



ICD-10 for Cardiology

UConn Health



Just himagine what we can accomplish together.

Introductions

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Agenda

- After attending this session, participants will be able to:
 - Describe the challenges associated with ICD-10 implementation
 - Identify documentation standards necessary for complete and accurate code assignment
 - Identify the importance of physician documentation and coding
 - Discuss the importance behind the query writing process and Physician response.



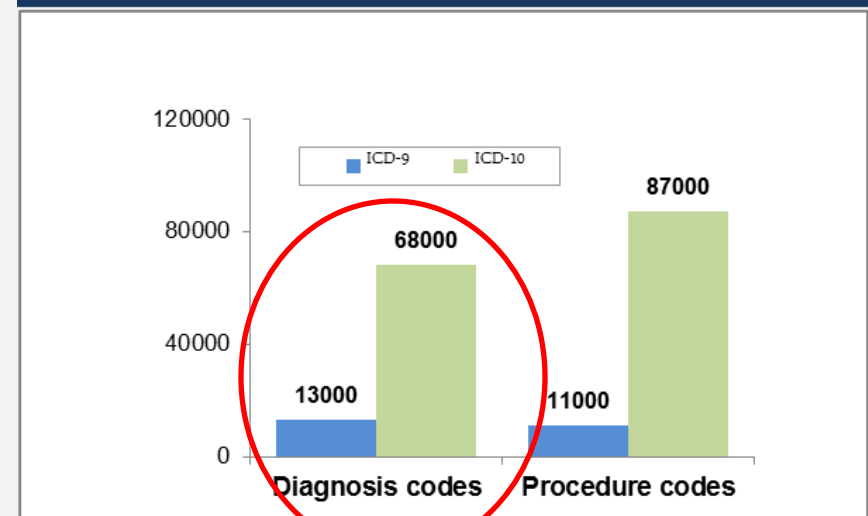
Changes to Diagnosis Codes

The most significant difference between ICD 9 and ICD 10 is the size and composition of the new codes

- ICD 9 is five digits where ICD 10 is 7 alphanumeric characters
- Re-structured classification
- Specificity and detail have been expanded

ICD 10 better describes acuity, complexity and laterality of the patients under your care

Number of ICD 9 and ICD 10 codes for diagnoses and procedures



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

Considerations

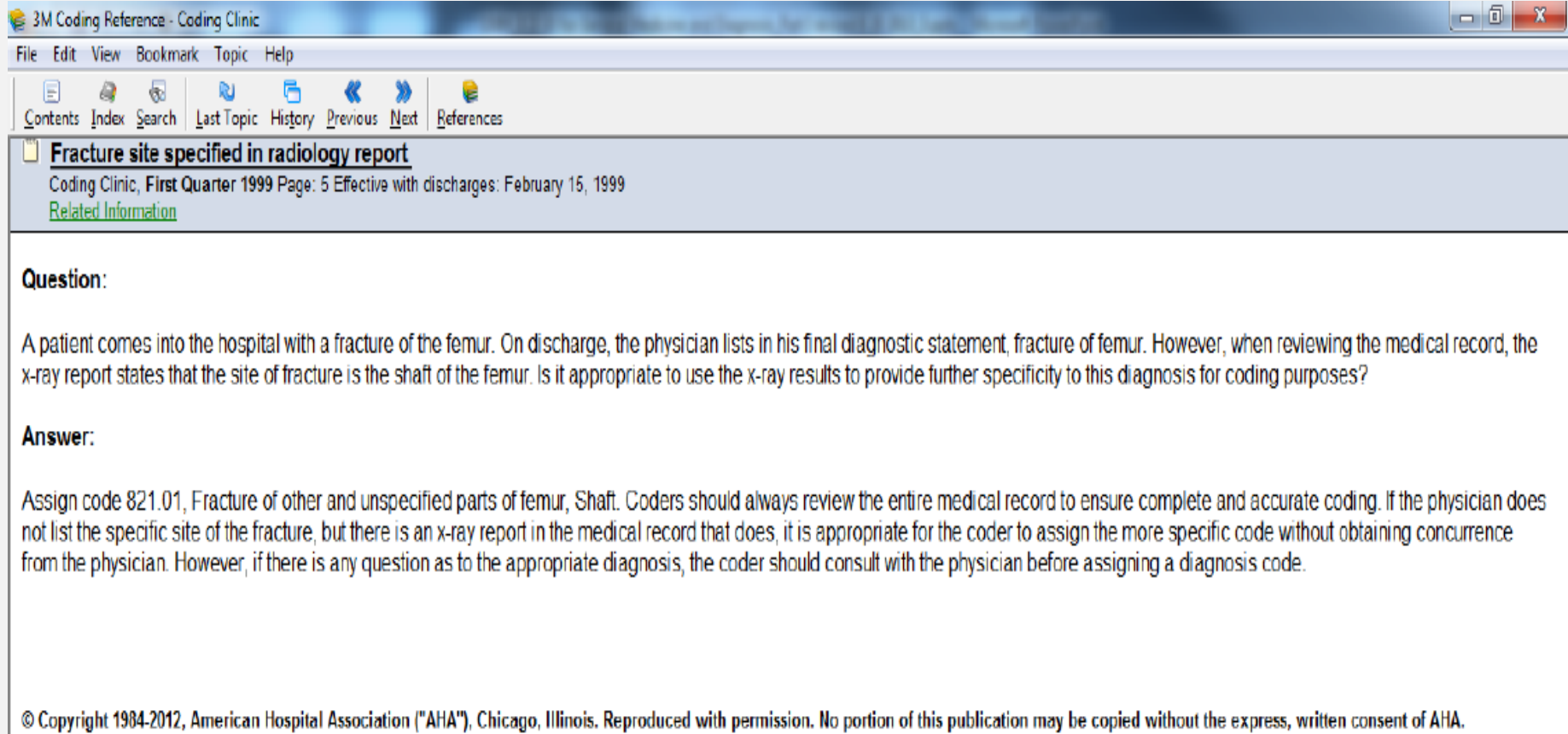
- ICD-10 requires collaboration, collaboration and more collaboration between all members of the clinical and non-clinical healthcare team:
 - Education of CDI/coder staff
 - Template revisions
 - Query revisions



