Canadian Coding Standards for ICD-10-CA and CCI Errata

Instruction	Chapter and Page Affected	Coding Standards Entries
Revise second directive—alter term	**General Coding Standards** **Page 23**	**If, after an episode of health care, the MRDx is still recorded by the physician as "suspected", "questionable", "rule~~d~~ out", "possible", "probable", etc., and there is no further information or clarification, code the suspected diagnosis as if it were established. Use the prefix "Q" in such circumstances whenever applicable.**
Revise note—alter code title	**General Coding Standards for CCI** **Page 42**	**Note:** In such a case scenario, the responsible physician will sometimes attempt to clear the plaque or thrombus formation by injection of an antithrombotic agent (Streptokinase) directly into the coronary artery. This should be coded to 1.IL.35.HA-C1 *Pharmacotherapy (local), vessels of heart, percutaneous injection approach, using an ~~anticoagulant~~ antithrombotic agent*. When a drug is administered via a venous approach it must be considered as systemic pharmacotherapy. When the drug is injected into an artery, it should always be coded to local pharmacotherapy
Revise last example—add phrase to description of case	**Chapter II** **Page 58**	***Example*:** The patient was admitted for left mastectomy for carcinoma of the breast. The pathology report describes infiltrating duct carcinoma and a noncontiguous carcinoma in situ in the 2 o'clock position. C50.41 (M) Malignant neoplasm of upper-outer quadrant of left breast D05.1 (1) Intraductal carcinoma in situ
Revise example—change the wording in the rationale	**Chapter IV** **Page 77**	**Rationale:** Diagnosis typing definitions have been applied: retinopathy is the condition that meets the definition for MRDx and since it is an asterisk code, it is assigned diagnosis type (6). Diabetes with renal complications meets the criteria for ~~Type 1~~ diagnosis type 1 since a consultant evaluated the condition and instituted treatment. All diabetes codes are from the same 3-digit category. Multiple diabetes codes have been assigned because more than one diabetic condition classified in the diabetes subcategories has been evaluated and/or treated.

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Revise second example—change diagnosis types	**Chapter IV** **Page 79**	***Example:*** Mr. T. L., a 54-year old patient, is admitted for vitreous hemorrhage. The physician notes that he has been a Type 2 diabetic, well controlled, for many years. H43.1 (M) Vitreous hemorrhage E11.33† (3) Type 2 diabetes mellitus with other retinopathy Diabetic retinopathy H36.0* (3)
Revise last example—change code and code title *and* add statement to rationale	**Chapter IV** **Page 81**	***Example:*** A patient is admitted for extraction of senile nuclear cataracts. The physician has indicated Type 2 diabetes on the history. H25.1 (M) Senile nuclear cataract E11.~~9~~38 ~~Type 2 diabetes mellitus without (mention of) complications~~ Type 2 diabetes mellitus with other specified ophthalmic complication not elsewhere classified **Rationale:** Do not assign E11.35 for this case; assign E11.38 and code separately, the senile cataract. Diagnosis type for the diabetes code will vary depending on the circumstances documented in the record. It is mandatory to code diabetes whenever it is documented by the physician.
Revise first directive—change term	**Chapter IX** **Page 103**	**Assign a code from the category I23.– *Certain current complications following acute myocardial infarction* for specified complications that occur ~~following~~ during the acute phase of a myocardial infarction.** **Do not assign an additional code when these complications occur concurrently with the infarction as they are included in the acute myocardial infarction code.**

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Substitute first example—replace the original example with this one	**Chapter IX** **Page 104**	***Example:***	Mrs. M is admitted in chest pain and no ST segment elevation on her ECG. The admission diagnosis is nonSTEMI acute coronary syndrome. There was no elevation of her troponins or cardiac enzymes and the final diagnosis was recorded as unstable angina. I20.0 (M) Unstable angina
Substitute second example—replace the original example with this one	**Chapter IX** **Page 104**	***Example:***	Mr. P is admitted in chest pain with ST segment elevation on his ECG. The admission diagnosis is STEMI. He was given thrombolytic therapy. Cardiac enzymes indicate myocardial damage. The final diagnosis is recorded as STEMI acute subendocardial myocardial infarction, inferior wall. I21.41 (M) Acute subendocardial myocardial infarction of inferior wall
Revise first example—add statement to description of case	**Chapter IX** **Page 105**	***Example:***	Mr. E is admitted in chest pain and has ST segment elevation on his ECG. He was given thrombolytic therapy. The admission diagnosis is STEMI. He was treated in CCU for 3 days and discharged after 5 days. The final diagnosis is recorded as STEMI. I21.9 (M) Acute myocardial infarction, unspecified

