March 2015

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Hospitalist

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Introductions

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ICD-10 Implementation Physician Advisor

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.

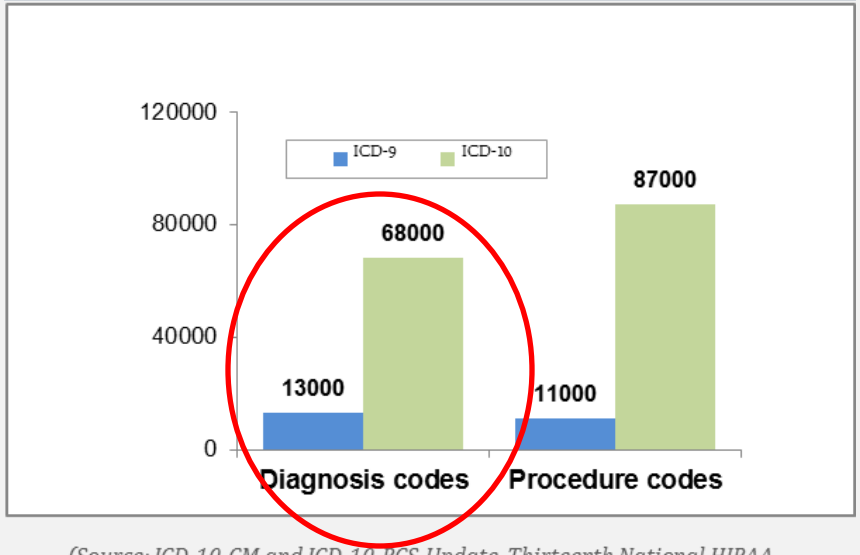
Changes to Diagnosis Codes

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)

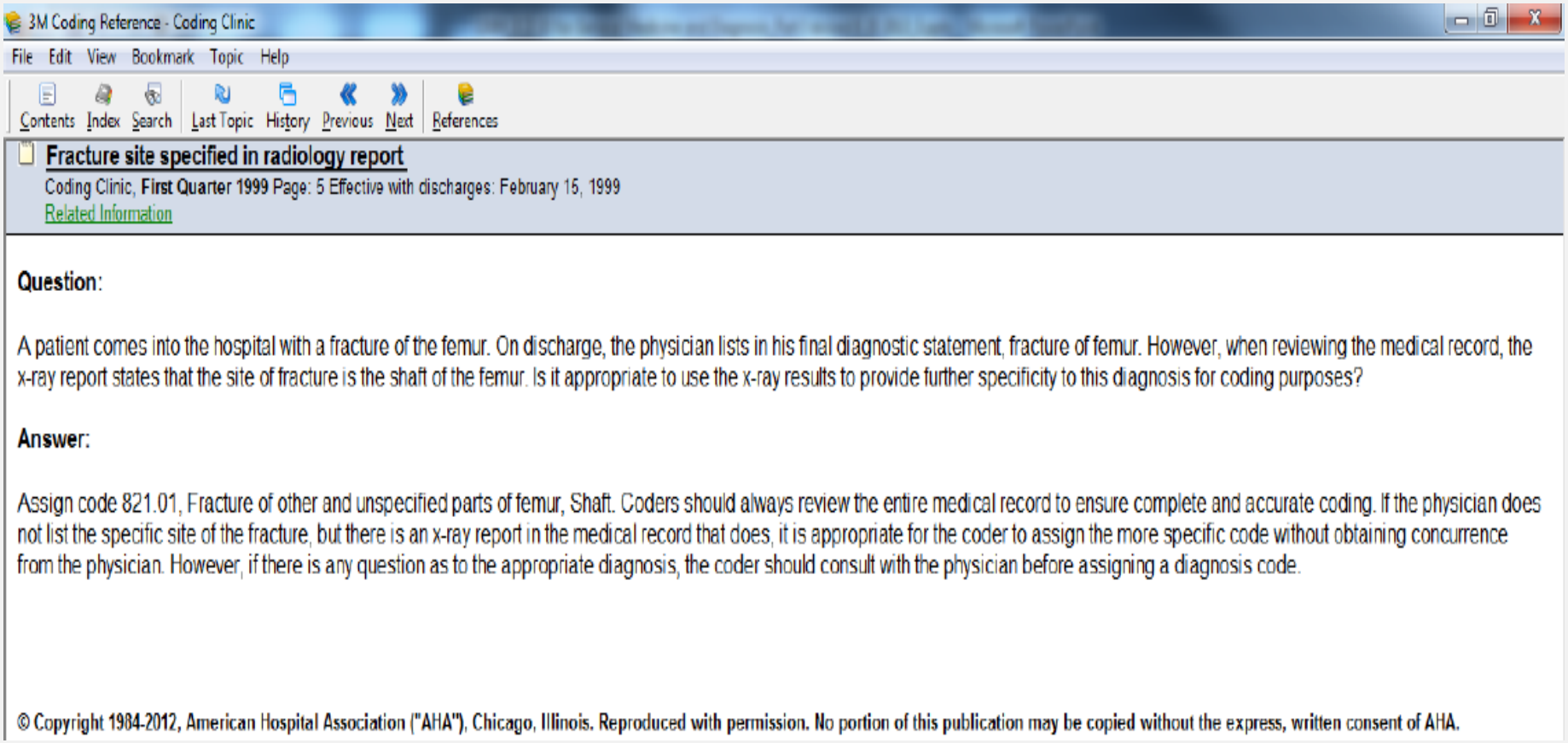
Considerations

- 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.

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

Future of Documentation

- This transition is NOT just for reimbursement for hospitals
- The data collection taking place over the next 2 years -- as well as 2 years following implementation -- will feed initiatives impacting:
  - Measurement of patient care outcomes
  - Quality of care initiatives
  - Healthcare policy development
  - Research related to profiling providers of healthcare
  - Pay for performance initiatives
  - Justifying medical necessity

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

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ICD-10 Hospitalist Diagnoses Documentation Examples

Clinical Examples – Documentation Improvement

Laterality

- ICD-10-CM introduces laterality to the diagnosis classification system. Many providers already document which side of the body the disease or injury occurred, but it is now a required data element with ICD-10-CM.

- **Over 5,000 diagnoses have a right and left distinction, such as:**
  - Joint pain/effusion
  - Pneumonia
  - Arthritis
  - Otitis Media

- The following are classification examples of when documentation of laterality is required:
  - M25.561 Pain in right knee
  - S52.521A Torus fracture of lower end of right radius
  - 89.011 Pressure ulcer of the right elbow, stage 1

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

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

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 lipoid metabolism
  - 272.9 Unspecified disorder of lipoid 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 lipoid metabolism, unspecified

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

Clinical Examples – Documentation Improvement

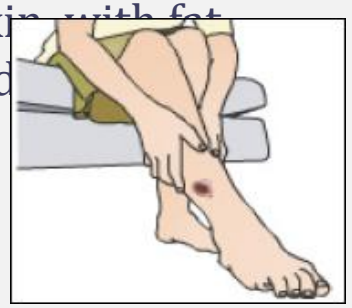
Documentation Requirements

- Relationship of conditions to diabetes must be documented if known by the attending physician
- An assumption of relationship cannot be made without documentation, and a query to the attending physician would be required
- Coders/CDI staff are not permitted to classify diseases from laboratory or vascular study results alone
- For inpatients: possible, probable and suspected conditions are coded as though they exist
- For outpatients: code only to the highest level of certainty

Pressure Ulcers

A patient is admitted with a chronic non-pressure ulcer of the leg.

