ICD-10-CM
Coding Essentials for LTC

April 2015
ICD-10-CM for LTC
Two-Day Agenda

Day 1

8:30am – 9:00am  Registration & Welcome
9:00am – 10:15am  History & Development of ICD-10
          Similarities & Differences
          Different Coding Systems
          How to Use Resource Books
          Official Coding Guidelines
10:15am – 10:30am  Break
10:30am – 12:00pm  Chapters 1, 2, and 3 of ICD-10-CM
12:00am – 1:00pm  Lunch
1:00pm – 2:15pm  Chapters 4, 5, and 6 of ICD-10-CM
2:15pm – 2:30pm  Break
2:30pm – 4:00pm  Chapters 7, 8, and 9 of ICD-10-CM

Day 2

9:00am – 10:15am  Chapters 10, 11, 12, and 13 of ICD-10-CM
10:15am – 10:30am  Break
10:30am – 12:00pm  Chapters 14, 15, 16, 17, and 18 of ICD-10-CM
12:00am – 1:00pm  Lunch
1:00pm – 2:15pm  Coding for Post-Acute Care
2:15pm – 2:30pm  Break
2:30pm – 4:00pm  Diagnosis Management
          Section I of the MDS
          Sequencing
          Claim Check Review
# CHAPTERS OF ICD-10-CM

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Who’s in the House

- RHIA
- RHIT
- RN / Manager
- LPN / Manager
- Therapist
- Consultant
- Administrator

- Business Office Manager
- MDS Coordinator
- HIM / Medical Records
- Physician

Review of Agenda
Objectives

• Comprehend definitions of ICD-10-CM terminology
• Understand official ICD-10 coding guidelines
• Distinguish the similarities & differences between ICD-9-CM and ICD-10-CM
• Demonstrate the ability to assign correct ICD-10-CM codes
• Utilize resource materials for accurate coding
• Be familiar with all chapters of ICD-10-CM

Objectives

• Be fluent in diagnosis management
• Analyze and code Section I of the MDS
• Sequence codes correctly for the billing process
• Evaluate final bills utilizing claim check review process
• Case Study Analysis to test knowledge of ICD-10-CM

History & Development of ICD-10

Raise Your ICD-10 IQ
History of ICD-10-CM

- CM – Clinical modification for US
- 1990 - ICD-10 adopted in 1990
- 1998 - First modification
  - Australia ICD-10-AM
- 1999 – US uses for mortality reporting
- 2015 – October 1st Go Live for ICD-10-CM and ICD-10-PCS

Development of ICD-10

- 1994
  - NCHS – National Center for Health Statistics
- 1997
  - Draft of tabular list and crosswalk were published for comment
- 2002-2013
  - Draft revisions made available for review
- 2014
  - One last update to code sets
- 2015
  - Annual updates each October

Compliance Date

- Date of Discharge for inpatient claims
- Date of Service for outpatient claims
  - LTC stay dates of service in September of 2015 will use ICD-9-CM codes
  - LTC stay dates of service in October of 2015 will use ICD-10-CM codes
**SIMILARITIES**

- Symbols, Code First, Use additional code
- Includes & Excludes
- Code to highest level of specificity
- Adherence to HIPAA & Official Guidelines
- Non-specific codes still available
- Inconsistent, missing, or conflicting documentation must be resolved by provider

**Similarities**

- Use of Coding Books or E-Encoder
- Tabular List similar to ICD-9 with some exceptions
- Main Terms – Indented Sub-terms
- Alphabetical Index of external causes
- Table of Neoplasms
- Table of Drugs & Chemicals
- Conventions, Abbreviations, Punctuation
DIFFERENCES

ICD-10-CM Diagnosis Structured Format

- Alpha (Except U)
- 2 – 7 Numeric or Alpha
- Additional Characters
- S 1 2
- 9 XX
- D
- Category
- Etiology, anatomic site, severity
- Added code extensions (7th Character) for obstetrics, injuries and external causes of injury
- 3 – 7 Characters

Examples of Structure

- S52 – Fx of Forearm
- S52.5 – Fx lower end of radius
- S52.52 – Torus Fx of lower end of radius
- S52.521 – Torus Fx of lower end of R radius
- S52.521D – Torus Fx of lower end of R radius, subsequent care
• More Codes! 17,000 versus 68,000
• More codes in the different categories
  • Diabetes – 59 to 200+
  • Pressure Ulcers – 9 to 125
  • Pathologic Fractures – 8 to 150
Codes are longer now (3-7 versus 3-5)
All codes begin with a letter (except “u”)
Code extensions are available for injuries & external causes
Combo codes are available for diagnoses & symptoms

• Increased precision with diagnoses
• Full diagnostic titles for each code
• More flexibility in incorporating advances in medicine & technology
• Uses more current & up to date med terms
• Laterality Added (left and right, both)

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<tr>
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<th>ICD-9</th>
<th>ICD-10</th>
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<td>Essential HTN</td>
<td>401.9 – Essential HTN, unspecified</td>
<td>110 – Essential primary HTN</td>
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<td>Asthma with acute exacerbation</td>
<td>493.92 – Asthma unspecified with acute exacerbation</td>
<td>345.21 – mild intermittent asthma with acute exacerbation &lt; 2 weeks or 345.31: &gt;2 weeks or 345.41: Daily</td>
</tr>
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Coding Systems

- ICD-9-CM
- ICD-10-CM
- ICD-10-PCS
- CPT
- DSM-V
- HCPCS

RESOURCE BOOKS

ICD-10-CM Book

- Table of Contents
- Introduction / How to Use
- Official Guidelines
- Alphabetical Index
- Table of Neoplasms
- Table of Drugs & Chemicals
- Index to External Causes
- Tabular List
Alphabetic Index

- Alphabetical list of terms and their corresponding code
- Consists of 4 parts:
  - Index of Diseases and Injury
  - Index of External Causes of Injury
  - Table of Neoplasms
  - Table of Drugs and Chemicals

Tabular List

Chronological list of codes divided into chapters based on body system or condition

Other Resource Books

Medical Dictionary
- Nursing Clinical Dictionary
- Taber's Medical Dictionary
Pharmacy Desk Reference

Medical Terminology
Anatomy & Physiology
Final Rule

- Modifications to HIPAA Electronic Health Transaction Standards
- Modifications to Medical Data Code Set
- Final Compliance Date

Official Guidance for ICD-10-CM

- Conventions
- General Guidelines
- Chapter Specific Guidelines
- Apply to all health care settings
- Approved by the cooperating parties
Official Guidelines

- Rules to accompany and complement the official conventions and instructions provided within the ICD-10-CM
- General instruction based on coding and sequencing instructions within Tabular List and Alphabetic Index
- Adherence when assigning diagnosis codes is required by HIPAA

What if Rules Conflict

Official Coding Guidelines

- Conventions
- State / MAC Requirements
- Organizational Policy

Guideline Sections

Section I
Conventions, general guidelines and chapter specific guidelines

Section II
Selection of principle diagnosis
ICD-10-CM Coding Manual

- Conventions and Guidelines are found in the beginning of the manual before the Alphabetic Index and Tabular List
- May also contain additional conventions from publisher
- At the beginning of chapters and sections in the Tabular List

Conventions

- General rules independent of the guidelines
  - Instructional notes
  - Abbreviations
  - Relational terms (and/or, with/without)
  - Punctuation
  - Cross references
- Take precedence over the guidelines

Main Term

- A term that must be used to locate a possible code in the tabular index
  - Bold
    - Left justified
    - It’s how you find the code!
    - Represent conditions, diseases, nouns, adjectives, but not usually anatomical sites
Examples of Main Terms

- Diseases: Influenza, Bronchitis
- Conditions: Fatigue, Fracture, Injury
- Nouns: Disease, Disturbance, Syndrome
- Adjectives: Double, Large, Kink

- Usually not the anatomical site, if you try to locate with anatomical site it will usually redirect you to “see condition”

Main Term Example

Main Term Look Up

What is the main term for each?
- Urinary Tract Infection
  - Infection
- Benign Prostatic Hypertrophy
  - Hypertrophy
- Chronic Obstructive Pulmonary Disease
  - Disease
Example: Crohn’s Disease

Eponym: a person after whom a discovery, invention, place, etc., is named or thought to be named

* Exception to the rule to find, and you will be sent somewhere else in the book

• Disease
• Crohn’s (takes you to enteritis, regional)

Examples of Main Terms

• Fracture
• Attention to
• Failure
• Aftercare
• Neoplasm
• Ulcer
• Hypertension
• Arteriosclerosis
• Dependence

• Adverse Affect
• Diabetes
• Poisoning
• Sequela
• Syndrome
• History of
• Anemia
• Complication
• Long Term Use