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Revise first example—change term	**Chapter XI** **Page 116**	***Example:*** Mr. P a 65-year old patient was admitted electively for arteriography of the lower limbs. He had been experiencing dull cramping pain in his thigh and he noticed that his symptoms were precipitated by walking and were relieved by rest. He had a history of hypertension and no history of diabetes. The physician documented the diagnosis as "PVD". The arteriogram demonstrated occlusions within the left ~~iliac~~ femoral artery system. I70.2 (M) Atherosclerosis of arteries of extremities
Revise first directive—change code	**Chapter XI** **Page 131**	**Assign the LOCATION attribute at 1.SY.80.^^, mandatory.** **Select "0" *Not Applicable*, only when the diagnosis does not reflect a hernia classifiable to categories K40 – K43 and K45 – K46.**
Revise second directive—add phrase *and* delete code, code title and statement.	**Chapter XI** **Page 139**	**When a colonoscope is passed into the terminal ileum and the physician documents findings, normal or abnormal, relating to the terminal ileum, assign:** **➢ 2.NK.70.^^ *Inspection, small intestine* with Location Attribute I** ~~**➢ 2.NM.70.^^ *Inspection, large intestine* with Location Attribute Z**~~ ~~**Sequence the inspection of the small intestine first, as it is the furthest site visualized.**~~ **When no findings related to the terminal ileum are documented, assign 2.NM.70.^^ only, as the entry into the terminal ileum in this case simply denotes that the furthest point has been reached.**

Instruction	Chapter and Page Affected	Coding Standards Entries
Revise first example—change description of case *and* delete code, attribute and code title *and* add statements to rationale	**Chapter XI** **Page 140**	***Example:*** The colonoscope was advanced through the colon into the terminal ileum. ~~The colon was free of disease. However, ileitis was noted in the terminal ileum.~~ The colon and the ileum were described to be free of disease. ~~Diagnosis: Crohn's ileitis~~ 2.NK.70.BA Location attribute: I — Inspection, small intestine, using endoscopic per orifice approach (or via stoma) ~~2.NM.70.BA Location attribute: Z~~ — ~~Inspection, large intestine, using endoscopic per orifice approach (or via stoma)~~ Rationale: Since findings were described in the terminal ileum, it qualifies as an inspection of this site.
Revise second example – delete code, attribute and code title	**Chapter XI** **Page 140**	***Example:*** The colonoscope was advanced through the colon into the terminal ileum. The colon was free of disease. However, ileitis was noted in the terminal ileum and a biopsy was taken of the ileum. Diagnosis: Crohn's ileitis 2.NK.71.BA Location attribute: I — Biopsy, small intestine, using endoscopic per orifice approach (or via stoma) ~~2.NM.70.BA Location attribute: Z~~ — ~~Inspection, large intestine, using endoscopic per orifice approach (or via stoma)~~ Rationale: When a biopsy and an inspection are performed at the same anatomical site, code only the biopsy.

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Revise last example—change term in description of case *and* delete code, attribute and code title *and* change attribute for second code	**Chapter XI** **Page 140**	***Example:*** The patient had an esophagogastroduodenoscopy (EGD) and a colonoscopy. The gastroscope was advanced to the ~~jejunum~~ duodenum. The colonoscopy was advanced into the terminal ileum and the physician noted findings of ileitis in the terminal ileum. 2.NK.70.BA Location attribute: I — Inspection, small intestine, using endoscopic per orifice approach (or via stoma) ~~2.NM.70.BA Location attribute: Z — Inspection, large intestine, using endoscopic per orifice approach (or via stoma)~~ 2.NK.70.BA Location attribute: ~~Z~~ D — Inspection, small intestine, using endoscopic per orifice approach (or via stoma)
Substitute flow chart	**Chapter XI** **Page 141**	Replace the flow chart on pages 141 and 142 with the flow chart which is attached.
Revise last example—add code, code type and code title	**Chapter XV** **Page 170**	***Example:*** O64.001 (M) Obstructed labor due to incomplete rotation of fetal head, delivered with or without mention of antepartum condition O66.401 (1) Other obstructed labor, failed trial of labor following previous cesarean Z37.0 (3) Outcome of delivery, single live birth

