecified knee
  - M12.37 Palindromic rheumatism, ankle and foot
    - M12.371 Palindromic rheumatism, right ankle and foot

S89 Other and unspecified injuries of lower leg

NOTE A fracture not indicated as open or closed should be coded to closed.

EXCLUDES 2 *other and unspecified injuries of ankle and foot (S99.-)*

AHA: 2018,2Q,12; 2018,1Q,3; 2015,3Q,37-39

TIP: The term "improper alignment" is not synonymous with malunion or nonunion of a fracture when noted in provider documentation.

The appropriate 7th character is to be added to each code from subcategories S89.0, S89.1, S89.2, and S89.3.

- A initial encounter for closed fracture
- D subsequent encounter for fracture with routine healing
- G subsequent encounter for fracture with delayed healing
- K subsequent encounter for fracture with nonunion
- P subsequent encounter for fracture with malunion
- S sequela

S89.0 Physeal fracture of upper end of tibia

AHA: 2019,4Q,56

- S89.00 Unspecified physeal fracture of upper end of tibia
  - S89.001 Unspecified physeal fracture of upper end of right tibia RIC
  - S89.002 Unspecified physeal fracture of upper end of left tibia RIC
  - S89.009 Unspecified physeal fracture of upper end of unspecified tibia RP RIC
- S89.01 Salter-Harris Type I physeal fracture of upper end of tibia
  - S89.011 Salter-Harris Type I physeal fracture of upper end of right tibia RIC
  - S89.012 Salter-Harris Type I physeal fracture of upper end of left tibia RIC
  - S89.019 Salter-Harris Type I physeal fracture of upper end of unspecified tibia RP RIC
- S89.02 Salter-Harris Type II physeal fracture of upper end of tibia
  - S89.021 Salter-Harris Type II physeal fracture of upper end of right tibia RIC
  - S89.022 Salter-Harris Type II physeal fracture of upper end of left tibia RIC
  - S89.029 Salter-Harris Type II physeal fracture of upper end of unspecified tibia RP RIC
- S89.03 Salter-Harris Type III physeal fracture of upper end of tibia
  - S89.031 Salter-Harris Type III physeal fracture of upper end of right tibia RIC
  - S89.032 Salter-Harris Type III physeal fracture of upper end of left tibia RIC
  - S89.039 Salter-Harris Type III physeal fracture of upper end of unspecified tibia RP RIC
- S89.04 Salter-Harris Type IV physeal fracture of upper end of tibia
  - S89.041 Salter-Harris Type IV physeal fracture of upper end of right tibia RIC
  - S89.042 Salter-Harris Type IV physeal fracture of upper end of left tibia RIC
  - S89.049 Salter-Harris Type IV physeal fracture of upper end of unspecified tibia RP RIC
- S89.09 Other physeal fracture of upper end of tibia
  - S89.091 Other physeal fracture of upper end of right tibia RIC
  - S89.092 Other physeal fracture of upper end of left tibia RIC
  - S89.099 Other physeal fracture of upper end of unspecified tibia RP RIC

S89.1 Physeal fracture of lower end of tibia

AHA: 2019,4Q,56

- S89.10 Unspecified physeal fracture of lower end of tibia
  - S89.101 Unspecified physeal fracture of lower end of right tibia
  - S89.102 Unspecified physeal fracture of lower end of left tibia
  - S89.109 Unspecified physeal fracture of lower end of unspecified tibia RP
- S89.11 Salter-Harris Type I physeal fracture of lower end of tibia
  - S89.111 Salter-Harris Type I physeal fracture of lower end of right tibia
  - S89.112 Salter-Harris Type I physeal fracture of lower end of left tibia
  - S89.119 Salter-Harris Type I physeal fracture of lower end of unspecified tibia RP
- S89.12 Salter-Harris Type II physeal fracture of lower end of tibia
  - S89.121 Salter-Harris Type II physeal fracture of lower end of right tibia
  - S89.122 Salter-Harris Type II physeal fracture of lower end of left tibia
  - S89.129 Salter-Harris Type II physeal fracture of lower end of unspecified tibia RP
- S89.13 Salter-Harris Type III physeal fracture of lower end of tibia

  EXCLUDES 1 *fracture of medial malleolus (adult) (S82.5-)*
  - S89.131 Salter-Harris Type III physeal fracture of lower end of right tibia
  - S89.132 Salter-Harris Type III physeal fracture of lower end of left tibia
  - S89.139 Salter-Harris Type III physeal fracture of lower end of unspecified tibia RP
- S89.14 Salter-Harris Type IV physeal fracture of lower end of tibia