Subterms

• Indented from Main term
• Describe differences in condition, anatomical site, cause, clinical type
Locating a Code

- Always locate the main term first in the Alphabetic Index
- Then verify the code in the Tabular List
- Read and be guided by the instructional notations that appear in both the Alphabetic Index and the Tabular List

Locating a Code

Alpha Index does not always provide the full code

- Laterality and 7th characters can only be assigned from the Tabular List
- A dash at the end of an Alphabetic Index code may indicate additional characters are required

Use of Codes for Reporting Purposes

- In order for code to be correct we must ensure that every digit possible is recorded
  - For reimbursement
  - For statistical reporting
  - For clinical accuracy
Placeholder Character “X”

• “X”
  – placeholder to allow for future expansion
  • Example: T49.8XS Adverse affect to a cosmetic
  – to allow for appropriate placement of 7th character
  • Example: T75.4 Electrocution – requires a 7th character D to identify the encounter
    – T75.4XXD

Punctuation

• [ ] Brackets
  – Alphabetic Index to identify mandatory manifestation codes
    – Alzheimer’s G30.9 [F02.80]
  – Tabular List to enclose words that provide additional information
    • Synonyms
    • Alternative wording
    • Explanatory phrases

Punctuation

• ( ) Parentheses
  – enclose supplementary words that may or may not be included in the documentation without affecting the code
  – Referred to as nonessential modifiers
  – Example:
    • Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic)
    • Falls (repeated)
**Punctuation**

**Colons**

Colons in the tabular list highlight an incomplete term

Needs a modifier

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**Other & Unspecified Codes**

- **Other or Other Specified**
  - Use when information in the medical record provides detail for which a specific code does not exist

- **Unspecified**
  - Use when the information in the medical record is insufficient to assign a more specific code
  - Last resort
  - E11.8 Type II diabetes mellitus with unspecified complications

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**Abbreviations**

- **NEC** – Not elsewhere classifiable
  - Represents “other specified”
  - Used when a specific code is not available for a condition

- **NOS** – Not otherwise specified
  - Equivalent of unspecified
Includes Notes

- A note that appears immediately under a category title to further define or give examples of the content

Inclusion Terms

- List of terms included under some codes
- Conditions for which the code is to be used
- Not an exhaustive list

Excludes 1

- Pure excludes note
  - NOT CODED HERE!
- Indicates that the code excluded should never be used at the same time as the code above the note

M08.2 Juvenile rheumatoid arthritis with systemic onset
Still's disease NOS

Excludes 1 adult-onset Still's disease (M06.1)
Excludes 1 Notes

A84.9 Tick-borne viral encephalitis, unspecified

Excludes 1 Notes

Excludes 2 Notes

– Not included here
– Patient may have both conditions at the same time
– Codes may be used together

G47.6 Sleep related movement disorders

Excludes 2 restless legs syndrome (G25.81)
Etiology/Manifestation

• For conditions with both an underlying etiology with manifestations
• Where this combination exists
  – “use additional code” note at the etiology code
  – “code first” note at manifestation code
• Code for underlying condition must be sequenced first

Manifestation Coding

• In most cases manifestation code will have “in diseases classified elsewhere” in title
• Never used as first-listed or primary code

Code First
"And"

- Should be interpreted to mean either "and" or "or"
- **Example:**
  - Cases of "tuberculosis of bones", "tuberculosis of joints" and "tuberculosis of bones and joints" are classified to subcategory A18.0, Tuberculosis of bones and joints

"With"

- Interpreted to mean "associated with" or "due to"
- Sequenced in Alphabetic Index right after main term
"See" and "See Also"

- **See**
  - Indicates another term *must* be referenced
  - Necessary to go to the main term referenced with the "see" note to locate the correct code

- **See Also**
  - Instructs that there is another main term that *may also* be referenced that may provide additional Alphabetic Index entries that may be useful

"Code Also" Note

- Instructs that two codes may be required to fully describe a condition
- Note does not provide sequencing direction
Signs & Symptoms

- acceptable for reporting purposes when related definitive diagnosis has not been established (or confirmed) by the provider
- Signs and symptoms that are an integral part of the disease process should *not* be assigned as additional codes *unless otherwise instructed by the classification*

Examples

- Do NOT code signs/symptoms integral to the disease or condition
  - Congestive heart failure
    - Edema, SOB
  - Bronchitis
    - cough

Examples

- DO code signs/symptoms even when integral if so instructed
**Acute and Chronic**

- If the same condition is described as both acute (sub-acute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both
- (acute code is sequenced first)

**Failure, failed**
- Renal N19
  - Acute N17.9 with
  - cortical necrosis (N17.1)
  - medullary necrosis (N17.2)
  - tubular necrosis (N17.0)
- Chronic N18.9
  - hypertensive – see hypertension, kidney

**Combination Code**

- A single code used to classify:
  - Two (or more) diagnoses
  - A diagnosis with an associated secondary process (manifestation)
  - A diagnosis with an associated complication
- **DO** Read all inclusion and exclusion notes in the Tabular List
- **DO NOT** Multiple code when there is a combo code that clearly identifies all of the elements documented by the diagnosis

**Sequela (Late Effects)**

- A residual effect after the acute phase of an illness or injury
- No time limit on when it can be used
- May require two codes
  - Chemical burn of cornea
  - Poisoning by cleaning chemical
Reporting Codes

• Each unique ICD-10-CM diagnosis code may be reported only once for an encounter
• Applies to bilateral conditions when there are no distinct codes identifying laterality
  – I73.9  Peripheral vascular disease, unspecified
• Applies when two different conditions are classified to the same code

Laterality

• If no bilateral code is provided and the condition is bilateral, assign separate codes for both left and right sides
• If side is not identified in medical record, assign the code for the unspecified side

BMI and Pressure Ulcer

• BMI, depth of non-pressure chronic ulcers and pressure ulcer stage codes
  – Clinician can assign
  – Associated diagnosis (overweight, obesity, pressure ulcer) must be documented by patient’s provider
CHAPTER 1

• Includes diseases generally recognized as communicable or transmissible
• Use additional code to identify resistance to antimicrobial drugs (Z16.-)
  – Unless infection code specifically identifies drug resistance
• Pay close attention to Chapter 1 Guidelines and category notes for HIV and sepsis coding

Sequela – Infections/Parasitic

• Codes B90-B94
  – used to indicate conditions in categories A00-B89 as the cause of sequela, which are themselves classified elsewhere
  – include residuals of diseases classifiable to the above categories if the disease itself is no longer present
  – Code first the condition (or "sequela") resulting from the infectious or parasitic disease

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A patient is seen for right lower leg muscle atrophy that is the result of a previous bout of polio. What is the correct diagnosis code?
- M62.561 Atrophy, muscle, lower leg
- B91 Late effect(s) – See Sequelae, Sequelae (of), polio myelitis (acute)

Supplementary or additional codes to identify the infectious agent(s) in diseases classified elsewhere

- An 80-year-old female with fever, malaise and left flank pain. Urinalysis shows bacteria >100,000/ml and culture shows E. coli growth. Provider diagnoses E. coli UTI.
  - N39.0 Infection, urinary (tract)
  - B96.20 Infection, bacterial NOS, as cause of disease classified elsewhere, Escherichia coli [E. coli] (see also Escherichia coli)
Sepsis

- Requires one code from category A41 if no documentation of severe sepsis or an associated organ dysfunction
- Assign appropriate code for underlying systemic infection
- If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism.

1.3 Sepsis Case Study

An 87-year-old nursing home patient is being treated with IV antibiotics for E. coli sepsis
- A41.51 Sepsis (generalized), Escherichia coli (E. coli). Review tabular for complete code assignment.

Severe Sepsis

- Requires a minimum of two codes:
  - first a code for the underlying systemic infection,
  - followed by a code from subcategory R65.2, Severe sepsis.
  - Additional code(s) for the associated organ dysfunction are also required (i.e., respiratory failure)
1.4 Severe Sepsis Case Study

A 75-year-old woman taken to the ER and diagnosed with gram-negative sepsis with acute respiratory failure.