- In ICD-9-CM Diagnosis, seven (7) codes specify the site of the lower limb.
- In ICD-10-CM, more than 100 codes are used to delineate:
  - Site of the chronic non-pressure ulcer
  - Laterality
  - Depth of ulcer of the lower limb (e.g., limited to breakdown of skin with fat layer exposed, with necrosis of muscle, with necrosis of bone and unspecified severity)



Pressure Ulcers ICD-10 Code Examples

Pressure Ulcers

L97.10 – Non-pressure chronic ulcer of unspecified thigh

L97.101 - Non-pressure chronic ulcer of unspecific thigh, limited to skin breakdown

L97.102 - Non-pressure chronic ulcer of unspecified thigh, with fat layer exposed

L97.103 – Non-pressure chronic ulcer of unspecified thigh, with necrosis of muscle

L97.104 – Non-pressure chronic ulcer of unspecified thigh, with necrosis of bone

L97.109 – Non-pressure chronic ulcer of unspecified thigh, with unspecified severity

Right, left, unspecified lower limbs with all the above complications are specified in ICD-10-CM

Backache ICD-9

- 724 Other and unspecified disorders of back
  - 724.0 Spinal stenosis, other than cervical
  - 724.1 Pain in thoracic spine
  - 724.2 Lumbago
  - 724.3 Sciatica
  - 724.4 Thoracic or lumbosacral neuritis or radiculitis
  - 724.5 Backache unspecified
  - 724.6 Disorders of sacrum
  - 724.7 Disorders of coccyx
  - 724.8 Other symptoms referable to back
  - 724.9 Other unspecified back disorders

Backache ICD-10

- M54 Dorsalgia
  - M54.0 Panniculitis affecting regions of neck and back
  - M54.1 Radiculopathy
  - M54.2 Cervicalgia
  - M54.3 Sciatica
  - M54.4 Lumbago with sciatica
  - M54.5 Low back pain
    - Includes Loin pain, Lumbago NOS
  - M54.6 Pain in thoracic spine
  - M54.8 Other dorsalgia
  - M54.9 Dorsalgia, unspecified

Correct Use of "R" (symptom) Codes

- Chapter 18. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)
  - Includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions.
  - Signs and symptoms pointing rather definitely to a given diagnosis have been assigned to a category in other chapters of the classification.
  - In general, categories in this chapter include the less well-defined conditions and symptoms that, without the necessary study of the case to establish a final diagnosis, point perhaps equally to two or more diseases or to two or more systems of the body.

Correct Use of "R" (symptom) Codes

- Chapter 18. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)
  - Cases for which no more specific dx can be made even after all facts bearing on the case have been investigated
  - Signs and symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined
  - Provisional diagnosis in a patient who failed to return for further investigation or care
  - Cases referred elsewhere for investigation or treatment before the diagnosis was made
  - Cases in which a more precise diagnosis was not available for any other reason
  - Certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right

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

Dysuria ICD-9

- 788 Symptoms involving urinary system
  - 788.0 Renal colic
  - 788.1 Dysuria
  - 788.2 Retention of urine
  - 788.3 Urinary incontinence
  - 788.4 Frequency of urination and polyuria
  - 788.5 Oliguria and anuria
  - 788.6 Other abnormality of urination
  - 788.7 Urethral discharge
  - 788.8 Extravasation or urine
  - 788.9 Other symptoms involving urinary system

Dysuria ICD-10

- R30 Pain associated with micturition
  - R30.0 Dysuria
  - R30.1 Vesical tenesmus (feeling of incomplete emptying after unination)
  - R30.2 Painful micturition, unspecified

- **[Painful micturition (dysuria, oliguria)].**
- [Article in German]
- Hochreiter W.
- **Source**
- Urologische Universitätsklinik, Inselspital, Bern.
- **Abstract**
- Painful micturition is one of the most common symptoms of urological diseases. The term "dysuria" is descriptive for micturition which the patient perceives as unpleasant.

Depression ICD-9

- 311 Depressive disorder, NEC
  - Includes
    - Depressive disorder NOS
    - Depressive state NOS
    - Depression NOS

Depression ICD-10

- F32 Major depressive disorder, single episode
  - F32.0 mild
  - F32.1 moderate
  - F32.2 severe without psychotic features
  - F32.3 severe with psychotic features
  - F32.4 in partial remission
  - F32.5 in full remission
  - F32.8 – Other depressive episodes
  - F32.9 unspecified includes Depression NOS, Depressive disorder NOS, Major depression NOS
- F33 Major depressive disorder, recurrent
  - F33.0 mild
  - F33.1 moderate
  - F33.2 severe without psychotic features
  - F33.3 severe with psychotic features
  - F33.4 in remission
    - F33.40 unspecified
    - F33.41 partial remission
    - F33.42 full remission
  - F33.8 other recurrent depressive disorders
  - F33.9 unspecified

Abdominal Pain ICD-9

- 789.0 Abdominal pain
  - 789.00 unspecified site
  - 789.01 RUQ
  - 789.02 LUQ
  - 789.03 RLQ
  - 789.04 LLQ
  - 789.05 periumbilic
  - 789.06 epigastric
  - 789.07 generalized
  - 789.09 other specific site
    - includes multiple sites

Abdominal Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.0 Acute abdomen
  - R10.1 Pain localized to upper abdomen
  - R10.2 Pelvic and perineal pain
  - R10.3 Pain localized to other parts of lower abdomen
  - R10.8 Other abdominal pain
  - R10.9 Unspecified abdominal pain

Abdominal Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.8 Other abdominal pain
    - R10.81 Abdominal tenderness
      - R10.811 RUQ
      - R10.812 LUQ
      - R10.813 RLQ
      - R10.814 LLQ
      - R10.815 Periumbilic
      - R10.816 Epigastric
      - R10.817 Generalized
      - R10.819 Unspecified site
    - R10.81 Rebound abdominal tenderness
      - R10.821 RUQ
      - R10.822 LUQ
      - R10.823 RLQ
      - R10.824 LLQ
      - R10.825 Periumbilic
      - R10.826 Epigastric
      - R10.827 Generalized
      - R10.829 Unspecified site
    - R10.83 Colic
    - R10.84 Generalized abdominal pain
  - R10.9 Unspecified abdominal pain

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

Colonoscopy/Prostate Screening ICD-9

- V76 Special screening for malignant neoplasms
  - V76.0 Respiratory organs
  - V76.1 Breast
  - V76.2 Cervix
  - V76.3 Bladder
  - V76.4 Other sites
    - V76.41 Rectum
    - V76.42 Oral cavity
    - V76.43 Skin
    - V76.44 Prostate
    - V76.45 Testis
    - V76.46 Ovary
    - V76.47 Vagina
    - V76.49 Other sites
  - V76.5 Intestine
    - V76.50 Intestine, unspecified
    - V76.51 Colon
    - V76.52 Small intestine
  - V76.8 Other neoplasm
  - V76.9 Unspecified

