A patient may be admitted with one type of pneumonia (e.g., code J13, Pneumonia due to Streptococcus pneumonia) and subsequently develop VAP. In this instance, the principal diagnosis would be the appropriate code from categories J12-J18 for the pneumonia diagnosed at the time of admission. Code J95.851, Ventilator associated pneumonia, would be assigned as an additional diagnosis when the provider has also documented the presence of ventilator associated pneumonia.

e. Vaping-related disorders

For patients presenting with condition(s) related to vaping, assign code U07.0, Vaping-related disorder, as the principal diagnosis. For lung injury due to vaping, assign only code U07.0. Assign additional codes for other manifestations, such as acute respiratory failure (subcategory J96.0-) or pneumonitis (code J68.0).

Associated respiratory signs and symptoms due to vaping, such as cough, shortness of breath, etc., are not coded separately, when a definitive diagnosis has been established. However, it would be appropriate to code separately any gastrointestinal symptoms, such as diarrhea and abdominal pain.

See Section I.C.1.g.1.c.i. for Pneumonia confirmed as due to COVID-19

11. Chapter 11: Diseases of the Digestive System (K00-K95)

Reserved for future guideline expansion

12. Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99)

a. Pressure ulcer stage codes

1) Pressure ulcer stages

Codes in category L89, Pressure ulcer, identify the site and stage of the pressure ulcer.

The ICD-10-CM classifies pressure ulcer stages based on severity, which is designated by stages 1-4, deep tissue pressure injury**,** unspecified stage, and unstageable.

Assign as many codes from category L89 as needed to identify all the pressure ulcers the patient has, if applicable.

See Section I.B.14 for pressure ulcer stage documentation by clinicians other than patient's provider.

2) Unstageable pressure ulcers

Assignment of the code for unstageable pressure ulcer (L89.--0) should be based on the clinical documentation. These codes are used for pressure ulcers whose stage cannot be clinically determined (e.g., the

ulcer is covered by eschar or has been treated with a skin or muscle graft). This code should not be confused with the codes for unspecified stage (L89.--9). When there is no documentation regarding the stage of the pressure ulcer, assign the appropriate code for unspecified stage (L89.-- 9).

If during an encounter, the stage of an unstageable pressure ulcer is revealed after debridement, assign only the code for the stage revealed following debridement.

3) Documented pressure ulcer stage

Assignment of the pressure ulcer stage code should be guided by clinical documentation of the stage or documentation of the terms found in the Alphabetic Index. For clinical terms describing the stage that are not found in the Alphabetic Index, and there is no documentation of the stage, the provider should be queried.

4) Patients admitted with pressure ulcers documented as healed

No code is assigned if the documentation states that the pressure ulcer is completely healed at the time of admission.

5) Pressure ulcers documented as healing

Pressure ulcers described as healing should be assigned the appropriate pressure ulcer stage code based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign the appropriate code for unspecified stage.

If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider.

For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission.

6) Patient admitted with pressure ulcer evolving into another stage during the admission

If a patient is admitted to an inpatient hospital with a pressure ulcer at one stage and it progresses to a higher stage, two separate codes should be assigned: one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay.

7) Pressure-induced deep tissue damage

For pressure-induced deep tissue damage or deep tissue pressure injury, assign only the appropriate code for pressure-induced deep tissue damage (L89.--6).

b. Non-Pressure Chronic Ulcers

1) Patients admitted with non-pressure ulcers documented as healed

No code is assigned if the documentation states that the non-pressure ulcer is completely healed at the time of admission.

2) Non-pressure ulcers documented as healing

Non-pressure ulcers described as healing should be assigned the appropriate non-pressure ulcer code based on the documentation in the medical record. If the documentation does not provide information about the severity of the healing non-pressure ulcer, assign the appropriate code for unspecified severity.

If the documentation is unclear as to whether the patient has a current (new) non-pressure ulcer or if the patient is being treated for a healing non-pressure ulcer, query the provider.

For ulcers that were present on admission but healed at the time of discharge, assign the code for the site and severity of the non-pressure ulcer at the time of admission.

3) Patient admitted with non-pressure ulcer that progresses to another severity level during the admission

If a patient is admitted to an inpatient hospital with a non-pressure ulcer at one severity level and it progresses to a higher severity level, two separate codes should be assigned: one code for the site and severity level of the ulcer on admission and a second code for the same ulcer site and the highest severity level reported during the stay.

See Section I.B.14 for pressure ulcer stage documentation by clinicians other than patient's provider

13. Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

a. Site and laterality

Most of the codes within Chapter 13 have site and laterality designations. The site represents the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis, there is a “multiple sites” code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.

1) Bone versus joint

For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M80, M81).