The most important thing a coder can do to prepare for coding rehabilitation cases in ICD-10-CM is to read the *ICD-10-CM Official Guidelines for Coding and Reporting*. The current version is for fiscal year 2016 and may be found at:


**ICD-10-CM Official Guidelines for Coding and Reporting FY 2016**

**Section II. Selection of Principal Diagnosis**

**K. Admissions/Encounters for Rehabilitation**

When the purpose for the admission/encounter is rehabilitation, sequence first the code for the condition for which the service is being performed. For example, for an admission/encounter for rehabilitation for right-sided dominant hemiplegia following a cerebrovascular infarction, report code I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, as the first-listed or principal diagnosis.

Also relevant to the coding of rehabilitation cases is knowledge of the following Guideline:

**Guideline I, C, 9, d,**

1. **Category I69, Sequelae of Cerebrovascular disease**

Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (neurologic deficits), themselves classified elsewhere. These “late effects” include neurologic deficits that persist after initial onset of conditions classifiable to categories I60-I67. The neurologic deficits caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition classifiable to categories I60-I67.

Codes from category I69, Sequelae of cerebrovascular disease, that specify hemiplegia, hemiparesis and monoplegia identify whether the dominant or nondominant side is affected. Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:

- For ambidextrous patients, the default should be dominant.

- If the left side is affected, the default is non-dominant.

- If the right side is affected, the default is dominant.

**Scenario 1:** A patient is discharged from the hospital and admitted to inpatient rehabilitation with a diagnosis of acute cerebral infarction with left-sided hemiparesis and dysphasia.

What does the coder know?

1. This is a rehabilitation admission.

2. The patient has hemiparesis secondary to an acute cerebral infarction. **I69.354**

3. The hemiparesis is on the patient’s left side without documentation of dominance, therefore the default is non-dominant.

4. The patient has dysphasia secondary to an acute cerebral infarction. **I69.321**
1, 2 and 3. This is a rehabilitation admission. The patient has hemiparesis secondary to an acute cerebral infarction. The hemiparesis is on the patient’s left side without documentation of dominance, therefore the default is non-dominant.

ICD-10-CM Index

- Hemiparesis — see Hemiplegia
- Hemiplegia G81.9-
- - following
- - - cerebrovascular disease I69.959
- - - - cerebral infarction I69.35-

ICD-10-CM Tabular

I69 Sequelae of cerebrovascular disease
  I69.3 Sequelae of cerebral infarction
    I69.35 Hemiplegia and hemiparesis following cerebral infarction
      I69.354 Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side

4 The patient has dysphasia secondary to an acute cerebral infarction.

ICD-10-CM Index

- Dysphasia R47.02
- - following
- - - cerebrovascular disease I69.921
- - - - cerebral infarction I69.321

ICD-10-CM Tabular

I69 Sequelae of cerebrovascular disease
  I69.3 Sequelae of cerebral infarction
    I69.32 Speech and language deficits following cerebral infarction
      I69.321 Dysphasia following cerebral infarction
The Guidelines continue with the following advice:

ICD-10-CM Official Guidelines for Coding and Reporting FY 2016

Section II. Selection of Principal Diagnosis

K. Admissions/Encounters for Rehabilitation (cont.)

If the condition for which the rehabilitation service is no longer present, report the appropriate aftercare code as the first-listed or principal diagnosis. For example, if a patient with severe degenerative osteoarthritis of the hip, underwent hip replacement and the current encounter/admission is for rehabilitation, report code Z47.1, Aftercare following joint replacement surgery, as the first-listed or principal diagnosis.

Scenario 2: Patient is admitted to rehabilitation with the following discharge diagnosis on the transfer sheet from the acute care facility: Osteoarthritis right knee, status post right total knee arthroplasty, difficulty walking.

What does the coder know?

1. This is a rehabilitation admission for a condition that no longer exists, therefore Aftercare. Z47.1
2. The patient has difficulty walking. R26.2
3. The patient had the right knee replaced. Z96.651

1 This is a rehabilitation admission for a condition that no longer exists, therefore Aftercare.

ICD-10-CM Index

- Aftercare (see also Care) Z51.89
- - following surgery (for) (on)
- - - joint replacement Z47.1

ICD-10-CM Tabular

Z47 Orthopedic aftercare

Z47.1 Aftercare following joint replacement surgery

Use additional code to identify the joint (Z96.6-)
2 The patient has difficulty walking.

ICD-10-CM Index

- Difficult, difficulty (in)
- - walking R26.2

ICD-10-CM Tabular

<table>
<thead>
<tr>
<th>R26</th>
<th>Abnormalities of gait and mobility</th>
</tr>
</thead>
<tbody>
<tr>
<td>R26.2</td>
<td>Difficulty in walking, not elsewhere classified</td>
</tr>
</tbody>
</table>

3 The patient had the right knee replaced.

ICD-10-CM Index

- Presence (of)
- - knee-joint implant (functional) (prosthesis) Z96.65-

ICD-10-CM Tabular

<table>
<thead>
<tr>
<th>Z96</th>
<th>Presence of other functional implants</th>
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<tr>
<td>Z96.6</td>
<td>Presence of orthopedic joint implants</td>
</tr>
<tr>
<td>Z96.65</td>
<td>Presence of artificial knee joint</td>
</tr>
<tr>
<td>Z96.651</td>
<td>Presence of right artificial knee joint</td>
</tr>
</tbody>
</table>

Finally we have the following from the Guidelines:

*ICD-10-CM Official Guidelines for Coding and Reporting FY 2016*

**I. C. 19. c. Coding of Traumatic Fractures**

1) **Initial vs. Subsequent Encounter for Fractures**

The aftercare Z codes should not be used for aftercare for traumatic fractures. For aftercare of a traumatic fracture, assign the acute fracture code with the appropriate 7th character.
Scenario 3: A patient is admitted to inpatient rehabilitation (following hospital treatment of a traumatic fracture of the right femur (ORIF)) for debility and gait training.

What does the coder know?

1. This is a rehabilitation admission following a traumatic fracture of the right femur. \textit{S72.91xD}
2. The patient is debilitated. \textit{R53.81}

1. This is a rehabilitation admission following a traumatic fracture of the right femur.

Note: The coder must be guided by documentation in the medical record of each individual case to make the correct code selections.