Colonoscopy/Prostate Screening ICD-10

- Z12 Encounter for screening for malignant neoplasms
  - Z12.0 stomach
  - Z12.1 intestinal tract
    - Z12.10 unspecified
    - Z12.11 colon
    - Z12.12 rectum
    - Z12.13 small intestine
  - Z12.2 respiratory organs
  - Z12.3 breast
  - Z12.4 cervix
  - Z12.5 prostate
  - Z12.6 bladder
  - Z12.7 other GU organ
  - Z12.8 other sites
  - Z12.9 site unspecified

Acquired Hypothyroidism ICD-9

- 244 Acquired hypothyroidism
  - 244.0 Postsurgical hypothyroidism
  - 244.1 Other postablative hypothyroidism
  - 244.2 Iodine hypothyroidism
  - 244.3 Other iatrogenic hypothyroidism
  - 244.8 Other specified acquired hypothyroidism
  - 244.9 Unspecified hypothyroidism

Acquired Hypothyroidism ICD-10

- E03 Other hypothyroidism
  - E03.0 Congenital hypothyroidism with diffuse goiter
  - E03.1 Congenital hypothyroidism w/o diffuse goiter
  - E03.2 Hypothyroidism due to medicaments and other exogenous substances
  - E03.3 Postinfectious hypothyroidism
  - E03.4 Atrophy of thyroid (acquired)
  - E03.5 Myxedema coma
  - E03.8 Other specified hypothyroidism
  - E03.9 Hypothyroidism, unspecified
    - Myxedema NOS

Iodine Deficiency Thyroid Disorder

- Iodine Deficiency Thyroid Disorder
  - Congenital Iodine-deficiency Disorder
    - Documentation requirement
      - Neurological type
      - Myxedematous type
      - Mixed type or
      - Unspecified
  - Iodine deficiency related thyroid disorder and allied conditions
    - Documentation requirements
      - Diffuse (endemic) goiter
      - Multinodular (endemic) goiter and
      - Endemic goiter unspecified

Hypothyroidism

- Congenital Hypothyroidism expanded to include:
  - With and without goiter
- Other (Acquired) hypothyroidism expanded to include:
  - Drug induced
  - Post infection
  - Atrophy
  - Myxedema coma

Thyroiditis/Hyperthyroidism

- Thyroiditis
  - Document acuity/underlying cause
    - Acute
    - Subacute
    - Chronic
    - Autoimmune
    - Drug induced
- Hyperthyroidism document:
  - Goiter/Nodule
    - Diffuse goiter
    - Toxic single thyroid nodule
    - Toxic multinodular goiter

Hypothyroidism Scenario

- Patient diagnosis
  - Hypothyroidism
  - Patient recently discontinued lithium due to history of bipolar depression
- Hypothyroidism (E03.9), unspecified coded

NOTE: Relationship of medications to disorders must be documented if known by the attending physician for reflection of appropriate patient acuity and quality of healthcare data. If determined to be drug related, code is E03.2.

Osteoarthritis

- Osteoarthritis
  - ICD-10-CM classifies Osteoarthritis by the following:
    - Generalized or specific site
    - Post-traumatic
    - Primary or secondary
  - Documentation must state the specific type or code will be for unspecified.

Osteoarthritis Scenario

Patient presents with osteoarthritis of the left knee known to be secondary to a traumatic injury. Admission note states that patient is admitted for a total knee replacement for osteoarthritis of the knee.

Osteoarthritis– Documentation Improvement

- If the documentation stated “post-traumatic osteoarthritis of the left knee”, scenario codes to:
  - M17.32 – unilateral post-traumatic osteoarthritis, left knee.

Chest Pain - Documentation Improvement

Nonischemic Chest Pain	Ischemic Chest Pain
• Anterior chest wall • Atypical • Central • Costochondral • Musculoskeletal • Noncardiac • Pericardial • Pleuritic • Pleurodynia • Precordial • Retrosternal • Substernal	• 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)

Nonishemic 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

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

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.

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

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
    - I25.73 – ASHD of nonautologus biological bypass grafts, w/ angina pectoris
      - I25.730 – with unstable angina
      - I25.731 – with documented spasm
      - I25.738 – with other forms of angina pectoris
      - I25.739 – with unspecified angina pectoris
    - I25.75 – ASHD of native coronary artery of transplanted heart w/ angina pectoris
      - I25.750 – with unstable angina
      - I25.751 – with documented spasm
      - I25.758 – with other forms of angina pectoris
      - I25.759 – with unspecified angina pectoris
    - I25.76 – ASHD of bypass graft of transplanted heart w/angina pectoris
      - I25.760 – with unstable angina
      - I25.761 – with documented spasm
      - I25.768 – with other forms of angina pectoris
      - I25.769 – with unspecified angina pectoris

CAD with Angina in ICD-10

- I25 – Chronic ischemic heart disease
  - I25.8 - ASHD of other coronary vessels without angina pectoris
    - I25.81 – ASHD of other coronary vessels , w/o angina pectoris
      - I25.810 – Bypass grafts, NOS
      - I25.811 – Native coronary artery of transplanted heart
      - I25.812 – Bypass graft of coronary artery of transplanted heart
      - I25.739 – with unspecified angina pectoris
    - I25.82 – Chronic total occlusion of coronary artery
    - I25.83 – Coronary atherosclerosis due to lipid rich plaque
    - I25.84 – Coronary atherosclerosis due to calcified coronary lesion
    - I25.89 – Other forms of chronic ischemic heart disease
  - I25.9 – Chronic ischemic heart disease, unspecified

Coronary Artery 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 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.

Acute Myocardial Infarction

- Acute phase changed from 8 to 4 weeks
- STEMI:
  - Specific site involvement:
    - Anterior
    - Inferior
    - Other/unspecified
  - Specific artery involvement:
    - Left main coronary artery
    - Left anterior descending coronary artery
    - Other coronary artery of anterior wall
    - Right coronary artery
    - Other coronary artery of inferior wall
    - Left circumflex coronary artery
- NSTEMI – No change

Acute Myocardial Infarction

- Part of the heart affected
  - Anterior wall
  - Inferior wall
  - Transmural
  - Apical-lateral
  - Basal-lateral
  - High lateral
  - Lateral
  - Posterior
  - Posterobasal
  - Posterolateral
  - Posteroseptal
  - Septal

Myocardial Infarction ICD-10 Code Examples

Myocardial Infarction

I21.0 ST elevation (STEMI) myocardial infarction of **anterior** wall

- I21.01 – ST elevation (STEMI) myocardial infarction involving **left main coronary artery**
- I21.02 – ST elevation (STEMI) myocardial infarction involving **left anterior descending** coronary artery
- I21.09 – ST elevation (STEMI) myocardial infarction involving **other coronary artery** of anterior wall

Acute Myocardial Infarction Scenario

- Patient diagnosed with acute STEMI
- Clinical/test results
  - EKG results show anterior wall injury and the cardiac cath shows a thrombus in the left main coronary artery
    - Specific site/artery must be documented by physician
    - Assumption by coders/CDI of test results to diagnosis is not permitted without physician documentation
    - I21.3 – AMI, site unspecified (without verification from physician documentation of clinical findings)

Sample of CDI Query for ICD-10 Specificity

Clarification for Specificity of an Acute Myocardial Infarction

Doctor:_____

Patient is admitted with excruciating chest pain radiating to the both arms and unrelieved by NTG, nausea and vomiting, hypotension, dizziness, shortness of breath. Patient is diagnosed with an Acute Myocardial Infarction (STEMI).