- A41.50 Sepsis (generalized), gram-negative (organism). (Review Tabular List for complete code assignment.)
- R65.20 Sepsis, with, organ dysfunction (acute)(multiple)
- J96.00 Failure, failed, respiration, respiratory, acute

It is essential that the coder searches the index and tabular list notes thoroughly when coding infections!
• Neoplasms grouped by behavior and then subgroups by site
• Neoplasm table found in the index
  – Identifies the behavior (columns) and site (rows)
• Important terms
  – Neoplasm
  – Tumor
  – Dysplasia
  – Mass

• Contains codes for most benign and all malignant neoplasms
• First step is to determine from medical record if neoplasm is benign, in-situ, malignant or of uncertain histologic behavior
• If malignant, any secondary (metastatic) sites should be determined
• The Neoplasm Table in the Alphabetic Index should be referenced first
  – Example: Adenoma (see also neoplasm, benign, by site)

• A primary malignant neoplasm overlapping 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
• Multiple noncontiguous neoplasms of the same site, such as tumors in different quadrants of the same breast, codes for each site should be assigned
• Z85-, Personal history of malignant neoplasm
  – History with no further treatment directed to the site and no evidence of existing primary malignancy
  – Any mention of extension, invasion or metastasis to another site is coded as a secondary malignant neoplasm to that site

2.1 Neoplasm Case Study

Small cell carcinoma of right lower lobe of lung with metastasis to the intrathoracic lymph nodes, brain and right rib
  – C34.31 lung, malignant, primary, lower lobe
  – C77.1 lymph gland, malignant, intrathoracic, secondary site
  – C79.31 brain, malignant, secondary site
  – C79.51 bone, malignant, rib, secondary site

2.2 Tumor Case Study

Benign carcinoid of the cecum
  – D3A.021 Carcinoid, see Tumor, carcinoid, benign, cecum
Chapter 2 Take Away Point

With the significantly increased number of codes, category reorganization and histological specificity, a coder must increase their knowledge of tumor pathology.

Chapter 3

Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism (D50-D89)

- Same basic coding rules
- No specific Coding Guidelines at this time
- We will code this chapter the same way that we coded in ICD-9 using the same rules and conventions
3.1 Anemia Case Study

Congenital red cell aplastic anemia
- D61.01 Anemia (essential) (general) (hemoglobin deficiency) (infantile) (primary) (profound), aplastic, red cell (pure), congenital

Chapter 3 Take Away Point

Although Chapter 3 has not changed very much, it still involves intricately detailed medical conditions that require attention to detail

Chapter 4

Endocrine, Nutritional and Metabolic Diseases (E00-E89)
Combination codes that include:
- Type of DM
- Body system affected
- Complications affecting that body system

No longer classified as controlled or uncontrolled
- Code by type with hyperglycemia

Use as many codes as necessary to describe all complications

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

If the record does not indicate the type of DM, but does indicate the use of insulin, code also Z79.4 Long-term (current) use of insulin

4.1 Diabetes Case Study

62-year-old male with mild nonproliferative diabetic retinopathy with macular edema. He has type 2 DM and takes insulin on a daily basis. He also has a diabetic cataract in his right eye.

(combo code for Diabetic retinopathy with macular edema)
4.1 Diabetes Case Study

- E11.321 Diabetes, diabetic (mellitus) (sugar), type 2, with, retinopathy, non-proliferative, mild, with macular edema
- E11.36 Diabetes, diabetic (mellitus) (sugar), type 2, with, cataract
- Z79.4 Long-term (current) (prophylactic) drug therapy (use of), insulin

4.2 Diabetes Case Study

Type 1 diabetic patient with severe chronic diabetic left foot ulcer with diabetic peripheral angiopathy. Also has diabetic stage 2 chronic kidney disease.

- Additional code needed for the CKD stage
- E10.22 Diabetes, diabetic (mellitus) (sugar) type 1, with, chronic kidney disease
- N18.2 Disease, diseased, kidney (functional) (pelvis), chronic, stage 2 (mild)
- E10.621 Non pressure ulcer, type I
- L97.529 Site, left foot,
- E10.51 Peripheral Angiopathy
Secondary Diabetes

- DM due to underlying condition, drug or chemical induced or other specified
- Always caused by another condition or event
- Z79.4 should only be assigned for patients who routinely use insulin – not if only given to temporarily control blood sugar
- E09, Drug or chemical induced DM – use additional code from Drug and Chemical Table to identify drug causing adverse effect

4.3 Secondary DM Case Study

Steroid induced diabetes mellitus due to prolonged use of corticosteroids, which are now discontinued. DM is managed with insulin over last 2 years.

T38.0X5D Corticosteroid adverse effect
E09.9 Diabetes, due to drug or chemical
Z79.4 Long term drug therapy, insulin

Chapter 4 Take Away Point

With the significantly expanded diabetes codes and the extensive use of combination codes, coders will need to approach the coding of diabetes with much greater deliberation and specificity
In Remission

- History of drug or alcohol dependence is coded “in remission”
- The appropriate codes for “in remission” are assigned only on the basis of provider documentation

Substance, Abuse and Dependence

When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.) only one code should be assigned to identify the pattern of use based on the following hierarchy:

1. Dependence
2. Abuse
3. Use
5.1 Alcohol Case Study

Alcohol dependence with chronic alcoholic gastritis.

F10.20 Dependence, alcohol
K29.20 Gastritis, alcoholic

5.2 Dementia Case Study

A 52-year-old with dementia and forgetfulness has been wandering from home and getting lost. The diagnosis is dementia due to early-onset of Alzheimer’s disease.

G30.0 Alzheimer’s Disease, early onset with behaviors
F02.81 Dementia, in Alzheimer’s
Z91.83 Wandering in diseases classified elsewhere
Chapter 5 Take Away Point

With a very thorough reorganization and reclassification of many conditions in the mental disorders chapter, coders will need to pay close attention to the updated terminology and new organization of codes and code categories.

CHAPTER 6

Diseases of the Nervous System (G00-G99)

Dominant / Nondominant Side

• If affected side is documented but not specified as dominant or nondominant:
  – For ambidextrous patients, the default should be dominant
  – If the left side is affected the default is nondominant
  – If the right side is affected the default is dominant
G89 Pain, NEC

- May be used with codes from other categories and chapters to provide more detail about pain.
- Must be documented as:
  - Acute or chronic
  - Post thoracotomy, post-procedural or neoplasm-related
- Do not use if underlying diagnosis is known
- Chronic pain must be documented by the provider
- Central pain syndrome and chronic pain syndrome are different than the term “chronic pain”
  - Only used when specifically documented by provider

Postoperative Pain

- Provider documentation guides coding
- Routine or expected postop pain should not be coded
- Postop pain associated with a specific complication is coded in Chapter 19 with an additional G89 code for acute or chronic pain.

Epilepsy and Migraine

- The following terms are considered to be equivalent to intractable
  - Pharmacoresistant (or pharmacologically resistant)
  - Treatment resistant
  - Refractory (medically)
  - Poorly controlled
  - “Classical” equals “with aura”
5.1 TIA Case Study

A 72-year-old patient with sudden weakness of the left arm and leg. The patient could speak in the emergency room but was unable to use his left arm and leg. The patient completely recovered and was able to ambulate with no neurological deficits within 24 hours of admission. It was determined that the patient had experienced a TIA. The patient also suffered an intractable classical migraine.

5.1 TIA Case Study

- G45.9 Attacks, TIA
- G43.119 Migraine w/aura, intractable

Coding Examples (5.2-5.4)

- Left-sided hemiplegia
  - G81.94 Hemiplegia
- Seizure disorder
  - G40.909 Epilepsy, unspecified, not intractable, without status epilepticus
    - Includes Recurrent Seizures and Seizure Disorder NOS
    - (Seizure = R56.9 Unspecified convulsions)
- Parkinson’s Disease
  - G20
Chapter 7

Diseases of the Eye and adnexa (H00-H59)

Glaucoma Guidelines

- Assign as many codes from category H40, Glaucoma, as needed to identify the type of glaucoma, the affected eye and the glaucoma stage
- Check for a bilateral code when both eyes are documented as same type and stage
- Code glaucoma to the highest stage documented

Coding Exercise 7.1

A patient with moderate primary open-angle glaucoma of the left eye.

- H40.11X2 Glaucoma, open angle, primary.
Cataract Case Studies 7.2-7.4

- Age-related nuclear cataract, right eye
  - H25.11
- Blindness, right eye, low vision, left eye
  - H54.11
- Nonulcerative bilateral blepharitis of upper eyelids
  - H01.001
  - H01.004

Chapter 7 Take Away Point

With the extensive use of laterality throughout the eye chapter, coders will need to glean that information from the record as it is reviewed.

CHAPTER 8

Diseases of the Ear and Mastoid Process (H60-H95)
Chapter Specific Note

• Use an external cause code, if applicable, following the code for the ear condition
  – Exposure to environmental tobacco smoke (Z77.22)
  – Exposure to tobacco smoke in the perinatal period (P96.81)
  – History of tobacco use (Z87.891)
  – Occupational exposure to environmental tobacco smoke (Z57.31)
  – Tobacco dependence (F17.-)
  – Tobacco use (Z72.0)

8.1 Otitis Media Case Study

Examination of patient reveals left acute serous otitis media and a total perforated tympanic membrane of the right ear due to chronic otitis media.