  EXCLUDES 1 *fracture of medial malleolus (adult) (S82.5-)*
  - S89.141 Salter-Harris Type IV physeal fracture of lower end of right tibia
  - S89.142 Salter-Harris Type IV physeal fracture of lower end of left tibia
  - S89.149 Salter-Harris Type IV physeal fracture of lower end of unspecified tibia RP
- S89.19 Other physeal fracture of lower end of tibia
  - S89.191 Other physeal fracture of lower end of right tibia
  - S89.192 Other physeal fracture of lower end of left tibia
  - S89.199 Other physeal fracture of lower end of unspecified tibia RP

S89.2 Physeal fracture of upper end of fibula

AHA: 2019,4Q,56

- S89.20 Unspecified physeal fracture of upper end of fibula
  - S89.201 Unspecified physeal fracture of upper end of right fibula RIC
  - S89.202 Unspecified physeal fracture of upper end of left fibula RIC
  - S89.209 Unspecified physeal fracture of upper end of unspecified fibula RP RIC
- S89.21 Salter-Harris Type I physeal fracture of upper end of fibula
  - S89.211 Salter-Harris Type I physeal fracture of upper end of right fibula RIC
  - S89.212 Salter-Harris Type I physeal fracture of upper end of left fibula RIC
  - S89.219 Salter-Harris Type I physeal fracture of upper end of unspecified fibula RP RIC
- S89.22 Salter-Harris Type II physeal fracture of upper end of fibula
  - S89.221 Salter-Harris Type II physeal fracture of upper end of right fibula RIC
  - S89.222 Salter-Harris Type II physeal fracture of upper end of left fibula RIC
  - S89.229 Salter-Harris Type II physeal fracture of upper end of unspecified fibula RP RIC
- S89.29 Other physeal fracture of upper end of fibula
  - S89.291 Other physeal fracture of upper end of right fibula RIC
  - S89.292 Other physeal fracture of upper end of left fibula RIC
  - S89.299 Other physeal fracture of upper end of unspecified fibula RP RIC

S89.3 Physeal fracture of lower end of fibula

AHA: 2019,4Q,56

- S89.30 Unspecified physeal fracture of lower end of fibula
  - S89.301 Unspecified physeal fracture of lower end of right fibula
  - S89.302 Unspecified physeal fracture of lower end of left fibula
  - S89.309 Unspecified physeal fracture of lower end of unspecified fibula RP