CDI notes clinical results including the following:

EKG results show anterior wall injury. Cardiac cath shows a thrombus in the left main coronary artery. Please specify injury site, as well as the specific coronary artery involved when known.

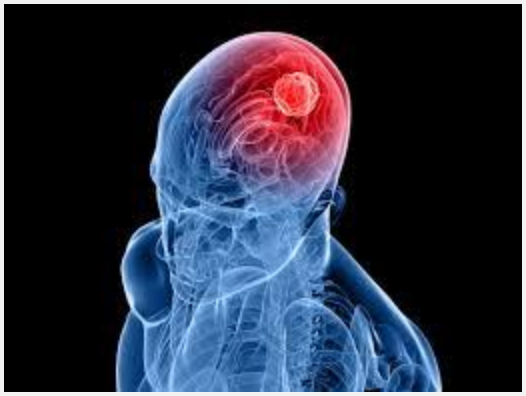
- ○ Anterior wall_____
  - Left main coronary artery
  - Left anterior descending coronary artery
  - Other coronary artery
- ○ Inferior wall_____
  - Right coronary artery
  - Other coronary artery
- ○ Other sites_____
  - Left circumflex coronary artery
  - Other
- ○ Unspecified site_____
- ○ Non-ST Elevation MI_____

Clinical Examples – Documentation Improvement

- Not synonymous with AMI
  - Troponin leak
  - Acute coronary syndrome
  - Acute ischemic heart disease
  - Acute coronary embolism/thrombosis
  - Acute coronary thromboembolism
- Provider documentation of AMI must be present

Cerebral Infarctions

- Cerebral Infarctions
  - ICD-10-CM classifies cerebral infarctions by the type of occlusion as well as the specific site.
    - Thrombosis
    - Embolism
    - Vertebral artery, left or right
    - Carotid artery, left or right
    - Cerebral artery, left or right
      - Middle
      - Anterior
      - Posterior



Cerebral Infarction Documentation Improvement

- Hemiplegia and monoplegia following cerebral infarction now include the classification of whether the right or left, dominant or non-dominant side was affected.

Cerebral Infarction Scenario

- Patient presents with dizziness and headache that have been going on for 2 weeks. Emergency physician sends patient for a CT scan and they are admitted with a diagnosis of cerebral infarction.

Cerebral Infarction Documentation Improvement

- If documentation specifies “cerebral infarction due to thrombosis of right middle cerebral artery”, scenario codes as:
  - I63.311 – Cerebral infarction due to thrombosis of right middle cerebral artery

Cerebral Infarction ICD-10 Codes

- I63.30 – Cerebral infarction due to thrombosis of unspecified cerebral artery
- I63.31 – Cerebral infarction due to thrombosis of **middle** cerebral artery
  - I63.311 – Cerebral infarction due to thrombosis of **right middle** cerebral artery
  - I63.312 – Cerebral infarction due to thrombosis of **left middle** cerebral artery
  - I63.319 – Cerebral infarction due to thrombosis of **unspecified middle** cerebral artery
- I63.32 – Cerebral infarction due to thrombosis of anterior cerebral artery

Cerebral Infarction ICD-10 Codes

- I69.35 – Hemiplegia and hemiparesis following cerebral infarction
  - I69.351 – hemiplegia and hemiparesis following cerebral infarction affecting **right dominant side**
  - I69.352 – hemiplegia and hemiparesis following cerebral infarction affecting **left dominant side**
  - I69.353 – hemiplegia and hemiparesis following cerebral infarction affecting **right non-dominant side**
  - I69.354 – hemiplegia and hemiparesis following cerebral infarction affecting **left non-dominant side**
  - I69.359 – hemiplegia and hemiparesis following cerebral infarction affecting **unspecified side**

Acute Respiratory Failure ICD-9

- 518.8 Other diseases of lung
  - 518.81 Acute respiratory failure
    - Respiratory failure NOS

Acute Respiratory Failure ICD-10

- J96 Respiratory failure, NEC

  Excludes respiratory arrest (RO9.2)

  - J96.0 Acute respiratory failure
    - J96.00 unspecified whether with hypoxia or hypercapnia
    - J96.01 with hypoxia
    - J96.02 with hypercapnia
  - NOTE: Respiratory failure must be documented as “acute” to be classified here. If respiratory failure is unspecified, default is “unspecified” respiratory failure (in ICD-9-CM, unspecified respiratory failure defaulted to “acute”)

Smoking ICD-9

- 305 Nondependent abuse of drugs

  Note: Includes cases where a person, for whom no other diagnosis is possible, has come under medical care because of the maladaptive effect of a drug on which he is not dependent and that he has taken on his own initiative to the detriment of his health or social functioning.
  - 305.0 Alcohol abuse
  - 305.1 Tobacco use disorder
  - 305.2 Cannabis abuse…..

Smoking ICD-10

- Z72 Problems related to lifestyle
  - Z72.0 Tobacco use
    - Excludes hx tobacco dependence, use in pregnancy
- F17.2 Nicotine dependence
  - F17.21 Nicotine dependence, cigarettes

Smoking ICD-10

- F17.2 Nicotine dependence
  - F17.20 Nicotine dependence, Unspecified
    - F17.200 – Uncomplicated
    - F17.201 – In remission
    - F17.203 – With withdrawal
    - F17.208 – With other nicotine-induced disorders
    - F17.209 – With unspecified nicotine-induced disorders
  - F17.21 Nicotine dependence, cigarettes
    - F17.210 – Uncomplicated
    - F17.211 – In remission
    - F17.213 – With withdrawal
    - F17.218 – With other nicotine-induced disorders
    - F17.219 – With unspecified nicotine-induced disorders
  - F17.29 Nicotine dependence, other tobacco products
    - F17.290 – Uncomplicated
    - F17.291 – In remission
    - F17.293 – With withdrawal
    - F17.298 – With other nicotine-induced disorders
    - F17.299 – With unspecified nicotine-induced disorders

COPD ICD-9

- 490 Bronchitis (not specified as acute or chronic)
- 491 Chronic bronchitis
  - 491.0 Simple chronic bronchitis
  - 491.1 Mucopurulent chronic bronchitis
  - 491.2 Obstructive chronic bronchitis
    - 491.20 without exacerbation
    - 491.21 with (acute) exacerbation
    - 491.22 with acute bronchitis
  - 491.8 Other chronic bronchitis
  - 491.9 Unspecified chronic bronchitis
- 492 Emphysema
- 493 Asthma
- 494 Bronchiectasis
- 495 Extrinsic allergic alveolitis
- 496 Chronic airway obstruction, NEC

COPD ICD-10

Chronic lower respiratory diseases (J40-J47)