Challenges

- ICD-10 is a classification system, not a clinical language system:
 - Physician documentation - primarily directed for communication between clinicians
 - Bridging gaps between coder classification language and physician clinical documentation

Challenges: Coding Specificity



3M Coding Reference - Coding Clinic

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Fracture site specified in radiology report

Coding Clinic, First Quarter 1999 Page: 5 Effective with discharges: February 15, 1999

[Related Information](#)

Question:

A patient comes into the hospital with a fracture of the femur. On discharge, the physician lists in his final diagnostic statement, fracture of femur. However, when reviewing the medical record, the x-ray report states that the site of fracture is the shaft of the femur. Is it appropriate to use the x-ray results to provide further specificity to this diagnosis for coding purposes?

Answer:

Assign code 821.01, Fracture of other and unspecified parts of femur, Shaft. Coders should always review the entire medical record to ensure complete and accurate coding. If the physician does not list the specific site of the fracture, but there is an x-ray report in the medical record that does, it is appropriate for the coder to assign the more specific code without obtaining concurrence from the physician. However, if there is any question as to the appropriate diagnosis, the coder should consult with the physician before assigning a diagnosis code.

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Challenges

- Documentation by the physician of specific components of a particular classification (diagnosis code) is required:
 - Test results, labs, x-rays, EKGs, echo reports, path reports, studies performed for diagnosis are not sufficient documentation for classifying (coding) a disease/injury
 - Coders are only allowed to use physician documentation to classify a disease/injury or procedure



Documentation for Diagnosis

Requirements for Detailed Documentation for Diagnoses	
Acuity	Acute, chronic or both
Specific site	Femur trochanteric – apophyseal, greater trochanter, intertrochanteric, lesser trochanter
Laterality	Right, left, bilateral
Specific type of fractures	Displaced/non-displaced fractures, transverse, oblique, spiral, comminuted, segmental
Etiology of diagnosis	Fracture/dislocation due to – pathological, recurrent, fatigue, age-related, osteoporosis
Link must be established between manifestations and underlying diseases	Osteomalacia – puerperal, senile, due to malabsorption or malnutrition, aluminum bone disease, drug induced
Non-pressure skin ulcers	Site, laterality and depth of tissue involvement



Documentation for Diagnosis (cont.)