Appendixes

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

A09 Infectious gastroenteritis and colitis, unspecified
A33 Tetanus neonatorum
A34 Obstetrical tetanus
A35 Other tetanus
A46 Erysipelas
A55 Chlamydial lymphogranuloma (venereum)
A57 Chancroid
A58 Granuloma inguinale
A64 Unspecified sexually transmitted disease
A65 Nonvenereal syphilis
A70 Chlamydia psittaci infections
A78 Q fever
A86 Unspecified viral encephalitis
A89 Unspecified viral infection of central nervous system
A90 Dengue fever [classical dengue]
A91 Dengue hemorrhagic fever
A94 Unspecified arthropod-borne viral fever
A99 Unspecified viral hemorrhagic fever
B03 Smallpox
B04 Monkeypox
B09 Unspecified viral infection characterized by skin and mucous membrane lesions
B20 Human immunodeficiency virus [HIV] disease
B49 Unspecified mycosis
B54 Unspecified malaria
B59 Pneumocystosis
B64 Unspecified protozoal disease
B72 Dracunculiasis
B75 Trichinellosis
B79 Trichuriasis
B80 Enterobiasis
B86 Scabies
B89 Unspecified parasitic disease
B91 Sequelae of poliomyelitis
B92 Sequelae of leprosy
C01 Malignant neoplasm of base of tongue
C07 Malignant neoplasm of parotid gland
C12 Malignant neoplasm of pyriform sinus
C19 Malignant neoplasm of rectosigmoid junction
C20 Malignant neoplasm of rectum
C23 Malignant neoplasm of gallbladder
C33 Malignant neoplasm of trachea
C37 Malignant neoplasm of thymus
C52 Malignant neoplasm of vagina
C55 Malignant neoplasm of uterus, part unspecified
C58 Malignant neoplasm of placenta
C61 Malignant neoplasm of prostate
C73 Malignant neoplasm of thyroid gland
D34 Benign neoplasm of thyroid gland
D45 Polycythemia vera
D62 Acute posthemorrhagic anemia
D65 Disseminated intravascular coagulation [defibrination A syndrome]
D66 Hereditary factor VIII deficiency
D67 Hereditary factor IX deficiency
D71 Functional disorders of polymorphonuclear neutrophils
D77 Other disorders of blood and blood-forming organs in diseases classified elsewhere
E02 Subclinical iodine-deficiency hypothyroidism
E15 Nondiabetic hypoglycemic coma
E35 Disorders of endocrine glands in diseases classified elsewhere
E40 Kwashiorkor
E41 Nutritional marasmus
E42 Marasmic kwashiorkor
E43 Unspecified severe protein-calorie malnutrition
E45 Retarded development following protein-calorie malnutrition
E46 Unspecified protein-calorie malnutrition
E52 Niacin deficiency [pellagra]
E54 Ascorbic acid deficiency
E58 Dietary calcium deficiency
E59 Dietary selenium deficiency
E60 Dietary zinc deficiency
E65 Localized adiposity
E68 Sequelae of hyperalimentation
F04 Amnestic disorder due to known physiological condition
F05 Delirium due to known physiological condition
F09 Unspecified mental disorder due to known physiological condition
F21 Schizotypal disorder
F22 Delusional disorders
F23 Brief psychotic disorder
F24 Shared psychotic disorder
F28 Other psychotic disorder not due to a substance or known physiological condition
F29 Unspecified psychosis not due to a substance or known physiological condition
F39 Unspecified mood [affective] disorder
F42 Obsessive-compulsive disorder
F54 Psychological and behavioral factors associated with disorders or diseases classified elsewhere
F59 Unspecified behavioral syndromes associated with physiological disturbances and physical factors
F66 Other sexual disorders
F69 Unspecified disorder of adult personality and behavior
F70 Mild intellectual disabilities
F71 Moderate intellectual disabilities
F72 Severe intellectual disabilities
F73 Profound intellectual disabilities
F79 Unspecified intellectual disabilities
F82 Specific developmental disorder of motor function
F88 Other disorders of psychological development
F89 Unspecified disorder of psychological development
F99 Mental disorder, not otherwise specified
G01 Meningitis in bacterial diseases classified elsewhere
G02 Meningitis in other infectious and parasitic diseases classified elsewhere
G07 Intracranial and intraspinal abscess and granuloma in diseases classified elsewhere
G08 Intracranial and intraspinal phlebitis and thrombophlebitis
G09 Sequelae of inflammatory diseases of central nervous system
G10 Huntington's disease
G14 Postpolio syndrome
G20 Parkinson's disease
G26 Extrapyramidal and movement disorders in diseases classified elsewhere
G35 Multiple sclerosis
G53 Cranial nerve disorders in diseases classified elsewhere
G55 Nerve root and plexus compressions in diseases classified elsewhere
G59 Mononeuropathy in diseases classified elsewhere
G63 Polyneuropathy in diseases classified elsewhere
G64 Other disorders of peripheral nervous system
G94 Other disorders of brain in diseases classified elsewhere
H22 Disorders of iris and ciliary body in diseases classified elsewhere
H28 Cataract in diseases classified elsewhere
H32 Chorioretinal disorders in diseases classified elsewhere
H36 Retinal disorders in diseases classified elsewhere
H42 Glaucoma in diseases classified elsewhere
I00 Rheumatic fever without heart involvement
I10 Essential (primary) hypertension
I32 Pericarditis in diseases classified elsewhere