- J40 Bronchitis (not specified as acute or chronic)
- J41 Simple and mucopurulent chronic bronchitis
- J42 Unspecified chronic bronchitis
- J43 Emphysema
- J44 Other COPD, includes
  - J44.0 COPD acute lower respiratory infection
  - J44.1 COPD with (acute) exacerbation
  - J44.9 COPD, unspecified
- J45 Asthma
- J47 Bronchiectasis

COPD ICD-10

- J44 Other COPD, includes
  - Asthma with COPD
  - Chronic asthmatic (obstructive) bronchitis
  - Chronic bronchitis with airways obstruction
  - Chronic bronchitis with emphysema
  - Chronic emphysematous bronchitis
  - Chronic obstructive asthma
  - Chronic obstructive bronchitis
  - Chronic obstructive tracheobronchitis
  - J44.0 COPD acute lower respiratory infection
  - J44.1 COPD with (acute) exacerbation
  - J44.9 COPD, unspecified

Asthma ICD-9

- 493 Asthma
  - 493.0 Extrinsic asthma
  - 493.1 Intrinsic asthma
  - 493.2 Chronic obstructive asthma
  - 493.8 Other forms of asthma
  - 493.9 Asthma, unspecified
    - 493.90 unspecified
    - 493.91 with status asthmaticus
    - 493.92 with (acute) exacerbation

Asthma

- Classified by
  - Mild intermittent
  - Mild persistent
  - Moderate persistent
  - Severe persistent
  - Other and unspecified
- Each classification includes
  - Uncomplicated
  - Acute exacerbation
  - Status Asthmaticus
- Conditions not specified will be coded to unspecified

Asthma ICD-10

- J45 Asthma
  - J45.2 Mild intermittent asthma
    - J45.20 uncomplicated, NOS
    - J45.21 acute exacerbation
    - J45.22 status asthmaticus
  - J45.3 Mild persistent asthma
    - J45.30 uncomplicated, NOS
    - J45.31 acute exacerbation
    - J45.32 status asthmaticus
  - J45.4 Moderate persistent asthma
    - J45.40 uncomplicated, NOS
    - J45.41 acute exacerbation
    - J45.42 status asthmaticus
  - J45.5 Severe persistent asthma
    - J45.50 uncomplicated, NOS
    - J45.51 acute exacerbation
    - J45.52 status asthmaticus
  - J45.9 Other and unspecified asthma

Asthma ICD-10

- J45.9 Other and unspecified asthma
  - J45.90 – Unspecified asthma
    - J45.901 with (acute) exacerbation
    - J45.902 with status asthmaticus
    - J45.909 uncomplicated
  - J45.99 Other asthma
    - J45.990 Exercise induced bronchospasm
    - J45.991 Cough variant asthma
    - J45.998 Other asthma

Asthma Classifications in ICD-10

	Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent
Symptoms	2 or less days per week	More than 2 days per week	Daily	Throughout the day
Nighttime Awakenings	2 X's per month or less	3-4 X's per month	More than once per week but not nightly	Nightly
Rescue Inhaler Use	2 or less days per week	More than 2 days per week, but not daily	Daily	Several times per day
Interference With Normal Activity	None	Minor limitation	Some limitation	Extremely limited
Lung Function	FEV1 >80% predicted and normal between exacerbations	FEV1 >80% predicted	FEV1 60-80% predicted	FEV1 less than 60% predicted

Asthma

Scenario

- Patient presents with a history of extrinsic asthma. She is complaining of waking up a couple of nights per week coughing and uses her rescue inhaler on a daily basis. She is sent for a PFT to evaluate her lung volume.

Clinical Examples – Documentation Improvement

Documentation Requirements

- Physician (provider) must document if asthma is **moderate persistent or some other level. Clinical findings from lung function tests are insufficient** to appropriately classify a disease without physician (provider) documentation of the specific classification.
  - Unspecified Asthma is how disease is classified without further documentation of the specific type of Asthma
    - J45.90 – Unspecified Asthma

Pneumococcal Pneumonia ICD-9

- 481 Pneumococcal pneumonia
- 486 Pneumonia, organism unspecified

Pneumonia ICD-10

Influenza and pneumonia (J09-J18)

- J12 Viral pneumonia, NEC
- J13 Pneumonia due to S. pneumoniae
- J14 Pneumonia due to H. influenzae
- J15 Bacterial pneumonia, NEC
- J16 Pneumonia due to other infectious organisms, NEC
- J17 Pneumonia in diseases classified elsewhere
- J18 Pneumonia, unspecified organism

Anemia ICD-9

- 285 Other and unspecified anemias
  - 285.0 Sideroblastic anemia
  - 285.1 Acute posthemorrhagic anemia
  - 285.2 Anemia of chronic disease
  - 285.3 Antineoplastic chemotherapy induced anemia
  - 285.8 Other specified anemias
  - 285.9 Anemia, unspecified

Anemia ICD-10

- D62 Acute posthemorrhagic anemia

- D64 Other anemias
  - D64.0 Hereditary sideroblastic anemia
  - D64.1 Secondary sideroblastic anemia due to disease
  - D64.2 Secondary sideroblastic anemia due to drugs and toxins
  - D64.3 Other sideroblastic anemias
  - D64.4 Congenital dyserythropoietic anemia
  - D64.8 Other specified anemias
  - D64.9 Anemia, unspecified

Urinary Tract Infection ICD-9

- 599 Other disorders of urethra and urinary tract
  - 599.0 Urinary tract infection, site not specified
    - Use additional code to identify organism, such as E. coli

Urinary Tract Infection ICD-10

Other diseases of the urinary system (N30-N39)

- N30 Cystitis
  - N30.0 Acute cystitis
  - N30.1 Interstitial cystitis (chronic)
  - N30.2 Other chronic cystitis
  - N30.3 Trigonitis
  - N30.4 Irradiation cystitis
  - N30.8 Other cystitis
  - N30.9 Cystitis, unspecified
    - N30.90 without hematuria
    - N30.91 with hematuria
- N39 Other disorders of urinary system
  - N39.0 Urinary tract infection, site not specified
    - Use additional codes (B95-B97), to identify infectious agent

Clinical Examples – Documentation Improvement

RIFLE Criteria – Acute Renal Failure

Category	GFR Criteria	Urine Output Criteria
Risk	Increased creatinine ×1.5GFR decrease >25%	UO < 0.5 mL/kg/h × 6 hr
Injury	Increased creatinine ×2GFR decrease >50%	UO < 0.5 mL/kg/h × 12 hr
Failure	Increase creatinine ×3GFR decrease >75%	UO < 0.3 mL/kg/h × 24 hrAnuria × 12 hr
Loss	Persistent ARF = complete loss of kidney function >4 weeks	
ESKD	End-stage kidney disease (>3 months)	

Acute Renal Failure ICD-9

- 584 Acute kidney failure, includes ARF
  - 584.5 With lesion of tubular necrosis
  - 584.6 With lesion of renal cortical necrosis
  - 584.7 With lesion of renal medullary (papillary) necrosis
  - 584.8 With other specified pathological lesion in kidney
  - 584.9 Unspecified

Acute Renal Failure ICD-10

- N17 Acute kidney failure
  - N17.0 With tubular necrosis
  - N17.1 With acute cortical necrosis
  - N17.2 With medullary necrosis
  - N17.8 Other acute kidney failure
  - N17.9 Acute kidney failure, unspecified