• H65.02 Otitis media, acute, serous, non-suppurative (L)
• H66.91 Otitis media, chronic (R)
• H72.821 Perforation, tympanum total

Ear Case Studies 8.2-8.4

• Bilateral conductive hearing loss
  – H90.0
• Meniere’s vertigo of left ear
  – H81.02
• Benign paroxysmal vertigo
  – H81.10
Chapter 8 Take Away Point

With the extensive use of laterality throughout the ear chapter, coders will need to glean that information from the record as it is reviewed.

CHAPTER 9

• You may not assume a causal relationship between hypertension and heart disease
• The documentation must state:
  – Hypertensive
  – Due to Hypertension
Hypertensive CKD

- Assign codes from category I12, Hypertensive CKD when both hypertension and a condition classifiable to category N18, chronic kidney disease, are present
- You may assume a causal relationship between these two conditions
- Also code from category N18 to identify the stage of CKD

HTN and Chronic Kidney Disease

- Assume a causal relationship between the hypertension and the CKD whether or not the condition is so designated
- Assign additional codes for the stage of CKD and heart failure, if present

Combination Codes...

- Hypertension and heart disease
  - No – do not assume a causal relationship
- I11 - Hypertensive heart disease
  - Yes – relationship must be stated to use
- I12 - Chronic kidney disease and hypertension
  - Yes – you may assume a causal relationship
- I13 - Chronic kidney disease and hypertensive heart disease
  - Yes – assume the relationship between the CKD and HTN
Transient HTN

- Comes and goes, not permanent "white coat syndrome" just an elevated BP
- Transient HTN
  - Assign code R03.0, Elevated blood pressure reading without diagnosis of hypertension (unless pt. has established HTN diagnosis)

9.1 HTN Case Study

Stage 3 chronic kidney disease with congestive heart failure due to hypertension

- I13.0 Hypertension w/heart failure, with Stage 1-4 CKD
- I50.9 CHF
- N18.3 CKD Stage 3

CAD and ANGINA

- Combo codes
- Additional code is not necessary to capture angina pectoris
- Causal relationship is assumed when patient has both atherosclerosis and angina unless documentation indicates otherwise
A 72-year-old male with a history of 2-vessel coronary artery bypass last year is seen for unstable angina. Cardiac catheterization shows continued evidence of coronary arteriosclerosis with both bypass grafts patent. He also has a history of CVA with right-sided hemiparesis.

9.2 CVD Case Study

- I25.110 Angina –see Arteriosclerosis, coronary (artery), native vessel with angina pectoris, unstable
- I69.351 Hemiplegia, following, cerebrovascular disease, cerebral infarction
- Z95.1 Status (post), aortocoronary bypass

Acute Myocardial Infarction

- Code category I21 for initial MI less than or equal to 4 weeks old
- Code category I22 for subsequent MI
  – Use when a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial AMI
  – Must be used in conjunction with a code from category I21-never alone
• I21.3, ST elevation (STEMI) myocardial infarction of unspecified site is default for “unspecified MI”
• If an AMI is documented as nontransmural or subendocardial, but the site is provided, it is still coded as a subendocardial AMI
• Old or healed MI not requiring further care is I25.2

9.3 AMI Case Study

Acute non-ST anterior wall myocardial infarction suffered 5 days ago and atrial fibrillation
I21.4 Infarct, myocardium acute with non ST elevation, 4 weeks or less (NSTEMI)
I48.91 Atrial Fibrillation

9.4 AMI Case Study

Patient from previous case presents to ED two weeks later with acute inferior wall MI. She is still being monitored following her initial MI two weeks ago and is still suffering from atrial fibrillation
I22.1 Infarct, myocardial acute, 4 weeks or less, recurrent
I21.4 Infarct, NSTEMI
I48.91 Atrial Fibrillation
Chapter 9 Take Away Point

With all coding rule changes, very significant expansion of specificity and detail, the greatly increased complexity of the codes, and the frequency in which circulatory disorders are coded, this will likely be the most challenging chapter to master.

Chapter 10

- Respiratory condition described as occurring in more than one site that is not specifically indexed, classify to the lower anatomical site (e.g. tracheobronchitis to bronchitis in 340)
- Additional codes required for some categories:
  - To identify infectious agent or virus
  - Associated lung abscess
  - Underlying disease
  - Tobacco use or exposure

Chapter Notes
• COPD and Asthma
  – acute exacerbation
    • Worsening or decompensation of a chronic condition
    • Not equivalent to an infection superimposed on a chronic condition
    • May be triggered by an infection

• Code only confirmed cases due to certain identified viruses (J09 and J10)
• Suspected, possible or probable should be coded to J11, Influenza due to unidentified influenza virus (use caution when coding these, clarify if possible)

• Only code based on provider documentation
• Additional code required to identify organism
• Do not use an additional code from categories J12-J18 to identify type of pneumonia
  – UNLESS: Patient was admitted to hospital with one type of pneumonia and subsequently developed VAP (which would become a secondary diagnosis)
10.1 COPD Case Study

COPD with emphysema

J43.9 Emphysema (remember that emphysema IS COPD) read the notes in the book – more specific – COPD is a generic code

* Pay attention to includes and excludes notes

10.2 Asthma Case Study

Moderate persistent asthma with status asthmaticus and acute exacerbation of chronic obstructive pulmonary disease

J45.42 Asthma, asthmatic, moderate persistent, with, status asthmaticus

J44.1 Disease, lung, obstructive (chronic), with, acute, exacerbation NEC

10.3 Pneumonia Case Study

MSSA pneumonia

– J15.211 Pneumonia due to methicillin susceptible Staphylococcus aureus (MSSA)
Upper respiratory tract infection due to novel influenza A virus
- J09.X2 Influenza (bronchial) (epidemic) (respiratory) (upper) (unidentified influenza virus), due to identified novel influenza A virus, with, respiratory manifestations, NEC

Chapter 10 Take Away Point

A coder must pay very close attention to the guidelines and notes in both the Alphabetic Index and the Tabular List in Chapter 10 to assign the correct codes
11.1 Hernia Case Study

Patient with recurrent right inguinal hernia with gangrene and obstruction

K40.41 Hernia, inguinal, with gangrene (and obstruction) recurrent

- Category note:
  - Hernia with both gangrene and obstruction is classified to hernia with gangrene

11.2 Gastric Ulcer Case Study

Acute gastric ulcer with hemorrhage

K25.0 Ulcer, ulcerated, ulcerating, ulceration, ulcerative, gastric – see Ulcer, stomach (eroded) (peptic) (round), acute, with, hemorrhage

11.3 Crohn’s Case Study

Crohn’s disease of small intestine with small bowel obstruction

- An additional code for the small bowel obstruction is not required as the combination code in ICD-10-CM identifies both the Crohn’s disease and the small bowel obstruction
- K50.012 Crohn’s disease – see Enteritis, regional, Enteritis (acute) (diarrheal) (hemorrhagic) (noninfective) (septic), regional (of), small intestine, with complication, intestinal obstruction
Chapter 11 Take Away Point

This chapter looks and feels the same as ICD-9 but close attention must be paid to combination codes and instructional notes indicating the need for additional codes.

CHAPTER 12

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

Pressure Ulcer Stage Codes

- Combination codes that identify site and stage
- Severity designated by stages 1-4, unstageable and unspecified based on clinical documentation
- Any associated gangrene should be sequenced first
- Unspecified vs. unstageable
- No code is assigned for healed pressure ulcer
12.1 Pressure Ulcer Case Study

Patient with gangrenous pressure ulcer of right hip with cellulitis and pressure ulcer of sacrum documented by physician. Nursing assessment indicated stage 2 sacral ulcer and stage 3 decubitus ulcer of right hip.

- I96 – Ulcer, gangrenous, gangrene
- L89.213 – Ulcer, pressure, Stage 3, hip
- L89.152 – Ulcer, Stage 2, sacral
- L03.115 – Cellulitis, lower limb

12.2 Stasis Ulcer Case Study

- Atherosclerosis of right ankle (native artery), with non-healing ulcer, with breakdown of skin
12.2 Stasis Ulcer Case Study

- I70.233  Atherosclerosis, see also arteriosclerosis. Arteriosclerosis, arteriosclerotic (diffuse) (obliterans) (of) (senile) (with calcification), extremities (native arteries) leg, right, with ulceration (and intermittent claudication and rest pain), ankle
- L97.311  Ulcer, ulcerated, ulcerating, ulceration, ulcerative, lower limb (atrophic) (chronic) (neurogenic) (perforating) (pyogenic) (trophic) (tropical) ankle, right, with skin breakdown only

12.3 Rash Case Study

A patient with a rash on the trunk and upper extremities over the last 3-4 days due to Ramipril taken for hypertension. Physician discontinues Ramipril and prescribes Captopril and a topical cream for localized dermatitis.