Requirements for Detailed Documentation for Diagnoses	
Complications of care	Intraoperative, postoperative, mechanical malfunctions, Infections (device vs. wound)
Injury details	Place of occurrence, activity causing the injury; accident details
Episode of care	Initial treatment, subsequent treatment (for routine or delayed healing), sequela
Drug reactions/interactions/adverse reactions	Poisoning (accidental/intentional/assault/undetermined), adverse effect, underdosing (due to financial hardship, age-related)
Degree of severity	Mild, moderate, severe, e.g., Malnutrition: mild, moderate, severe

Cardiology Diagnoses Documentation Examples



Top Diagnosis Codes

Cardiology- Diagnosis

794.31 - ABNORM ELECTROCARDIOGRAM
786.50 - CHEST PAIN NOS
427.89 - CARDIAC DYSRHYTHMIAS NEC
427.31 - ATRIAL FIBRILLATION
414.00 - CORONARY ATHEROSCLEROSIS OF UNSPECIFIED VESSEL
272.4 - HYPERLIPIDEMIA NEC/NOS
401.1 - BENIGN HYPERTENSION
786.09 - RESPIRATORY ABNORM NEC
401.9 - HYPERTENSION NOS
785.1 - PALPITATIONS
785.0 - TACHYCARDIA NOS
428.0 - CONGESTIVE HEART FAILURE
425.4 - PRIM CARDIOMYOPATHY NEC
780.2 - SYNCOPE AND COLLAPSE
424.1 - AORTIC VALVE DISORDER
V72.81 - PRE-OPERATIVE CARDIOVASCULAR EXAMINATION
250.00 - DM W/O MENTION OF COMP,TYPE II[NIDDM]
426.4 - RT BUNDLE BRANCH BLOCK
V58.69 - LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
424.0 - MITRAL VALVE DISORDER
443.9 - PERIPH VASCULAR DIS NOS
785.2 - UNDIAGNOSED CARDIAC MURMURS
278.02 - OVERWEIGHT
427.32 - ATRIAL FLUTTER
427.0 - PAROX ATRIAL TACHYCARDIA



Chest Pain - Documentation Improvement

Nonischemic Chest Pain

- Anterior chest wall
- Atypical
- Central
- Costochondral
- Musculoskeletal
- Noncardiac
- Pericardial
- Pleuritic
- Pleurodynia
- Precordial
- Retrosternal
- Substernal

Ischemic Chest Pain

- Angina equivalent (include symptoms)
- Angina of effort
- Angina pectoris
- Angina pectoris with documented spasm (angiospastic, Prinzmetal, spasm-induced, variant)
- Anginal syndrome
- Cardiac angina
- Coronary slow flow syndrome
- Impending myocardial infarction
- Intermediate coronary syndrome
- Myocardial chest pain
- Preinfarction syndrome
- Stable angina
- Stenocardia
- Unstable angina (accelerated, crescendo, de novo effort, worsening effort)

Nonischemic Chest Pain ICD-9

- 786.5 Chest pain
 - 786.50 Chest pain, unspecified
 - 786.51 Precordial pain
 - 786.52 Painful respiration
 - 786.59 Other



Nonischemic Chest Pain ICD-10 Code Examples

Nonischemic Chest Pain

R07 – Pain in throat and chest

R07.0 – Pain in throat

R07.1 – Chest pain on breathing

R07.2 – Precordial pain

R07.8 – Other chest pain

R07.81 – Pleurodynia

R07.82 – Intercostal pain

R07.89 – Other chest pain

R07.9 – Chest pain, unspecified

Ischemic Chest Pain ICD-10

- I20 - Angina Pectoris
 - I20.0 - Unstable angina
 - Accelerated angina
 - Crescendo angina
 - De novo effort angina
 - Intermediate coronary syndrome
 - Pre-infarction syndrome
 - Worsening effort angina
 - I20.1 - Angina pectoris with documented spasm
 - Angiospastic angina
 - Prinzmetal angina
 - Spasm-induced angina
 - Variant angina
 - I20.8 - Other forms of angina pectoris
 - Angina equivalent
 - Angina of effort
 - Coronary slow flow syndrome
 - Stenocardia
 - I20.9 - Angina pectoris, unspecified

Heart Failure

To properly classify heart failure in ICD-10-CM, physicians must specify the **acuity and type of coronary heart failure**:

- systolic/diastolic or a combination of both
- acute, chronic or acute on chronic
- Cardiac arrest is further delineated as:
 - Due to underlying cardiac condition
 - Other underlying condition
 - Cause unspecified
- Diastolic and systolic heart failure now use combination codes.
- “Congestive” is a non-essential modifier and is included in the classifications for both systolic and diastolic heart failure.
- Unspecified heart failure includes:
 - CHF (NOS)
 - Biventricular failure