Septicemia ICD-9

- 038 Septicemia
  - 038.0 Streptococcal septicemia
  - 038.1 Staphylococcal septicemia
  - 038.2 Pneumococcal septicemia
  - 038.3 Septicemia due to anaerobes
  - 038.4 Septicemia due to other gram-negative organisms
  - 038.8 Other specified septicemias
  - 038.9 Unspecified septicemia

Septicemia ICD-10

- A40 Streptococcal sepsis
- A41 Other sepsis
  - A41.0 Staphylococcus aureus
    - A41.01 – MSSA
    - A41.02 – MRSA
  - A41.1 Other specified staphylococcus
  - A41.2 Unspecified staphylococcus
  - A41.3 Hemophilus influenzae
  - A41.4 Anaerobes
  - A41.5 Other Gram-negative organisms
  - A41.8 Other specified sepsis
    - A41.81 Enterococcus
    - A41.89 Other specified sepsis
  - A41.9 Sepsis, unspecified organism

Septicemia ICD-10

Severe sepsis/organ dysfunction requires the use of an additional "R" code.

- R65.2 Severe sepsis
  - R65.20 Severe sepsis without septic shock
  - R65.21 Severe sepsis with septic shock

Gastro-esophageal Reflux ICD-9

- 530.8 Other specified disorders of esophagus
  - 530.81 Esophageal reflux
    - Includes gastroesophageal reflux
    - Excludes reflux esophagitis (530.11)
  - 530.82 Esophageal hemorrhage
  - 530.83 Esophageal leukoplakia
  - 530.84 Tracheoesophageal fistula
  - 530.85 Barrett's esophagus
  - 530.86 Infection of esophagostomy
  - 530.87 Mechanical complication of esophagostomy
  - 530.89 Other

Gastro-esophageal Reflux ICD-10

- K21 Gastro-esophageal reflux disease
  - K21.0 Gastro-esophageal reflux disease with esophagitis
  - K21.1 Gastro-esophageal reflux disease without esophagitis

Nausea with Vomiting ICD-9

- 787.0 Nausea and vomiting
  - 787.01 Nausea with vomiting
  - 787.02 Nausea alone
  - 787.03 Vomiting alone
  - 787.04 Bilious emesis

Nausea with Vomiting ICD-10

- R11 Nausea and vomiting
  - R11.0 Nausea
  - R11.1 Vomiting
    - R11.10 Vomiting, unspecified
    - R11.11 Vomiting, without nausea
    - R11.12 Projectile vomiting
    - R11.13 Vomiting of fecal matter
    - R11.14 Bilious vomiting
  - R11.2 Nausea with vomiting, unspecified

Dehydration ICD-9

- 276.5 Volume depletion
  - 276.50 Volume depletion, unspecified
  - 276.51 Dehydration
  - 276.52 Hypovolemia
- 276.6 Fluid overload
  - 276.61 – TACO (Transfusion assoc circ overload)
  - 276.69 – Other
- 276.7 Hyperpotassemia
- 276.8 Hypopotassemia
- 276.9 Electrolyte and fluid disorders NEC

Dehydration ICD-10

- E86.0 Volume depletion
  - E86.0 Dehydration
  - E86.1 Hypovolemia
    - Depletion of volume of plasma
  - E86.2 Volume depletion, unspecified

Hypokalemia ICD-9

- 276.5 Volume depletion
  - 276.50 Volume depletion, unspecified
  - 276.51 Dehydration
  - 276.52 Hypovolemia
- 276.6 Fluid overload
  - 276.61 – TACO (Transfusion assoc circ overload)
  - 276.69 – Other
- 276.7 Hyperpotassemia
- 276.8 Hypopotassemia
- 276.9 Electrolyte and fluid disorders NEC

Hypokalemia ICD-10

- Other disorders of fluid, electrolyte and acid-base balance
  - E87.0 Hyperosmolality and hypernatremia
  - E87.1 Hypo-osmolality and hyponatremia
  - E87.2 Acidosis
  - E87.3 Alkalosis
  - E87.4 Mixed disorder of acid-base balance
  - E87.5 Hyperkalemia
  - E87.6 Hypokalemia
  - E87.7 Fluid overload
  - E87.8 Other disorders of electrolyte and fluid balance, NEC

Encephalopathy ICD-9

- 348.3 Encephalopathy NEC
  - 348.30 Encephalopathy unspecified
  - 348.31 Metabolic encephalopathy
  - 348.39 Other encephalopathy

Encephalopathy ICD-10

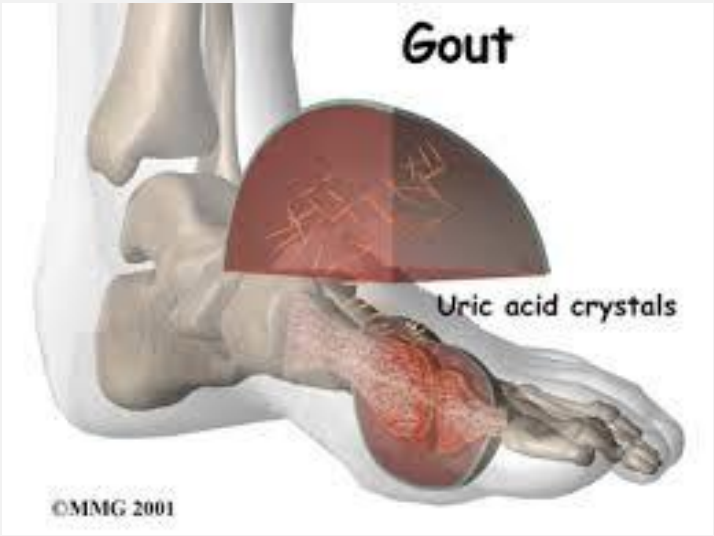
- G93 Other disorders of brain
  - G93.0 Cerebral cysts
  - G93.1 Anoxic brain damage NEC
  - G93.2 Benign intracranial hypertension
  - G93.3 Postviral fatigue syndrome
  - G93.4 Other and unspecified encephalopathy
    - G93.40 Encephalopathy, unspecified
    - G93.41 Metabolic encephalopathy
    - G93.49 Other encephalopathy
  - G93.5 Compression of brain
  - G93.6 Cerebral edema
  - G93.7 Reye's syndrome
  - G93.8 Other specified disorders of brain
    - G93.81 Temporal sclerosis
    - G93.88 Brain death
    - G93.89 Other specified disorders of brain
  - G93.9 Disorder of brain, unspecified

Pregnancy

- ICD-9-CM Diagnosis
  - 648.03 –Diabetes Mellitus in mother complicating pregnancy, antepartum.
- ICD-10-CM
  - O24.912 – Unspecified diabetes mellitus in pregnancy, second trimester.
- **The trimester or number of weeks in which the condition occurred should be coded from physician documentation.**
- It is also important to know whether the condition is pre-existing or not.