- L27.1  Dermatitis, (eczematous) due to drugs and medicaments, (generalized) (internal use) localized skin eruption
- T46.4X5  Table of Drugs and Chemicals, Ramipril, Adverse Effect, late effects
- I10  Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic)
Chapter 12 Take Away Point

Chapter 12 is another chapter with extensive use of laterality; however, coders need to carefully understand the details in the combination codes for pressure and non-pressure ulcers.

CHAPTER 13

Musculoskeletal System

• Most codes have site and laterality designations
• Site represents bone, joint or muscle involved
• “Multiple sites” codes
Seventh Characters

- A – initial encounter
- D – subsequent encounter
- G – subsequent encounter – delayed healing
- K – subsequent encounter – nonunion
- P – subsequent encounter – malunion
- S – sequelae

*****If code starts with M or S – look for direction regarding 7th characters

Aftercare

- Aftercare for broken bones will now be coded to fracture with 7th character D in post acute care
- Pathological and stress fractures are found in this chapter
- We will still use aftercare codes for post surgical status

Osteoporosis

- Use category M81, Osteoporosis without pathologic fx, for patients with osteoporosis who do not current have a pathologic fracture due to osteoporosis
  - patients with a history of osteoporosis fractures, status code Z87.310, Personal history of (healed) osteoporosis fracture, should follow code M81
Pathological Fracture

• Use category M80, Osteoporosis with current pathological fracture, for patients who have a current pathologic fracture at the time of an encounter
  – DO NOT USE traumatic fracture code here
  – this must be determined and documented by the physician.

13.1 Path Fracture Case Study

An 80-year-old female with senile osteoporosis complaining of severe back pain with no history of trauma. Provider documentation reveals pathological compression fractures of several lumbar vertebrae.
  – M80.08XD

Case Studies 13.2-13.3

Bacterial Septic Arthritis
  – M00.80

Degenerative disc disease, lumbar region, with myelopathy
  – M51.06
Although the detail in this musculoskeletal chapter is not that complicated, coders will need to pay very close attention when consulting the index and tabular due to the sheer volume of codes and the ease of miscoding from viewing so many similar codes.

**CHAPTER 14**

Diseases of the Genitourinary System (N00-N99)

**Stages of Chronic Kidney Disease**

- CKD classification based on severity designated by stages 1-5
- End stage renal disease (ESRD) is assigned when it has been documented by the provider
- If both a stage of CKD and ESRD have been documented, assign the code for ESRD only
14.1 Kidney Failure Case Study

An 83-year-old man with complaints of lower abdominal pain and the inability to urinate over the past 24 hours, diagnosed as acute kidney failure due to acute tubular necrosis, caused by a urinary obstruction. The urinary obstruction was a result of the patient’s benign prostatic hypertrophy.

14.1 Kidney Failure Answer

N17.0 – Failure, kidney, acute w/tubular necrosis
N40.1 – Hypertrophy, prostate – see enlargement, prostate with LUTS
N13.8 – Obstruction, urinary

14.2 UTI Case Study

- A 78-year-old female with fever, malaise, and left flank pain. A urinalysis shows bacteria of more than 100,000/ml present in the urine and subsequent urine culture shows Proteus growth as the cause of the urinary tract infection. The patient also has a history of repeated UTIs over the past several years.
14.2 UTI Case Study

- N39.0 Infection, infected, infective, (opportunistic), urinary (tract)
- B96.4 Infection, infected, infective (opportunistic), bacterial NOS, as cause of disease classified elsewhere, proteus (mirabilis) (morganii)
- Z87.440 History, personal (of), infection, urinary (recurrent) (tract)

Chapter 14 Take Away Point

Chapter 14 – Diseases of the Genitourinary System has changed very little in comparison to other chapters; however, coders must remain diligent in selecting codes to avoid simple mistakes.
• Even though it is rare there are long term care providers that do care for pregnant moms
• Code the condition for which the patient is receiving care and any other diagnoses secondary
• Example: Fractured ankle, with secondary pregnancy

CHAPTER 16

• Even though it may be rare to care for babies in long term care it does happen
• Code the diagnosis for which you are caring for the patient
• Cleft Palate, tube feeding, then any other secondary diagnoses
CHAPTER 17

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

• Assigned any time in a patient’s life if being diagnosed or treated
• May be present at birth but not diagnosed until later in life
• If previously treated and resolved, code personal history code

Manifestations

• DO NOT code manifestations if they are inherent to the malformation/deformation/abnormality
• DO code manifestations that are not inherent
• EX: Down Syndrome – Use F70-79 to further identify the intellectual disability

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17.1 & 17.2 Case Study

Down Syndrome
- Q90.9

Septal heart defect
- Q21.9

Chapter 17 Take Away Point

With the significant expansion of conditions and sites, coders will need to collect more detail on congenital conditions.
Symptoms, signs, abnormal results and ill-defined conditions without a classifiable diagnosis

- Only use if definitive diagnosis has not been established
- May be used in addition to a definitive diagnosis as long as the sign or symptom is not routinely associated with that diagnosis

Signs & Symptoms

- R29.6, falls (repeated)
  - when patient has recently fallen and the reason is being investigated
- Z91.81, History of falling
  - when a patient has fallen in the past and is at risk for future falls
- May be assigned together

Example

- R53.2, Functional quadriplegia
  - Lack of ability to use one's limbs or to ambulate due to extreme debility
  - NOT associated with neurologic deficit or injury
18.1 Fever Case Study

Patient with fever of 101 degrees with chills. Lab tests and urinalysis are within normal limits. Physician gives final diagnosis as fever with chills, possible viral syndrome.

- R50.9 Fever (of unknown origin) (persistent)(with chills) (with rigor)

18.2 Pain Case Study

Patient complaining of right upper quadrant abdominal pain in addition to nausea and vomiting. Patient also has elevated blood pressure readings, but diagnosis of hypertension is not made. Patient referred for follow up appointment.

- R10.11 Pain, abdominal, upper, right quadrant
- R11.2 Nausea, with vomiting
- R03.0 Elevated, elevation, blood pressure, reading (incidental) (isolated) (nonspecific), no diagnosis of hypertension
CHAPTER 19

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

7th Characters

- A – initial encounter
  - Active treatment (surgical treatment, ED encounter, evaluation & treatment by new physician)
- D – subsequent encounter
  - Routine care during healing or recovery phase
  - Aftercare Z codes are not used for aftercare for injuries or poisonings where 7th characters are provided to identify subsequent care
- S – sequelae
  - Complications or conditions arising as direct result of condition

Injuries

- Assign separate codes for each injury unless a combo code is provided
- Superficial injuries are not coded when associated with more severe injuries of same site
- Do not assign traumatic injury codes for normal, healing surgical wounds or complications of these
Aftercare

• Aftercare for broken bones will now be coded to Fracture with 7th character D
• Traumatic fractures are found in this chapter
• No longer need aftercare codes for injuries and fractures, we will use the actual fracture or injury code with the appropriate 7th character extension

Traumatic Fractures

• A fracture not indicated as open or closed should be coded to closed
• A fracture not designated as displaced or non-displaced should be coded to displaced
• 7th characters
  – Some fractures have expanded 7th characters to identify open fractures
• Compound fracture = open fracture

Fracture Specificity

• Greater specificity for fractures
  – Type (buckle, greenstick, incomplete)
  – Specific site (femur, radius, humerus)
  – Displaced vs. non-displaced
  – Routine vs. delayed healing
  – Mal-union
  – Type of encounter
A patient admitted for aftercare following traumatic lateral epicondyle fracture of the right elbow, which is healing normally.

- S42.431D Fracture, traumatic (abduction) (adduction) (separation), humerus, lower end, epicondyle, lateral (displaced)

A patient admitted following surgery for an infected right hip prosthesis.

- T84.51XD Complication(s) (from) (of), joint prosthesis, internal, infection or inflammation, hip. Review the Tabular for complete code assignment and seventh character.

- Drug correctly prescribed and properly administered
- Code nature of adverse effect followed by the code for the cause in the Table of Drugs and Chemicals
  - Tachycardia, delirium, vomiting, renal failure
- DO NOT code directly from the Table!
A patient taking Digoxin is experiencing nausea, vomiting and profound fatigue. The patient indicates that she has been taking the drug as prescribed. Evaluation and treatment focused on adjustment of medication only.