Chronic Ischemic Heart Disease and Angina

To properly classify ischemic heart disease and angina, specify the **type of heart disease**:

- Unstable Angina
 - Accelerated
 - Crescendo
 - De novo effort
 - Intermediate coronary syndrome
 - Pre-infarction syndrome
 - Worsening effort
- Angina pectoris with documented spasm
 - Angiospastic angina
 - Prinzmetal angina
 - Spasm-induced angina
 - Variant angina





Chronic Ischemic Heart Disease and Angina

Documentation Requirements (cont'd)

- Other forms of angina pectoris
 - Angina equivalent
 - Angina of effort
 - Coronary slow flow syndrome
 - Stenocardia
- Angina pectoris, unspecified
 - Angina, NOS
 - Anginal syndrome
 - Cardiac angina
 - Ischemic chest pain



Heart Valve Disorders

To properly classify heart valve disorders in ICD-10-CM, physicians must specify rheumatic or non-rheumatic valve disease.

- Heart valve disorders are assumed to be non-rheumatic unless specific documentation exists to delineate "rheumatic" valve disease. This differs from ICD-10-CM from the 2012 draft revision in which valve disorders were assumed to be rheumatic unless documented as non-rheumatic. Of note, in ICD-9 CM the default was also "non-rheumatic".



Arrhythmia/Depolarization

To properly classify arrhythmia or depolarization in ICD-10-CM, specify the cause and type:

- Cardiac arrest due to:
 - Underlying cardiac condition
 - Other underlying condition
 - Cause unspecified
- Paroxysmal tachycardia:
 - Re-entry ventricular arrhythmia
 - Supraventricular tachycardia
 - Ventricular tachycardia
 - Unspecified



Arrhythmia/Depolarization

- Other cardiac arrhythmias:
 - Ventricular fibrillation/flutter
 - Atrial premature depolarization
 - Junctional premature depolarization
 - Ventricular premature depolarization
 - Other/unspecified depolarization
 - Sick sinus syndrome
 - Other specified/unspecified arrhythmia



Arrhythmia/Depolarization

- Atrial fibrillation
 - Paroxysmal
 - Chronic
 - Persistent
- Flutter
 - Typical
 - Atypical

If flutter / fib rhythm code both.

Note: Atrial fibrillation is further classified as paroxysmal, chronic, persistent and atrial flutter is further classified as typical and atypical. These are new classification terminology requiring documentation by providers and/or physicians for appropriate classifications of these conditions.



Atrial Fibrillation ICD-9

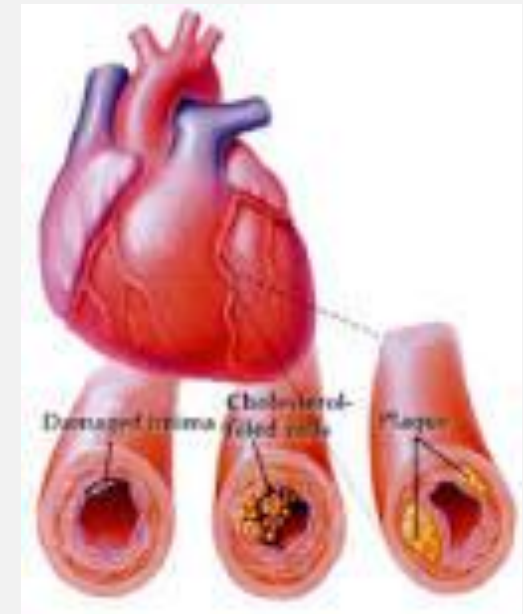
- 427.3 Atrial fibrillation and flutter
 - 427.31 Atrial fibrillation
 - 427.32 Atrial flutter

Atrial Fibrillation ICD-10

- I48 Atrial fibrillation and flutter
 - I48.0 Paroxysmal atrial fibrillation
 - I48.1 Persistent atrial fibrillation
 - I48.2 Chronic atrial fibrillation
 - I48.3 Typical atrial flutter
 - I48.4 Atypical atrial flutter
 - I48.9 Unspecified atrial fibrillation and atrial flutter
 - I48.91 Unspecified atrial fibrillation
 - I48.92 Unspecified atrial flutter