Gout – Documentation Improvement

- Document the type and site of the gout in order to get the most specific classification



Clinical Examples – Documentation Improvement

- Gout
  - Classifications include:
    - Acute
      - Idiopathic
      - Lead-induced
      - Drug-induced
      - Due to renal impairment
      - Other or unspecified
      - ***6th character for site***
    - Chronic
      - Idiopathic
      - Lead-induced
      - Drug-induced
      - Due to renal impairment
      - Other or unspecified- M10.9
      - ***6th character for site; 7th character for with or without tophus***

Gout ICD-10 Code Examples

Gout M10.0 – Idiopathic gout
- M10.00 – Idiopathic gout, unspecified site
- M10.01 – Idiopathic gout, shoulder
  - M10.011 – idiopathic gout, right shoulder
  - M10.012 – idiopathic gout, left shoulder
  - M10.019 – idiopathic gout, unspecified shoulder

M10.1 – Lead-induced gout
M10.2 – Drug-induced gout
M10.3 – Gout due to renal impairment
M10.4 – Other secondary gout
M10.9 – Gout, unspecified

Intraoperative/Postprocedural Complications

- When appropriate, specify disorders or complications as **directly related** to the procedure or surgery.
  - Intra-operative
  - Post-procedural
  - As well as whether or not it is related to a:
    - Cardiac procedure or
    - Other type of procedure
  - Specific conditions classified are:
    - Postcardiotomy syndrome
    - Postmastectomy lymphedema
    - Postprocedural hypertension
    - Hematoma/hemorrhage
    - Accidental laceration/puncture

Sprains and Strains– Documentation Improvement

- The ICD-10-CM classification of sprains includes specific ligaments as well as the laterality.
  - Ankle
    - Calcaneofibular
    - Deltoid
    - Tibiofibular
    - Other/unspecified
  - Toe
    - Interphalangeal joint
    - Metatarsophalangeal joint
    - unspecified
  - Foot
    - Tarsal ligament
    - Tarsometatarsal ligament

Injuries and Fractures

- ICD-10-CM relies more heavily on categorizing the episodes of care for injuries and illnesses. Detailed documentation is required, for example, for fractures:
  - Fracture codes in ICD-10 include greater specificity:
    - Type of fracture
    - Anatomical site
    - Displaced or not
    - Laterality

Fractures

- Classification also includes episodes of care (EOC):
  - Initial
  - Subsequent
  - Sequela
- Gustilo-Anderson grade is required for some open fractures utilizing a 7th character in the code. There are 10 EOC codes relating to this grading system which specify grade 1/2 or 3A/3B/3C for initial visit, routine healing, delayed healing, nonunion, and malunion.
- Fractures not indicated as open or closed will be classified as a closed fracture
- Fracture modifiers are “displaced” (default if not further specified) and “non-displaced”

Episodes of Care

Fractures in ICD-10-CM:

- Open Fracture of the Right Wrist, Initial Encounter - S62.101B

Character	
A	Initial Encounter/Closed Fracture
B	Initial Encounter/Open Fracture
D	Subsequent Encounter/Fracture Routine Healing
E	Subsequent Encounter for Open Fracture, Type I or II Routine Healing
G	Subsequent Encounter/Fracture Delayed Healing
K	Subsequent Encounter/Fracture Nonunion
P	Subsequent Encounter/Fracture Malunion
S	Sequela

Pathological Fractures

- ICD-10-CM introduces more specificity in the classification of pathological fractures due to osteoporosis.
  - Age related, includes
    - Senile
    - Post menopausal
  - Other, includes
    - Drug induced
    - Idiopathic
    - Post oophorectomy
    - Postsurgical malabsorption
    - Post traumatic

Open Wounds/Lacerations

Below is an example of the classification differences between ICD-9-CM Diagnosis and ICD-10-CM for an open wound or laceration of the thumb with a foreign body.

ICD-9-CM Diagnosis

- 883.1 Complicated open wound of the finger.

ICD-10-CM

- S61.021A Laceration with foreign body of right thumb without damage to nail, initial encounter.
- **Much more descriptive of the injury allowing for reflection of patient acuity, outcome/prognosis, evaluation as well as follow up expectations.**

Overweight & Obesity and Hyeralimentation

- Overweight and obesity
  - Documentation requirement if applicable:
    - Drug induced,
    - Alveolar hypoventilation
- Hyperalimentation
  - Documentation requirement
    - Hypervitaminosis A
    - Hypercarotinemia
    - Hypervitaminosis D
    - Other specified hyperalimentation
- Sequela of hyperalimentation

Overweight and Obesity ICD-10 Code Examples

Overweight and Obesity

E66.0 – Obesity due to excess calories

- E66.01 – Morbid(severe) obesity due to excess calories
- 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

BMI– Documentation Improvement

The BMI should also be documented and coded along with the obesity. These classifications are specific to adults or children.

- Z68.4 – Body mass index (BMI) 40 or greater, adult.
- Z68.41 – Body mass index (BMI) 40.0-44.9, adult.

Clinical Examples – Documentation Improvement

Crohn's Disease

- ***Classifications now include***
  - ***Without complications***
  - ***With complications***
    - Rectal bleeding
    - Intestinal obstruction
    - Fistula
    - Abscess
    - Other or unspecified

Crohn's Disease ICD-10 Code Examples

Crohn's Disease (sm. Intestine, large intestine, both, unspecified)

K50.0 – Crohn's disease of small intestine

- K50.00 – Crohn's disease of small intestine **without complications**
- K50.01 – Crohn's disease of small intestine **with complications**
  - K50.011 – Crohn's disease of small intestine with **rectal bleeding**
  - K50.012 – Crohn's disease of small intestine with **intestinal obstruction**
  - K50.013 – Crohn's disease of small intestine with **fistula**
  - K50.014 – Crohn's disease of small intestine with **abscess**
  - K50.018 – Crohn's disease of small intestine with **other complication**
  - K50.019 – Crohn's disease of small intestine with **unspecified complication**

Clinical Examples – Documentation Improvement

Documentation Requirements

- Physician (provider) must document if obstruction is **associated with or caused by the Crohn's disease.**
- **Clinical findings from colonoscopy or CT studies are insufficient** to appropriately classify a disease without physician (provider) documentation of specific cause and effect relationship.
  - Crohn's disease without complication is how disease is classified without further documentation of relationship between obstruction and Crohn's
    - Code K50.90 – Crohn's disease unspecified without complications

Clinical Examples – Documentation Improvement

Alcohol Abuse/Use

- ***Classifications include***
  - ***Uncomplicated***
  - ***Complications***
    - With intoxication
    - Delirium
    - Delusions
    - Hallucinations
    - Anxiety disorder
    - Sexual dysfunction
    - Sleep disorder
    - unspecified

Alcohol- Documentation Improvement

- Documentation Requirements
  - Physician (provider) must document whether the complication is associated with/due to the alcohol abuse.
  - Alcohol abuse uncomplicated is how disease is classified without further documentation of relationship between specified complication and the alcohol abuse.
    - F10.10 – Alcohol abuse, uncomplicated

Alcohol Abuse ICD-10 Code Examples

Alcohol Abuse

F10.10 – Alcohol abuse, uncomplicated

F10.12 – Alcohol abuse **with intoxication**

F10.14 – Alcohol abuse with **alcohol-induced mood disorder**

F10.15 – Alcohol abuse with **alcohol-induced psychotic disorder**

- F10.150 – alcohol abuse with **alcohol-induced psychotic disorder with delusions**
- F10.151 – alcohol abuse with **alcohol-induced psychotic disorder with hallucinations**
- F10.159 – alcohol abuse with **alcohol-induced psychotic disorder, unspecified**

F10.18 – Alcohol abuse with **other alcohol-induced disorder**

F10.19 – Alcohol abuse **with unspecified alcohol-induced disorder**

Underdosing

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

Underdosing

Underdosing of drugs specifies documentation of intentional or unintentional underdosing:

- Intentional underdosing
  - Due to financial hardship
  - Other reasons
- Unintentional underdosing
  - Age-related debility
  - Other reasons

Separate "Z" code that is submitted alongside the code for underdosing.

