# ICD-10

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# ICD-10.
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## ICD-10-PCS Code Updates

The 2014 ICD-10-PCS (procedure) files are now available and posted on the CMS website. ICD-10-PCS will be used for coding inpatient procedures when the U.S. transitions to ICD-10 on October 1, 2014. ICD-10-PCS will replace ICD-9-CM, Volume 3. CPT codes will continue to be used for outpatient procedures and services.

The new ICD-10-PCS files include:

- Updated "Official ICD-10-PCS Coding Guidelines" with guidance from the ICD Cooperating Parties: CMS, the Centers for Disease Control and Prevention, the American Hospital Association, and the American Health Information Management Association
- The 2014 ICD-10-PCS code tables and index, which add four procedure codes created to capture new technologies

To find out more about the 2014 ICD-10-PCS files, see the accompanying "What's New" document. The 2014 General Equivalence Mappings (GEMs) and 2014 Reimbursement Mapping files will be released in October 2013.

The FY 2014 ICD-9-CM procedure code files are posted on the Updates and Revisions to ICD-9-CM Procedure Codes website. There will not be any FY 2014 ICD-9-CM diagnosis files, as CDC is not updating ICD-9-CM diagnosis codes for FY 2014.

**Clarification on the Use of External Cause and Unspecified Codes in ICD-10-CM**

Just as with ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. If a provider has not been reporting ICD-9-CM external

cause codes, the provider will not be required to report ICD-10-CM codes in Chapter 20, unless a new state or payer-based requirement regarding the reporting of these codes is instituted. Such a requirement would be independent of ICD-10-CM implementation. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

**Sign/Symptom/Unspecified Codes**
In both ICD-9-CM and ICD-10-CM, sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the health care encounter. Each health care encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). In fact, unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

**Keep Up to Date on ICD-10**
Visit the CMS ICD-10 website for the latest news and resources and the ICD-10 continuing medical education modules developed by CMS in partnership with Medscape to help you prepare for the **October 1, 2014**, deadline.

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