Coronary Heart Disease

- The classification of Coronary Artery Disease now includes that of:
 - Native coronary arteries
 - Coronary artery bypass grafts
 - Autologous veins or arteries
 - Nonautologous biological
 - Transplanted heart
 - With or without angina, unstable
 - With documented spasm



Coronary Atherosclerosis ICD-9

- 414.0 Coronary atherosclerosis
 - 414.00 Of unspecified type of vessel, native or graft
 - 414.01 Of native coronary artery
 - 414.02 Of autologous biological bypass graft
 - 414.03 Of non-autologous biological bypass graft
 - 414.04 Of artery bypass graft
 - 414.05 Of unspecified type of bypass graft
 - 414.06 Of native coronary artery of transplanted heart
 - 414.07 Of bypass graft (artery) (vein) of transplanted heart

CAD with Angina in ICD-10

- I25 – Chronic ischemic heart disease
 - I25.1 - **ASHD of native coronary artery**
 - I25.10 – without angina pectoris
 - I25.11 – with angina pectoris
 - I25.110 – with unstable angina
 - I25.111 – with documented spasm
 - I25.118 – with other forms of angina pectoris
 - I25.119 – with unspecified angina pectoris
 - I25.2 – Old MI
 - I25.3 – Aneurysm of heart
 - I25.4 – Coronary artery aneurysm and dissection
 - I25.41 – Aneurysm
 - I25.42 – Dissection
 - I25.5 – Ischemic cardiomyopathy
 - I25.6 – Silent myocardial ischemia

CAD with Angina in ICD-10

- I25 – Chronic ischemic heart disease
 - I25.7 - ASHD of bypass grafts and coronary artery of transplanted heart with angina pectoris
 - I25.70 – ASHD of bypass grafts, unspecified with angina pectoris
 - I25.700 – with unstable angina
 - I25.701 – with documented spasm
 - I25.708 – with other forms of angina pectoris
 - I25.709 – with unspecified angina pectoris
 - I25.71 – ASHD of autologous vein bypass graft with angina pectoris
 - I25.710 – with unstable angina
 - I25.711 – with documented spasm
 - I25.718 – with other forms of angina pectoris
 - I25.719 – with unspecified angina pectoris
 - I25.72 – ASHD of autologous artery bypass graft with angina pectoris
 - I25.720 – with unstable angina
 - I25.721 – with documented spasm
 - I25.728 – with other forms of angina pectoris
 - I25.729 – with unspecified angina pectoris

Coronary Artery Disease Scenario

Patient presents with chest pain and undergoes a cardiac catheterization. H&P documents a history of a CABG. The cardiac cath results show atherosclerosis of the right coronary artery with unstable angina.

Coronary Artery Disease

- With documentation of atherosclerosis of right coronary artery, history of CABG, scenario codes as:
 - I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris.
- If the documentation stated, “atherosclerosis of the internal mammary bypass graft”, scenario would code as:
 - I25.720 – Atherosclerotic heart disease of autologous artery bypass graft with unstable angina pectoris.

Palpitations ICD-9

- 785 Symptoms involving cardiovascular system
 - 785.0 Tachycardia, unspecified
 - 785.1 Palpitations
 - 785.2 Undiagnosed cardiac murmurs
Heart murmur NOS
 - 785.3 Other abnormal heart sounds
 - 785.4 Gangrene
 - 785.5 Shock without mention of trauma
 - 785.50 Shock, unspecified
 - 785.59 Other
 - 785.6 Enlargement of lymph nodes
 - 785.9 Other symptoms involving cardiovascular system

Palpitations ICD-10

- R00 Abnormalities of heart beat
 - R00.0 Tachycardia, unspecified
 - R00.1 Bradycardia, unspecified
 - **R00.2 Palpitations**
 - R00.8 Other abnormalities of heart beat
 - R00.9 Unspecified abnormalities of heart beat

Hyperlipidemia ICD-9

- 272 Disorders of lipid metabolism
 - 272.0 Pure hypercholesterolemia
 - 272.1 Pure hyperglyceridemia
 - 272.2 Mixed hyperlipidemia
 - 272.3 Hyperchylomicronemia
 - 272.4 Other and unspecified hyperlipidemia
 - 272.5 Lipoprotein deficiencies
 - 272.6 Lipodystrophy
 - 272.7 Lipidoses
 - 272.8 Other disorders of lipid metabolism
 - 272.9 Unspecified disorder of lipid metabolism