- R11.2 Nausea, with vomiting
- R53.83 Fatigue
- T46.0X5S Table of Drugs and Chemicals, Digoxin, adverse effect

Poisoning

- Error made in drug prescription
- Overdose of drug intentionally taken
- Non-prescribed drug taken with correctly prescribed and properly administered drug
- Interaction of drugs and alcohol
- 5th or 6th character shows intent
- Use additional code for manifestations of poisoning
Under-dosing

• Taking less than is prescribed by provider or manufacturers instruction inadvertently or deliberately
• Noncompliance (Z91.12-, Z91.13-) or complication of care (Y63.61, Y63.8-Y63.9) codes are to be used in addition to indicate intent, if known

Toxic Effects

• Harmful substance is ingested or comes in contact with a person
• Associated intent
  – Accidental
  – Intentional self-harm
  – Assault
  – Undetermined

Chapter 19 Take Away Point

With all the extensive expansion of conditions, sites, laterality, and associated coding rules, coders will need to be very careful when coding from this new injury and poisoning chapter.
External Causes of Morbidity

- Coded by hospitals for statistical purposes
- Not used in LTC for billing
- Never sequenced as first listed diagnosis
- Example: Fall from stairs, car accident
- These were “E Codes” in ICD-9

External Cause Coding

- Place of Occurrence (home, work)
- Intent (accident, assault)
- Cause (fall from ladder)
- Status (Military, civilian)

Auto Insurance or Worker’s Compensation may ask for but as a general rule, LTC does not need to code external causes
Factors Influencing Health Status and contact with health services (Z00-Z99)

Chapter 21

- Previously V Codes
- For use in any health care setting
- Aftercare (except for fractures & rehab)
- Personal history codes
- Noncompliance
- Acquired absence of limb
- Devices

Z Codes

Coding Examples

- Resistance to penicillin, Z16.11
- Body mass index, adult, (33.0), Z68.33
- Long term (current) use of antibiotics, Z79.2
- Personal history of malignant neoplasm, bladder Z85.51
- Presence of automatic implantable cardiac defibrillator Z95.810
A 75-year-old woman was admitted for occupational therapy (OT) following cardiac bypass surgery. She continues to have significant acute post-thoracotomy pain. Assign the correct diagnostic code(s).

- Z48.812  Aftercare, following surgery (for)(on), circulatory system
- Z95.1  Status (post), aortocoronary bypass
- G89.12  Pain(s) (see also Painful), acute, post-thoracotomy

With the major redesign and moving around of codes, coders will need to carefully study this health status chapter.
This 81-year-old female is a resident of the nursing facility due to CHF and atrial fibrillation. She fell from the bed at the nursing facility and was transferred to the hospital. She was readmitted to the nursing facility to resume care and to add physical therapy following open reduction and pinning of left comminuted sub-capital femoral neck fracture.

- I50.9 Failure, heart, congestive
- I48.91 Fibrillation, atrial or auricular (established)
- S72.012D Fracture, traumatic, femoral neck, see Fracture, femur, upper end, subcapital (displaced)
- R29.6 Falls (repeated)
Coding for Post-Acute Care

- Analyze clinical documentation from discharge summaries and history & physicals
- Locate main term in alpha index
- Identify all of component elements of the diagnostic statement
- Follow cross reference instructions as directed

Coding for Post-Acute Care

- Use sub-terms and modifiers to assist in obtaining correct code
- Verify the code obtained from the Alphabetical Index in the Tabular List

Coding for Post-Acute Care

- Sequelae – complications or conditions that arise as a direct result of the injury (late effect)
  - Extension “S” for late effects or sequelae
- Subsequent – After the patient receives active treatment of injury and receiving routine care during healing or recovery period
  - Extension “D” for subsequent episode of care
Coding for Post-Acute Care

• Should I assign a code for DNR?
  – Benefits & Risks
• Should I assign external cause codes?
  – When is it appropriate
• First Listed Diagnosis – this is the diagnosis listed first on the UB-04

Terms

• Principle – Hospital term “MI”
• Primary – Ambulatory Care Term “gout”
• Admitting – Assigned before all tests are complete “chest Pain”
  – LTC uses all of these terms interchangeably

Use Caution

• Probable
• Suspected
• Likely
• Questionable
• Possible
• Still to be ruled out
• Use caution
General Equivalent Mappings (GEMs)

- General Equivalent Mappings
- Translates/converts ICD-9 to ICD-10 codes
- Forward & backward mapping
- Because code sets are different there are very few matches between ICD-9 and ICD-10

GEMs

- Translating lists of coded data or converting a system or application of certain ICD-9 codes
- Creating a “one-to-one” applied mapping (aka crosswalk) between code sets that will be used ongoing to translate records or other coded data
Do Not Use GEMs if

- Short list of ICD-9 codes with code description
- You have access to the clinical record
- You have access to other forms of clinical information such as text descriptions or clinical terms from surveys, research, or clinical software applications

Diagnosis Management

Face Sheet / Admission Record

- Coding for the admission
- Admissions on evenings and weekends
- Paper vs. electronic
- How to keep it updated
  - Care Conference / MDS Schedule
  - Thinning Guidelines
  - Chart Order
**Diagnosis Listing**

- Where are they located in the record
- How often to update the list
  - Use care conference schedule as a guide to audit and keep updated
- Resolving / Discontinuing Diagnoses
  - UTI

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**First Listed Diagnosis**

- Principle
- Primary
- Admitting
- Secondary
- History of
- Status Post

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**Section I of the MDS**
Section I of MDS

Intent of Section I
To code diseases that have a relationship to the resident’s current functional status, cognitive status, mood and behavior status, medical treatments, nursing monitoring and risk of death. To generate an updated, accurate picture of the resident’s health status.

Active vs. Current

Active Diagnoses have 2 look-back periods:
• Diagnosis identification (Step 1) is a 60-day look-back period
  – That are documented by a physician (within last 60 days)

Active vs. Current

– Diagnosis status: Determine if the diagnosis is Active or Inactive (Step 2) is a 7-day look-back period.
– If you are expending additional resources to care for the patient consider the rules and see if you can code the diagnosis as active
Active Diagnosis Indicators

Physician documented Diagnosis *plus one* of the following:

- Recent onset or acute exacerbation of the disease or condition indicated by a Positive test, study or procedure, hospitalization for acute symptoms and/or recent change in therapy in last 7 days

- Abnormal Signs or symptoms indicating ongoing decompensated disease in last 7 days. A symptom must be specifically attributed to the disease.
- Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in last 7 days

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Care Area Assessments (CAAs)

1. Delirium
2. Cognition loss/dementia
3. **Visual Function**
4. Communication
5. ADL
6. Urinary Incontinence/Catheter
7. **Psychosocial Well-Being**
8. Mood State
9. Behavioral Symptoms
10. Activities
11. Falls
12. Nutritional Status
13. Feeding Tubes
14. **Dehydration/Fluid Maintenance**
15. Dental Care
16. Pressure Ulcer
17. Psychotropic Drug Use
18. Physical Restraints
19. Pain
20. Return to Community Referral
MDS Section I Diagnoses

- Pneumonia
- Septicemia
- Diabetes
- Aphasia
- Cerebral Palsy
- Hemiplegia
- Hemiparesis
- Quadriplegia
- Multiple Sclerosis
- Parkinson's
- Asthma
- COPD
- Respiratory Failure

Payment Categories Affected

- Special Care High
- Special Care Low
- Clinically Complex

Special Care High

- Comatose and completely ADL Dependent or ADL did not occur
- Septicemia
- Diabetes with both: Insulin injections 7 Days and Insulin order changes on 2 or more days
- Quadriplegia with ADL score of ≥5
- Fever and one of the following:
  - Pneumonia, Vomiting, Weight loss, Feeding Tube
- Parenteral/IV Feedings
- Respiratory Therapy for all 7 days
### Special Care High

<table>
<thead>
<tr>
<th>ADL Score</th>
<th>RUG IV Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 16</td>
<td>HE2 (Depression)</td>
</tr>
<tr>
<td>15 – 16</td>
<td>HE1</td>
</tr>
<tr>
<td>11 – 14</td>
<td>HD2 (Depression)</td>
</tr>
<tr>
<td>11 – 14</td>
<td>HD1</td>
</tr>
<tr>
<td>6 – 10</td>
<td>HC2 (Depression)</td>
</tr>
<tr>
<td>6 – 10</td>
<td>HC1</td>
</tr>
<tr>
<td>2* – 5</td>
<td>HB2 (Depression)</td>
</tr>
<tr>
<td>2* – 5</td>
<td>HB1</td>
</tr>
</tbody>
</table>

* If ADL score is 0 or 1 then the resident classifies into Clinically Complex.