Instruction	Chapter and Page Affected	Coding Standards Entries
Revise last example—change second code and code title	**Chapter XV** **Page 172**	***Example:*** Ms. J is a primipara. She presents to hospital in labor. After 20 hours of labor her obstetrician recommends that they proceed to cesarean section because her cervix remains at 6 cm dilation. She delivered a healthy baby girl by cesarean section. O63.001 (M) Prolonged first stage (labor), delivered, with or without mention of antepartum condition ~~O62.001 (1) Primary indadequate contractions, delivered, with our without mention of antepartum condition~~ O62.101 (1) Secondary uterine inertia, delivered, with or without mention of antepartum condition Z37.0 (1) (3) Outcome of delivery, single live birth
Revise directive—alter term in second statement	**Chapter XVI** **Page 181**	**Assign any other code(s), additionally, to identify “light” or “small” for gestational age (P05.9 *Slow fetal growth, unspecified)* and prematurity (P07.2 *Extreme immaturity* or P07.3 *Other preterm infants)*.**
Revise directive—change wording of first statement	**Chapter XIX** **Page 201**	**When a ~~burn qualifies as a significant injury~~ code from T20- T29 is assigned, assign a mandatory additional code, as a comorbid diagnosis type, from the category:**

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Revise example—change first code and code title	**Chapter XIX** **Page 216**	***Example:*** T84.8 (M) Other complications of internal orthopedic prosthetic devices, implants and grafts NEC M25.55 (3) Pain in joint, pelvic region and thigh (optional code) Y83.1 (9) Surgical operation with implant of artificial internal device as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure (required code) —
Revise example—change second code and code title	**Chapter XIX** **Page 225**	***Example:*** Patient was admitted to hospital for an abdominal hysterectomy. During the intervention, a hemorrhage occurred, documented on the operative report as substantial and with an estimated blood loss of 800 cc. Hemorrhage was controlled and patient stabilized: the intervention was completed without further incident. T81.0 (2) Hemorrhage and hematoma complicating a procedure, not elsewhere classified ~~Y83.6~~ ~~(9)~~ ~~Removal of other organ (partial) (total) as the cause of abnormal reaction of the patient, or of later complication, without mention of misadventure at the time of the procedure~~ Unintentional cut, puncture, perforation or haemorrhage during surgical and medical care, during surgical operation Y60.0 (9)
Revise edit—delete last statement	**Appendix E—Classification Edits**	Diagnosis questionable as a Type 3 — 10 04 52 — Diagnosis codes T31 and T32 at the 3-digit level cannot be coded as diagnosis type 3. This is a warning message only. No change is made to the original data recorded on the abstract. ~~The data as originally recorded on the abstract appears under "Old Data".~~

Diagnostic Endoscopic Interventions Performed on the Lower Gastrointestinal Tract