Hyperlipidemia ICD-10

- E78 Disorders of lipoprotein metabolism and other lipidemias
 - E78.0 Pure hypercholesterolemia
 - E78.1 Pure hyperglyceridemia
 - E78.2 Mixed hyperlipidemia
 - E78.3 Hyperchylomicronemia
 - E78.4 Other hyperlipidemia
 - E78.5 Hyperlipidemia, unspecified
 - E78.6 Lipoprotein deficiency
 - E78.7 Disorders of bile acid and cholesterol metabolism
 - E78.8 Other disorders of lipoprotein metabolism
 - E78.9 Disorder of lipid metabolism, unspecified

Hypertension ICD-9

- 401 Essential hypertension
 - 401.0 Malignant
 - 401.1 Benign
 - 401.9 Unspecified

Hypertension ICD-10

- **I10 Essential (primary) hypertension**
 - Includes high blood pressure, hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
 - Excludes hypertension complicating pregnancy and associated with end organ disease

Hypertension

- There is only one code for hypertension without manifestations (benign, malignant, essential, etc...) in ICD-10.
 - The code is I10
- Documentation is required for any relationship between hypertension and other diseases.
 - Hypertensive heart disease- I11
 - Hypertensive chronic kidney disease- I12

Debility ICD-9

- 799 Other ill-defined and unknown causes of morbidity and mortality
 - 799.0 Asphyxia and hypoxemia
 - 799.1 Respiratory arrest
 - 799.2 Signs and symptoms involving emotional state
 - **799.3 Debility, unspecified**
 - 799.4 Cachexia
 - 799.8 Other ill-defined conditions
 - 799.9 Other unknown and unspecified cause

Debility ICD-10

- R53 Malaise and fatigue
 - R53.0 Neoplastic (malignant) related fatigue
 - R53.1 Weakness
 - R53.2 Functional quadriplegia
 - R53.8 Other malaise and fatigue
 - R53.81 Other malaise
 - Includes debility NOS, chronic debility, general physical deterioration, malaise NOS, nervous debility
 - R53.82 Chronic fatigue, unspecified
 - R53.83 Other fatigue
- R54 Age-related physical debility
 - Includes frailty, old age, senescence, senile asthenia, senile debility

Fatigue ICD-9

- 780.7 Malaise and fatigue
 - 780.71 Chronic fatigue syndrome
 - 780.72 Functional quadriplegia
 - 780.79 Other malaise and fatigue

Fatigue ICD-10

- R53 Malaise and fatigue
 - R53.0 Neoplastic (malignant) related fatigue
 - R53.1 Weakness
 - R53.2 Functional quadriplegia
 - R53.8 Other malaise and fatigue
 - R53.81 Other malaise
 - R53.82 Chronic fatigue, unspecified
 - R53.83 Other fatigue
 - fatigue NOS, lack of energy, lethargy, tiredness

Routine General Medical Exam ICD-9

- V70 General medical examination
 - V70.0 General medical examination at a health care facility, excludes
 - Health checkup of infant/child >28 d/o (V20.2)
 - Health supervision of newborn 8-28 d/o (V20.32)
 - Health supervision of newborn under 8 d/o (V20.31)
 - Preprocedural general physical exam (V72.83)

Routine General Medical Exam ICD-10

- Z00 Encounter for general exam w/o complaint, suspected or reported diagnosis
 - Z00.0 **General adult medical exam**
 - Z00.00 without abnormal findings
 - Z00.01 with abnormal findings
 - Use additional code to identify abnormal findings
 - Z00.1 Newborn, infant and child health exams
 - Z00.2 Period of rapid growth in childhood
 - Z00.3 Adolescent development state
 - Z00.5 Potential donor of organ and tissue
 - Z00.6 Normal comparison and control in clinical research program
 - Z00.7 Delayed growth in childhood
 - Z00.8 Other general examination