### Special Care Low

(If ADL < 2, classifies to Clinically Complex)

- **Cerebral Palsy** and an ADL score of = or >5
- **Multiple Sclerosis** and an ADL score of = or > 5
- **Parkinson's disease** and an ADL score = or > 5
- Respiratory failure and Oxygen Therapy while a resident
- **Tube Feed**
- 2 or more **Pressure Ulcers** Stage 2 or higher and 2 treatments

### Special Care Low

- **Pressure Ulcers** Stage 3 or 4 and 2 treatments
- 2 or more **Venous/Arterial Ulcers** and 2 treatments
- 1 Stage-2 **Pressure ulcer** and 1 **Venous/Arterial ulcer** and 2 treatments
- **Foot Infection, Diabetic Foot Ulcer** or **other open lesion of the foot** and application of dressings to the feet
- **Radiation treatment** while a resident
- **Dialysis treatment** while a resident
### Special Care Low

#### RUGs for this category

<table>
<thead>
<tr>
<th>ADL Score</th>
<th>RUG IV Class</th>
</tr>
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<tbody>
<tr>
<td>15 – 16</td>
<td>LE2 (Depression)</td>
</tr>
<tr>
<td>11 – 14</td>
<td>LD2 (Depression)</td>
</tr>
<tr>
<td>6 – 10</td>
<td>LC2 (Depression)</td>
</tr>
<tr>
<td>2 – 5</td>
<td>LB2 (Depression)</td>
</tr>
</tbody>
</table>

### Clinically Complex

- **Pneumonia**
- **Hemiplegia/hemiparesis** with ADL score ≥5
- **Surgical wounds or open lesions** and selected treatments
- **Burns**
- **Chemotherapy** while a resident
- **Oxygen therapy** while a resident
- **IV Medication** while a resident
- **Transfusions** while a resident

#### RUGs for this category

<table>
<thead>
<tr>
<th>ADL Score</th>
<th>RUG IV Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 – 16</td>
<td>CE2 (Depression)</td>
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<tr>
<td>11 – 14</td>
<td>CD2 (Depression)</td>
</tr>
<tr>
<td>6 – 10</td>
<td>CC2 (Depression)</td>
</tr>
<tr>
<td>2 – 5</td>
<td>CB2 (Depression)</td>
</tr>
<tr>
<td>0 – 1</td>
<td>CA2 (Depression)</td>
</tr>
</tbody>
</table>
Coding on the MDS form

Coding Active Diagnosis

- V-Codes listed must have related primary condition checked in I0100-17900 or I8000 (waiting for instruction on ICD-10)
  - V57.89 Multiple therapies, you would have to check a diagnosis above that corresponds with the V Code
- ICD-10 codes should be “right justified” (unused boxes on left)

Coding UTI

Coding UTI

The look back period for UTI’s is 30 days
Indications of an active diagnosis must include:
1. Diagnosis of a UTI in last 30 days
2. Signs and symptoms of UTI in last 30 days
3. “Significant laboratory findings” (The Physician should determine the level of significant lab findings AND whether or NOT a culture should be obtained).
4. Current medication for treatment in the last 30 days

Scenario #1

Scenario #1

- A resident is prescribed hydrochlorothiazide for hypertension
- The resident requires regular blood pressure monitoring to determine whether blood pressure goals are achieved by the current regimen
- Physician Progress note documents hypertension
Scenario #1 Coding Answer

Check I0700 Hypertension.

- This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

Scenario #2

Mr. J. fell and fractured his hip 2 years ago.

- At the time of the injury, the fracture was surgically repaired. Following the surgery, the resident received several weeks of physical therapy in an attempt to restore him to his previous ambulation status, which had been independent without any devices.
- Although he received therapy services at that time, he now requires assistance to stand from the chair and uses a walker.
- He also needs help with lower body dressing because of difficulties standing and leaning over.

Scenario #2 coding Answer

Do not check I3900 Hip Fracture.

- Although the resident has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7-day look-back period.
- Hip Fracture would be considered inactive.
Scenario #3

Scenario #3
- A resident with a past history of healed peptic ulcer is prescribed a non-steroidal anti-inflammatory (NSAID) medication for arthritis
- The physician also prescribes a proton-pump inhibitor to decrease the risk of peptic ulcer disease (PUD) from NSAID treatment

Scenario #3 Coding Options
A. Check I1200 Gastro-esophageal Reflux Disease (GERD) or Ulcer.
B. Check I3700 Arthritis.
C. Check both I1200 and I3700.
D. Check neither I1200 and I3700.

Scenario #3 Answer Explanation
Arthritis would be considered an active diagnosis because of the need for medical therapy.
- Given that the resident has a history of a healed peptic ulcer without current symptoms, the proton-pump inhibitor prescribed is preventive; therefore, PUD would not be coded as an active disease
SEQUENCING

Purpose

- To support reimbursement for services provided
- To gather data important for care and quality improvement
- To support clinical decision making
- Comply with federal standards for reporting diagnostic data
- To collect statistical data

Unique to LTC

- There are no specific sequencing rules for long term care
- Residents typically stay after the initial episode of illness has ended
- Example: Resident admitted for aftercare from a hip fracture but is unable to return home due to Parkinson’s, COPD, or chronic kidney disease
Unique to LTC

- Codes can be assigned
  - Upon admission
  - Return from hospital
  - Expiration
  - Discharge
  - As conditions arise during length of stay

Unique to LTC

- Conflict in requirements and terminology
  - Primary is often used to indicate reason for skilled Medicare services
  - May not be the same reason for the resident's continued stay
  - Primary may conjure different definitions depending on individual

Medicare Guidelines

- Refers to the term primary diagnosis as the reason for therapy services
- Also known as medical diagnosis
- Appendix C offers guidance on reporting and sequencing diagnoses in the health record and on the UB-04 claim form
Unique to LTC

- **Principle**
  - Indicates principle, primary, and first listed diagnosis
  - Example: Resident transfers to hospital to receive treatment for acute condition (pneumonia) and then returns to the facility for further care of chronic condition (COPD), the first listed would be COPD
  - In field 67A of UB-04

UB-04

- When the purpose for the admission is rehabilitation, the actual diagnosis code is used in ICD-10 with the appropriate 7th character
- Only one code is required as the first listed
- Code each separate condition if more than one type of rehabilitation is performed during a single encounter

Newly Diagnosed Condition

- Will be listed after the principle diagnosis to reflect new conditions that affect the resident
- The principle diagnosis may or may not be the reason for Medicare skilled services
Example

• Initial admission followed by continued stay
• Resident was admitted to receive PT and OT for aftercare of hip fracture
• Resident remains because of Parkinson’s

Example

ICD-9-CM
• Upon initial admission, the following codes will be reported
  – V57.89 Multiple therapies
  – V54.13 Aftercare for healing of traumatic hip fracture
  – 332.0 Parkinson’s disease
• Codes V57.89 & V54.13 are resolved at discontinuation of Medicare Part A stay
• 332.0 becomes the principle / primary

ICD-10-CM
• Upon initial admission, the following codes will be reported
  – S72.041D Displaced fracture of right femur, subsequent care
  – No aftercare code
  – G20 Parkinson’s
• Code S72.041D is resolved at discontinuation of Medicare Part A stay
• G20 becomes primary

Principle Diagnosis

• UHDDS Definition – the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care
• The application of the UHDDS definitions has been expanded to include long term care and other settings
• Universal Hospital Data Discharge Set
• Section I
  – General guidelines, coding conventions, terminology
  – Chapter specific guidelines that are unique to each chapter of the ICD-10-CM

• Section II
  – Guidelines on how to select the principle diagnosis
  – If the diagnosis documented includes; probable, suspected, likely, questionable, possible, or still to be ruled out it is not coded in LTC facilities

• Section III
  – Reporting additional diagnoses as conditions that affect the patient care in terms of requiring
    • Clinical evaluation
    • Therapeutic treatment
    • Diagnostic procedures
    • Extended length of hospital stay
    • Increased nursing care or monitoring
Official Coding Guidelines

- Section IV
  - For outpatient services
  - Not utilized for nursing homes

Claim Check Review

Before Claims Submission

- Select appropriate codes for UB-04
- Sequence the codes according to priority of services provided
- No strict hierarchy inherent regarding sequencing of secondary diagnosis codes
  - Primary may change
  - Admitting will not
- Flexible
Claim Check Review

• Meet at pre-close and consider the following participants
  – Administrator
  – Director of Nursing
  – Business Office Manager
  – Health Information
  – Therapy
  – MDS / RAI Coordinator

Claim Check Review Form

Question & Answer
Chapter 1 Certain Infectious and Parasitic Diseases

1.1 A patient is seen for right lower leg muscle atrophy that is the result of a previous bout of polio.

Code(s): _______________________________________________________________________

1.2 An 80-year-old female with fever, malaise and left flank pain. Urinalysis shows bacteria >100,000/ml and culture shows E. coli growth. Provider diagnoses E. coli UTI

Code(s): _______________________________________________________________________

1.3 An 87-year-old nursing home patient is being treated with IV antibiotics for E. coli sepsis

Code(s): _______________________________________________________________________

1.4 A 75-year-old woman taken to the ER and diagnosed with gram-negative sepsis with acute respiratory failure.

Code(s): _______________________________________________________________________

Chapter 2 Neoplasms

2.1 Small cell carcinoma of right lower lobe of lung with metastasis to the intrathoracic lymph nodes, brain and right rib.