Code	Title	Tier	RIC Excl
B18.2	Chr viral hep C	3	03
B19.Ø	Unsp viral hep w hep coma	3	03
B19.11	Unsp viral hep B w hep coma	3	03
B19.21	Unsp viral hep C w hep coma	3	03
B2Ø	HIV	3	
B25.Ø	Cytomegaloviral pneumonitis	3	15
B26.1	Mumps meningitis	3	03, 05
B26.2	Mumps encephalitis	3	03
B26.3	Mumps pancreatitis	3	
B33.3	Retrovirus infections, nec	3	
B37.1	Pulmonary candidiasis	3	15
B37.5	Candidal meningitis	3	03, 05
B37.6	Candidal endocarditis	3	14
B37.7	Candidal sepsis	3	
B37.81	Candidal esophagitis	3	
B38.4	Coccidioidomycosis meningitis	3	03, 05
B39.Ø	Ac pulmonary histoplasm capsulati	3	15
B39.1	Chr pulmonary histoplasm capsulati	3	15
B39.2	Pulm histoplasm capsulati, unsp	3	15
B39.3	Disseminated histoplasm capsulati	3	15
B39.4	Histoplasm capsulati, unsp	3	15
B39.5	Histoplasm duboisii	3	
B39.9	Histoplasm, unsp	3	15
B44.Ø	Invasive pulm aspergillosis	3	15
B45.1	Cerebral cryptococcosis	3	03, 05
B58.2	Toxoplasma meningoencephalitis	3	03, 05
B58.3	Pulmonary toxoplasmosis	3	15
B58.81	Toxoplasma myocarditis	3	14
B59	Pneumocystosis	3	15
B77.81	Ascariasis pneumonia	3	15
B94.1	Sequelae of viral encephalitis	3	03
B96.5	Pseudomonas as the cause of dis class elwh	2	
B97.3Ø	Unsp retrovirus as the cause of dis class elwh	3	
B97.31	Lentivirus as the cause of dis class elwh	3	
B97.32	Oncovirus as the cause of dis class elwh	3	
B97.33	HTLV-I as the cause of dis class elwh	3	06
B97.34	HTLV-II as the cause of dis class elwh	3	06
B97.35	HIV 2 as the cause of dis class elwh	3	
B97.39	Oth retrovirus as cause of dis class elwh	3	
C91.ØØ	Ac lymphoblastic leuk no remis	3	
C91.Ø2	Ac lymphoblastic leuk, in relapse	3	
C92.ØØ	Ac myeloblastic leuk, no remis	3	
C92.Ø2	Ac myeloblastic leuk, in relapse	3	
C92.4Ø	Ac promyelocytic leuk, no remis	3	
C92.42	Ac promyelocytic leuk, in relapse	3	
C92.5Ø	Ac myelomonocytic leuk, no remis	3	
C92.52	Ac myelomonocytic leuk, in relapse	3	
C92.6Ø	Ac myeloid leuk w 11q23-abnormality no remis	3	
C92.62	Ac myeloid leuk w 11q23-abnormality in relapse	3	
C92.AØ	Ac myeloid leuk w multilineage dysplasia, no remis	3	
C92.A2	Ac myeloid leuk w multilineage dysplasia, in relapse	3	
C93.ØØ	Ac monoblastic/monocytic leuk, no remis	3	
C93.Ø2	Ac monoblastic/monocytic leuk, in relapse	3	
C94.ØØ	Ac erythroid leuk, no remis	3	
C94.Ø2	Ac erythroid leuk, in relapse	3	
C95.ØØ	Ac leuk of unsp cell type no remis	3	
C95.Ø2	Ac leuk of unsp cell type, in relapse	3	
D57.Ø-	Hb-SS w crisis	3	
D57.1	Sickle-cell wo crisis	3	
D57.2Ø	Sickle-cell/Hb-C wo crisis	3	
D57.21-	Sickle-cell/Hb-C w crisis	3	
D57.411	Sickle-cell thal unsp w ac chest synd	3	
D57.8Ø	Oth sickle-cell d/o wo crisis	3	
D57.81-	Oth sickle-cell d/o w crisis	3	
D6Ø.-	Acq pure red cell aplasia	3	
D61.-	Oth aplastic anemia/oth bone marrow fail syndr	3	
D64.81	Anemia d/t antineo chemo	3	
D65	DIC	3	
D66	Hereditary factor VIII deficiency	3	
D67	Hereditary factor IX deficiency	3	
E08.2-	DM d/t underlying condition w kidney complications	3	
E08.31-	DM d/t underlying condition w unsp diabetic retinopathy	3	
E08.32-	DM d/t underlying condition w mild nonprolif diabetic retinopathy	3	
E08.33-	DM d/t underlying condition w mod nonprolif diabetic retinopathy	3	
E08.34-	DM d/t underlying condition w severe nonprolif diabetic retinopathy	3	
E08.351-	DM d/t underlying condition w prolif diabetic retinopathy w macular edema	3	
E08.359-	DM d/t underlying condition w prolif diabetic retinopathy w/o macular edema	3	
E08.36	DM d/t underlying condition w cataract	3	
E08.39	DM d/t underlying condition w other ophthalmic compl	3	
E08.40	DM d/t underlying condition w diabetic neuro, unsp	3	06
E08.41	DM d/t underlying condition w diabetic mononeuro	3	
E08.42	DM d/t underlying condition w diabetic polyneuro	3	06
E08.43	DM d/t underlying condition w diabetic autonomic (poly)neuro	3	
E08.44	DM d/t underlying condition w diabetic amyotrophy	3	
E08.49	DM d/t underlying condition w oth diabetic neuro complication	3	
E08.5-	DM d/t underlying condition w circulatory complications	3	
E08.61-	DM d/t underlying condition w diabetic arthropathy	3	
E08.62-	DM d/t underlying condition w skin complications	3	
E08.63-	DM d/t underlying condition w oral complications	3	
E08.649	DM d/t underlying condition w hypoglycemia wo coma	3	
E08.65	DM d/t underlying condition w hyperglycemia	3	
E08.69	DM d/t underlying condition w oth spec complication	3	
E09.2-	Drug/chem induced DM w kidney complications	3	
E09.31-	Drug/chem induced DM w unsp diabetic retinopathy	3	
E09.32-	Drug/chem induced DM w mild nonprolif diabetic retinopathy	3	
E09.33-	Drug/chem induced DM w mod nonprolif diabetic retinopathy	3	
E09.34-	Drug/chem induced DM w severe nonprolif diabetic retinopathy	3	
E09.351-	Drug/chem induced DM w prolif diabetic retinopathy w macular edema	3	
E09.359-	Drug/chem induced DM w prolif diabetic retinopathy w/o macular edema	3	

Arteries