Diabetes Mellitus ICD-9

- 250 Diabetes mellitus
 - 250.0 **Diabetes mellitus without mention of complication**
 - 250.00 **type II or unspecified type, not stated as uncontrolled**
 - 250.01 type I, not stated as uncontrolled
 - 250.02 type II or unspecified type, uncontrolled
 - 250.03 type I, uncontrolled
 - 250.1 Diabetes with ketoacidosis
 - 250.2 Diabetes with hyperosmolarity
 - 250.3 Diabetes with other coma
 - 250.4 Diabetes with renal manifestations
 - 250.5 Diabetes with ophthalmic manifestations
 - 250.6 Diabetes with neurological manifestations
 - 250.7 Diabetes with peripheral circulatory disorders
 - 250.8 Diabetes with other specified manifestations
 - 250.9 Diabetes with unspecified complication

Diabetes Mellitus ICD-10

- **E11 Type II diabetes mellitus, includes diabetes NOS**
 - E11.0 with hyperosmolarity
 - E11.2 with kidney complications
 - E11.3 with ophthalmic complications
 - E11.4 with neurological complications
 - E11.5 with circulatory complications
 - E11.6 with other specified complications
 - E11.8 with unspecified complications
 - **E11.9 without complications**



ICD-10-CM Changes for Diabetes

Condition	New in ICD-10-CM	Description of Change
Diabetes Mellitus (DM)	Poorly controlled, out of control, inadequately controlled and controlled are no longer used in ICD-10-CM	Diabetes must be described by type with hyperglycemia
Gestational Diabetes	Classified to insulin controlled, diet controlled, or puerperal in the OB chapter	If described as puerperal, the diet controlled or insulin controlled component must be described as well
Other specified complications of Diabetes	Expanded to include with neuropathic arthropathy, dermatitis and oral complication including periodontal disease	Documentation of complication relationships to diabetes continues to be an opportunity for improvement
Secondary Diabetes	Specify if due to underlying condition or drug or chemical induced	Documentation must reflect the underlying cause of the DM

Diabetes Mellitus: Complication and Manifestations

- Circulatory Complication
 - Document Manifestation
 - Peripheral angiopathy with/without gangrene
- Neurological Complication
 - Document Manifestation
 - Neuropathy
 - Mononeuropathy
 - Polyneuropathy
 - Autonomic (poly) neuropathy
 - Amyotrophy

Long-term Use of Medications ICD-9

- V58.6 Long-term (current) drug use
 - V58.61 anticoagulants
 - V58.62 antibiotics
 - V58.63 antiplatelets/antithrombotics
 - V58.64 NSAID
 - V58.65 steroids
 - V58.66 aspirin
 - V58.67 insulin
 - V58.69 other medications



Clinical Example: Documentation Improvement

Underdosing – new concept in ICD-10

- Taking less of a medication than prescribed by physician or manufacturer's instruction
 - Noncompliance
 - Complication of care

Underdosing – *Documentation Needed:*

- If a patient is purposely stopping or altering their medication regimen this needs to be documented to provided accurate coding

Obesity ICD-9

- 278 Overweight, obesity, and other hyperalimentation
 - 278.0 Overweight and obesity
 - 278.00 Obesity, unspecified (Obesity NOS)
 - 278.01 Morbid obesity
 - 278.02 Overweight

Obesity

- E66 Overweight and obesity
 - E66.0 Obesity due to excess calories
 - E66.01 Morbid (severe) obesity due to excess calories, excludes E66.2
 - E66.09 Other obesity due to excess calories
 - E66.1 Drug-induced obesity
 - E66.2 Morbid (severe) obesity with alveolar hypoventilation
 - E66.3 Overweight
 - E66.8 Other obesity
 - E66.9 Obesity, unspecified (Obesity NOS)

Cardiology Procedure Documentation Examples





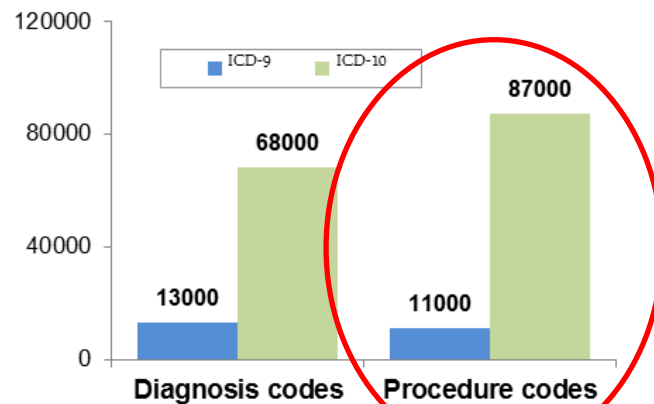
Overview of ICD-10-PCS

- Basic principles used when developing the system were that **no diagnostic information is included** in the procedure description (i.e., no codes for procedures exclusive to aneurysms, cleft lip, strictures or neoplasms, etc.).
- This procedure classification system is only utilized in the **inpatient hospital setting**.