Code(s): _______________________________________________________________________

2.2 Benign carcinoid of the cecum

Code(s): _______________________________________________________________________
Chapter 3 Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving the Immune Mechanism

3.1 Congenital red cell aplastic anemia

Code(s): ___________________________________________________________________

Chapter 4 Endocrine, Nutritional and Metabolic Diseases

4.1 A 62-year-old male with mild nonproliferative diabetic retinopathy with macular edema. He has type 2 DM and takes insulin on a daily basis. He also has a diabetic cataract in his right eye. What is the correct code assignment?

Code(s): ___________________________________________________________________

4.2 Type 1 diabetic patient with severe chronic diabetic left foot ulcer with diabetic peripheral angiopathy. Also has diabetic stage 2 chronic kidney disease.

Code(s): ___________________________________________________________________

4.3 Steroid induced diabetes mellitus due to prolonged use of corticosteroids, which are now discontinued. DM is managed with insulin over last 2 years.

Code(s): ___________________________________________________________________

Chapter 5 Mental and Behavioral Disorders

5.1 Alcohol dependence with chronic alcoholic gastritis.

Code(s): ___________________________________________________________________

5.2 A 52-year-old with dementia and forgetfulness has been wandering from home and getting lost. The diagnosis is dementia due to early-onset of Alzheimer’s disease.

Code(s): ___________________________________________________________________
Chapter 6 Diseases of the Nervous System

6.1 A 72-year-old patient with sudden weakness of the left arm and leg. The patient could speak in the emergency room but was unable to use his left arm and leg. The patient completely recovered and was able to ambulate with no neurological deficits within 24 hours of admission. It was determined that the patient had experienced a TIA. The patient also suffered an intractable classical migraine.

Code(s): _______________________________________________________________________

6.2 Left-sided hemiplegia

Code(s): _______________________________________________________________________

6.3 Seizure disorder

Code(s): _______________________________________________________________________

6.4 Parkinson’s disease

Code(s): _______________________________________________________________________

Chapter 7 Diseases of the Eye and Adnexa

7.1 A patient with moderate primary open-angle glaucoma of the left eye.

Code(s): _______________________________________________________________________

7.2 Age-related nuclear cataract, right eye

Code(s): _______________________________________________________________________

7.3 Blindness, right eye, low vision, left eye

Code(s): _______________________________________________________________________
7.4 Nonulcerative bilateral blepharitis of upper eyelids

Code(s): ___________________________________________________________

Chapter 8 Diseases of the Ear and Mastoid Process

8.1 Examination of patient reveals left acute serous otitis media and a total perforated tympanic membrane of the right ear due to chronic otitis media.

Code(s): ___________________________________________________________

8.2 Bilateral conductive hearing loss

Code(s): ___________________________________________________________

8.3 Meniere’s vertigo of left ear

Code(s): ___________________________________________________________

8.4 Benign paroxysmal vertigo

Code(s): ___________________________________________________________

Chapter 9 Diseases of the Circulatory System

9.1 Stage 3 chronic kidney disease with congestive heart failure due to hypertension

Code(s): ___________________________________________________________

9.2 A 72-year-old male with a history of 2-vessel coronary artery bypass last year is seen for unstable angina. Cardiac catheterization shows continued evidence of coronary arteriosclerosis with both bypass grafts patent. He also has a history of CVA with right-sided hemiparesis.

Code(s): ___________________________________________________________

9.3 Acute non-ST anterior wall myocardial infarction suffered 5 days ago and atrial fibrillation

Code(s): ___________________________________________________________
9.4 Patient from previous case presents to ED two weeks later with acute inferior wall MI.

Code(s): ________________________________________________________________

Chapter 10 Diseases of the Respiratory System

10.1 COPD with emphysema

Code(s): ________________________________________________________________

10.2 Moderate persistent asthma with status asthmaticus and acute exacerbation of chronic obstructive pulmonary disease

Code(s): ________________________________________________________________

10.3 MSSA pneumonia

Code(s): ________________________________________________________________

10.4 Upper respiratory tract infection due to novel influenza A virus

Code(s): ________________________________________________________________

Chapter 11 Diseases of the Digestive System

11.1 Patient with recurrent right inguinal hernia with gangrene and obstruction

Code(s): ________________________________________________________________

11.2 Acute gastric ulcer with hemorrhage

Code(s): ________________________________________________________________

11.3 Crohn’s disease of small intestine with small bowel obstruction

Code(s): ________________________________________________________________

Chapter 12 Diseases of the Skin and Subcutaneous Tissue

12.1 Patient with gangrenous pressure ulcer of right hip with cellulitis and pressure ulcer of sacrum

Code(s): ________________________________________________________________
documented by physician. Nursing assessment indicated stage 2 sacral ulcer and stage 3 decubitus ulcer of right hip.

Code(s): ___________________________________________________________

12.2 Atherosclerosis of right ankle (native artery), with non-healing ulcer, with breakdown of skin

Code(s): ___________________________________________________________

12.3 A patient with a rash on the trunk and upper extremities over the last 3-4 days due to Ramipril taken for hypertension. Physician discontinues Ramipril and prescribes Captopril and a topical cream for localized dermatitis.

Code(s): ___________________________________________________________

Chapter 13 Diseases of the Musculoskeletal System and Connective Tissue

13.1 An 80-year-old female with senile osteoporosis complaining of severe back pain with no history of trauma. Provider documentation reveals pathological compression fractures of several lumbar vertebrae.

Code(s): ___________________________________________________________

13.2 Bacterial Septic Arthritis

Code(s): ___________________________________________________________

13.3 Degenerative disc disease, lumbar region, with myelopathy

Code(s): ___________________________________________________________

Chapter 14 Diseases of the Genitourinary System

14.1 An 83-year-old man with complaints of lower abdominal pain and the inability to urinate over the past 24 hours, diagnosed as acute kidney failure due to acute tubular necrosis, caused by a urinary obstruction. The urinary obstruction was a result of the patient’s benign prostatic hypertrophy.
14.2 A 78-year-old female with fever, malaise, and left flank pain. A urinalysis shows bacteria of more than 100,000/ml present in the urine and subsequent urine culture shows Proteus growth as the cause of the urinary tract infection. The patient also has a history of repeated UTIs over the past several years.

Chapter 17 Congenital Malformations, Deformations and Chromosomal Abnormalities

17.1 Down Syndrome

17.2 Septal Heart Defect

Chapter 18 Symptoms, Signs and Abnormal Clinical and Laboratory Findings

18.1 Patient with fever of 101 degrees with chills. Lab tests and urinalysis are within normal limits. Physician gives final diagnosis as fever with chills, possible viral syndrome.

18.2 Patient complaining of right upper quadrant abdominal pain in addition to nausea and vomiting. Patient also has elevated blood pressure readings, but diagnosis of hypertension is not made. Patient referred for follow up appointment.
Chapter 19 Injury, Poisoning, and Certain Other Consequences of External Causes

19.1 A patient admitted for aftercare following traumatic lateral epicondyle fracture of the right elbow, which is healing normally.

Code(s): _______________________________________________________________________

19.2 A patient admitted following surgery for an infected right hip prosthesis.

Code(s): _______________________________________________________________________

19.3 A patient taking Digoxin is experiencing nausea, vomiting and profound fatigue. The patient indicates that she has been taking the drug as prescribed. Evaluation and treatment focused on adjustment of medication only.

Code(s): _______________________________________________________________________

Chapter 21 Factors Influencing Health Status and contact with health services

21.1 A 75-year-old woman was admitted for occupational therapy (OT) following cardiac bypass surgery. She continues to have significant acute post-thoracotomy pain. Assign the correct diagnostic code(s).

Code(s): _______________________________________________________________________

<table>
<thead>
<tr>
<th>Resident</th>
<th>Admit Date</th>
<th>Pay Source</th>
<th>Days of MC used</th>
<th>Name, HIC#, DOB correct in CWF</th>
<th>Admission note present</th>
<th>Copies of MC/INS Cards</th>
<th>Orders to eval &amp; treat</th>
<th>Minutes of PT</th>
<th>Minutes of OT</th>
<th>Minutes of ST</th>
<th>Scheduler / RUGs match</th>
<th>Restorative Doc. is in place</th>
<th>MD Cert.</th>
<th>Therapy Cert.</th>
<th>Nsg Doc. In place</th>
<th>Dx on UB04</th>
<th>Charges accurate</th>
<th>Comments</th>
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