

## **h. COVID-19 Infection in Newborn**

For a newborn that tests positive for COVID-19, assign code U07.1, COVID-19, and the appropriate codes for associated manifestation(s) in neonates/newborns in the absence of documentation indicating a specific type of transmission. For a newborn that tests positive for COVID-19 and the provider documents the condition was contracted in utero or during the birth process, assign codes P35.8, Other congenital viral diseases, and U07.1, COVID-19. When coding the birth episode in a newborn record, the appropriate code from category Z38, Liveborn infants according to place of birth and type of delivery, should be assigned as the principal diagnosis.

## **17. Chapter 17: Congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)**

Assign an appropriate code(s) from categories Q00-Q99, Congenital malformations, deformations, and chromosomal abnormalities when a malformation/deformation or chromosomal abnormality is documented. A malformation/deformation/or chromosomal abnormality may be the principal/first-listed diagnosis on a record or a secondary diagnosis.

When a malformation/deformation or chromosomal abnormality does not have a unique code assignment, assign additional code(s) for any manifestations that may be present.

When the code assignment specifically identifies the malformation/deformation or chromosomal abnormality, manifestations that are an inherent component of the anomaly should not be coded separately. Additional codes should be assigned for manifestations that are not an inherent component.

Codes from Chapter 17 may be used throughout the life of the patient. If a congenital malformation or deformity has been corrected, a personal history code should be used to identify the history of the malformation or deformity. Although present at birth, a malformation/deformation/or chromosomal abnormality may not be identified until later in life. Whenever the condition is diagnosed by the provider, it is appropriate to assign a code from codes Q00-Q99. For the birth admission, the appropriate code from category Z38, Liveborn infants, according to place of birth and type of delivery, should be sequenced as the principal diagnosis, followed by any congenital anomaly codes, Q00-Q99.

## **18. Chapter 18: Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)**

Chapter 18 includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded. Signs and symptoms that point to a specific diagnosis have been assigned to a category in other chapters of the classification.

### **a. Use of symptom codes**

Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

## **b. Use of a symptom code with a definitive diagnosis code**

Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes. The definitive diagnosis code should be sequenced before the symptom code.

Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

## **c. Combination codes that include symptoms**

ICD-10-CM contains a number of combination codes that identify both the definitive diagnosis and common symptoms of that diagnosis. When using one of these combination codes, an additional code should not be assigned for the symptom.

## **d. Repeated falls**

Code R29.6, Repeated falls, is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated.

Code Z91.81, History of falling, is for use when a patient has fallen in the past and is at risk for future falls. When appropriate, both codes R29.6 and Z91.81 may be assigned together.

## **e. Coma**

**Code R40.20, Unspecified coma, may be assigned in conjunction with codes for any medical condition.**

Do not report codes for **unspecified coma**, individual or total Glasgow coma scale scores for a patient with a medically induced coma or a sedated patient.

### **1) Coma Scale**

The coma scale codes (R40.21- to R40.24-) can be used in conjunction with traumatic brain injury codes. These codes are primarily for use by trauma registries, but they may be used in any setting where this information is collected. The coma scale codes should be sequenced after the diagnosis code(s).

These codes, one from each subcategory, are needed to complete the scale. The 7<sup>th</sup> character indicates when the scale was recorded. The 7<sup>th</sup> character should match for all three codes.

At a minimum, report the initial score documented on presentation at your facility. This may be a score from the emergency medicine technician (EMT) or in the emergency department. If desired, a facility may choose to capture multiple coma scale scores.

Assign code R40.24-, Glasgow coma scale, total score, when only the total score is documented in the medical record and not the individual score(s).

**If multiple coma scores are captured within the first 24 hours after hospital admission, assign only the code for the score at the time of admission. ICD-10-CM does not classify coma scores that are reported after admission but less than 24 hours later.**

*See Section I.B.14 for coma scale documentation by clinicians other than patient's provider*

#### **f. Functional quadriplegia**

GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2017

#### **g. SIRS due to Non-Infectious Process**

The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious disease processes, such as trauma, malignant neoplasm, or pancreatitis. When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as an injury, should be assigned, followed by code R65.10, Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction, or code R65.11, Systemic inflammatory response syndrome (SIRS) of non-infectious origin with acute organ dysfunction. If an associated acute organ dysfunction is documented, the appropriate code(s) for the specific type of organ dysfunction(s) should be assigned in addition to code R65.11. If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is associated with SIRS or due to another condition (e.g., directly due to the trauma), the provider should be queried.

#### **h. Death NOS**

Code R99, Ill-defined and unknown cause of mortality, is only for use in the very limited circumstance when a patient who has already died is brought into an emergency department or other healthcare facility and is pronounced dead upon arrival. It does not represent the discharge disposition of death.

#### **i. NIHSS Stroke Scale**

The NIH stroke scale (NIHSS) codes (R29.7- -) can be used in conjunction with acute stroke codes (I63) to identify the patient's neurological status and the severity of the stroke. The stroke scale codes should be sequenced after the acute stroke diagnosis code(s).

At a minimum, report the initial score documented. If desired, a facility may choose to capture multiple stroke scale scores.

*See Section I.B.14 for NIHSS stroke scale documentation by clinicians other than patient's provider*