Rubrics for use with this flowchart

2.NQ.70—Inspection, Rectum

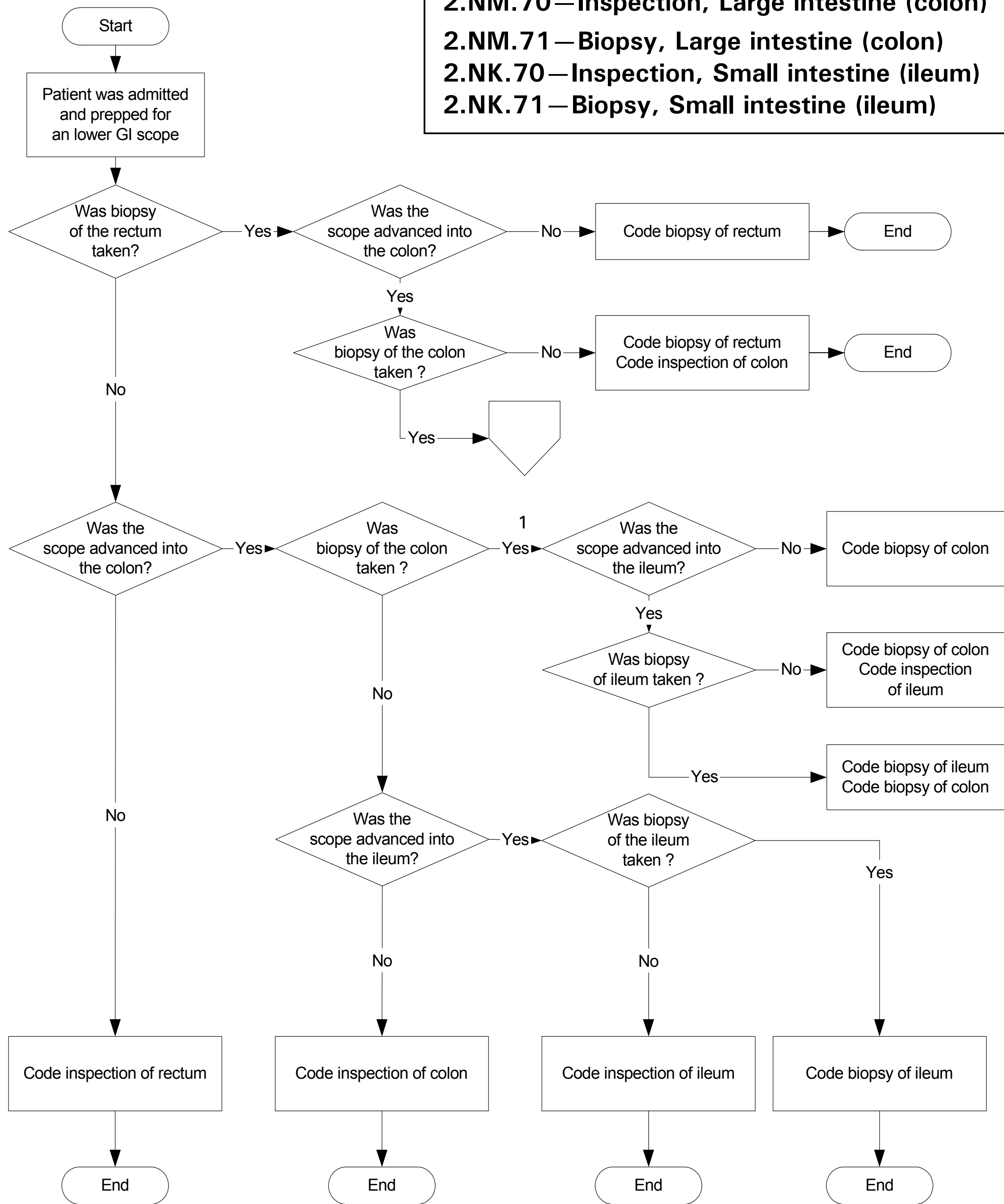
2.NQ.71—Biopsy, Rectum

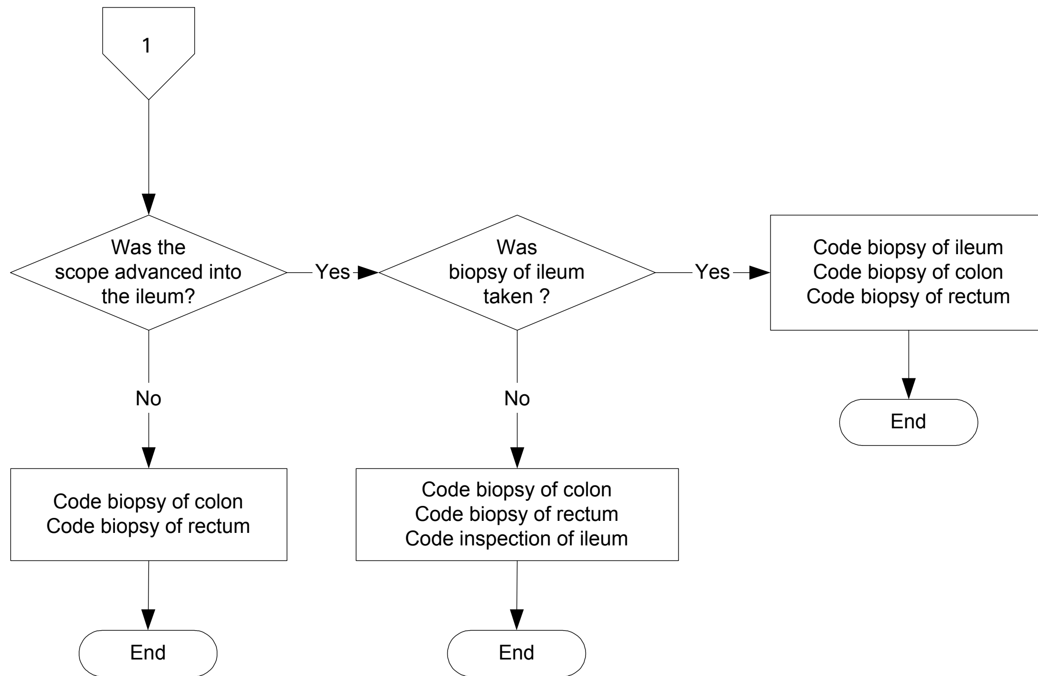
2.NM.70—Inspection, Large intestine (colon)

2.NM.71—Biopsy, Large intestine (colon)

2.NK.70—Inspection, Small intestine (ileum)

2.NK.71—Biopsy, Small intestine (ileum)




1
Was the scope advanced into the ileum?
Yes
No
Was biopsy of ileum taken ?
Yes
No
Code biopsy of ileum
Code biopsy of colon
Code biopsy of rectum
End
Code biopsy of colon
Code biopsy of rectum
End
Code biopsy of colon
Code biopsy of rectum
Code inspection of ileum
End