f. **Bacterial Sepsis of Newborn**

Category P36, Bacterial sepsis of newborn, includes congenital sepsis. If a perinate is documented as having sepsis without documentation of congenital or community acquired, the default is congenital and a code from category P36 should be assigned. If the P36 code includes the causal organism, an additional code from category B95, Streptococcus, Staphylococcus, and Enterococcus as the cause of diseases classified elsewhere, or B96, Other bacterial agents as the cause of diseases classified elsewhere, should not be assigned. If the P36 code does not include the causal organism, assign an additional code from category B96. If applicable, use additional codes to identify severe sepsis (R65.2-) and any associated acute organ dysfunction.

g. **Stillbirth**

Code P95, Stillbirth, is only for use in institutions that maintain separate records for stillbirths. No other code should be used with P95. Code P95 should not be used on the mother’s record.

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, malformation/deformation/or chromosomal abnormality may not be identified until later in life. Whenever the condition is diagnosed by the physician, 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.