ICD-10-PCS

Number of ICD 9 and ICD 10 codes for diagnoses and procedures



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

ICD-10 procedure codes will require additional and significant detail in surgical reporting

- Key ICD-10 characteristics
 - ICD-10 is a “dramatic departure” from current practice
 - Surgical codes lack decimals
 - The new code set will allow for incorporation of new procedures and technologies
 - Terminology is precisely defined and used consistently across all codes

ICD-10-PCS Chest Tube with Drainage

Patient presents for chest tube placement

ICD-10-PCS

0W9930Z

- Drainage of Right Pleural Cavity with Drainage Device, Percutaneous Approach



ICD-10-PCS Table

<i>Section</i>	0 Medical and Surgical		
<i>Body System</i>	W Anatomical Regions, General		
<i>Operation</i>	9 Drainage: Taking or letting out fluids and/or gases from a body part		
<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
0 Head 1 Cranial Cavity 2 Face 3 Oral Cavity and Throat 4 Upper Jaw 5 Lower Jaw 6 Neck 8 Chest Wall 9 Pleural Cavity, Right B Pleural Cavity, Left C Mediastinum D Pericardial Cavity F Abdominal Wall G Peritoneal Cavity H Retroperitoneum J Pelvic Cavity K Upper Back L Lower Back M Perineum, Male N Perineum, Female	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	0 Drainage Device	Z No Qualifier

Catheter Insertion into Vein

- Procedures require documentation of:
 - Specific vein where insertion performed
 - Right or left internal jugular vein
 - Right or left external jugular vein
 - Approach
 - Open
 - Percutaneous
 - Percutaneous endoscopic
 - Type of device
 - Infusion
 - intraluminal
 - Code examples
 - ICD-9 – 38.93 – venous catheterization.
 - ICD-10-PCS – 05HM33Z – Insertion, internal jugular vein right, percutaneous, infusion device.



Catheter Insertion

S <i>System</i>	0 Medical and Surgical
B <i>Body System</i>	2 Heart and Great Vessels
O <i>Operation</i>	H Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

<i>Body Part</i>	<i>Approach</i>	<i>Device</i>	<i>Qualifier</i>
4 Coronary Vein 6 Atrium, Right 7 Atrium, Left K Ventricle, Right L Ventricle, Left	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	0 Monitoring Device, Pressure Sensor 2 Monitoring Device 3 Infusion Device D Intraluminal Device J Cardiac Lead, Pacemaker K Cardiac Lead, Defibrillator M Cardiac Lead	Z No Qualifier
P Pulmonary Trunk Q Pulmonary Artery, Right R Pulmonary Artery, Left S Pulmonary Vein, Right T Pulmonary Vein, Left V Superior Vena Cava W Thoracic Aorta	0 Open 3 Percutaneous 4 Percutaneous Endoscopic	0 Monitoring Device, Pressure Sensor 2 Monitoring Device 3 Infusion Device D Intraluminal Device	Z No Qualifier



Reimagine Healthcare.

Physician Queries



Query...why?

A query is a communication tool used to clarify documentation in the health record for accurate code assignment.



The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query...when?

A query is written when the Health record Documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
 - Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
 - Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
 - Provides a diagnosis without underlying clinical validation
 - Is unclear for present on admission indicator assignment
- “A proper query process ensures that appropriate documentation appears in the health record”**

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query...when?

“A proper query process ensures that appropriate documentation appears in the health record”



Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query... answer how?

Queries are generated to elicit more information from the Provider.

- A response is ***necessary*** from the provider to fulfill this process.



- ***A. signature alone on a generated query does not fulfill this requirement***

Query... answer how?

Queries are generated in various formats depending on the information being requested:

- *Written response* format
 - Requesting provider to freehand a response
- *Multiple Choice* format
 - Requesting provider select one of the offered responses



Please sign, date and time Queries!

Query... answer how?

A Physician response, 'see notes' does not fulfill the request generated by the query.

- The coder has already reviewed the notes and Medical Record Documentation
- ***Although the response may seem 'obvious' coders are only 'reporters' of the medical record and *cannot code a diagnosis* that is *not documented by the Provider.****





Questions?