Underdosing

- These codes also require a 7th character to identify whether this is:
  - **A**: Initial encounter – when the patient is receiving active treatment/first visit by that physician
  - **D**: Subsequent encounter – after the active phase of treatment and when the patient is receiving repeat or routine care for the injury.
  - **S**: Sequela is assigned for complication or condition that arises as a direct result of an injury (takes priority for code- if no sequelae, code initial or subsequent)

Influenza Vaccine ICD-9

- V04 Need for prophylactic vaccination and innoculation against certain diseases (also separate procedure code)
  - V04.0 Poliomyelitis
  - V04.1 Smallpox
  - V04.2 Measles alone
  - V04.3 Rubella alone
  - V04.4 Yellow fever
  - V04.5 Rabies
  - V04.6 Mumps alone
  - V04.7 Common cold
  - V04.8 Other viral diseases
    - V04.81 Influenza
    - V04.82 RSV
    - V04.89 Other viral diseases

Influenza Vaccine ICD-10

- Z23 Encounter for immunization
  - Code 1st any routine childhood examination
  - NOTE – Procedure codes are required to identify the types of immunizations given

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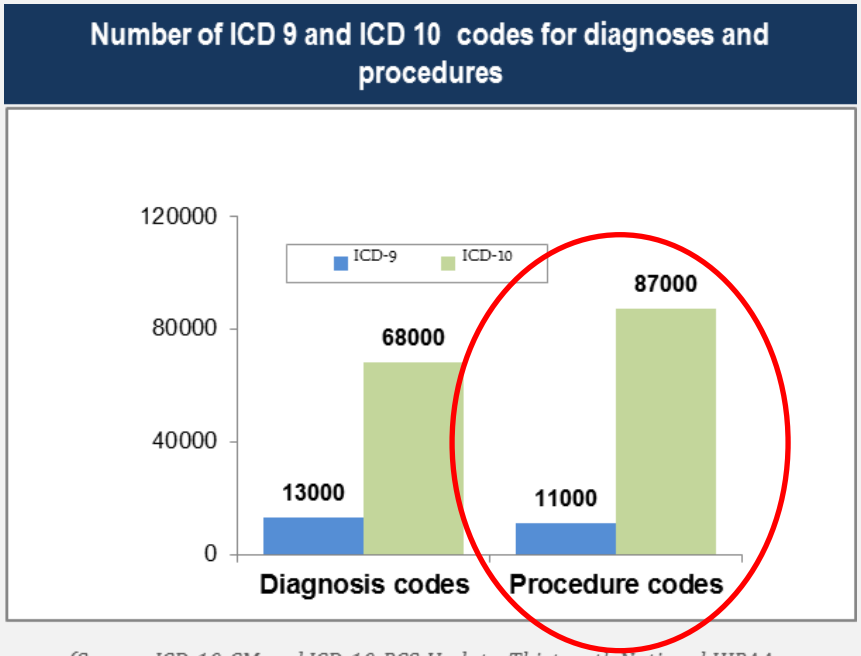
ICD-10-PCS

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



(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 Lumbar Puncture

Patient presents lumbar puncture to rule out meningitis

ICD-10-PCS

009U3ZX

- Drainage of Spinal Canal, Percutaneous Approach, Diagnostic

ICD-10-PCS Table

Section	**0**	Medical and Surgical
Body System	**0**	Central Nervous System
Operation	**9**	Drainage: Taking or letting out fluids and/or gases from a body part

Body Part	*Approach*	*Device*	*Qualifier*
0 Brain **1** Cerebral Meninges **2** Dura Mater **3** Epidural Space **4** Subdural Space **5** Subarachnoid Space **6** Cerebral Ventricle **7** Cerebral Hemisphere **8** Basal Ganglia **9** Thalamus **A** Hypothalamus **B** Pons **C** Cerebellum **D** Medulla Oblongata **F** Olfactory Nerve **G** Optic Nerve **H** Oculomotor Nerve **J** Trochlear Nerve **K** Trigeminal Nerve **L** Abducens Nerve **M** Facial Nerve **N** Acoustic Nerve **P** Glossopharyngeal Nerve **Q** Vagus Nerve **R** Accessory Nerve **S** Hypoglossal Nerve **T** Spinal Meninges **U** Spinal Canal **W** Cervical Spinal Cord **X** Thoracic Spinal Cord **Y** Lumbar Spinal Cord	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier

ICD-10-PCS Lumbar Puncture

1st	2nd	3rd	4th	5th	6th	7th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	0	9	U	3	Z	X

The ICD-10-PCS code structure tells a story

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

Section	**0**	Medical and Surgical
Body System	**W**	Anatomical Regions, General
Operation	**9**	Drainage: Taking or letting out fluids and/or gases from a body part

Body Part	*Approach*	*Device*	*Qualifier*
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

Section	**0** Medical and Surgical		
Body System	**2** Heart and Great Vessels		
Operation	**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		
Body Part	*Approach*	*Device*	*Qualifier*
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

Infusion of Chemotherapy

- Procedures require documentation of:
  - Body part where infusion took place
    - Peripheral vein/artery
    - Central vein/artery
  - Approach
    - Open
    - Percutaneous
  - Substance
    - Antineoplastic
    - High dose/Low dose Interleukin-2
  - Code examples
    - ICD-9 – 00.15 – Injection or infusion of high dose Interleukin-2.
    - ICD-10-PCS – 3E03302 – Introduction, peripheral vein, percutaneous, high dose interleukin-2.

Infusion of Chemotherapy

Section	**3** Administration
Body System	**E** Physiological Systems and Anatomical Regions
Operation	**0** Introduction: Putting in or on a therapeutic, diagnostic, nutritional, physiological, or prophylactic substance except blood or blood products

Body System / Region	Approach	Substance	Qualifier
3 Peripheral Vein	**0** Open	**V** Hormone	**G** Insulin **H** Human B-type Natriuretic Peptide **J** Other Hormone
3 Peripheral Vein	**0** Open	**W** Immunotherapeutic	**K** Immunostimulator **L** Immunosuppressive
3 Peripheral Vein	**3** Percutaneous	**0** Antineoplastic	**2** High-dose Interleukin-2 **3** Low-dose Interleukin-2 **5** Other Antineoplastic **M** Monoclonal Antibody **P** Clofarabine
3 Peripheral Vein	**3** Percutaneous	**1** Thrombolytic	**6** Recombinant Human-activated Protein C **7** Other Thrombolytic
3 Peripheral Vein	**3** Percutaneous	**2** Anti-infective	**8** Oxazolidinones **9** Other Anti-infective
4 Central Vein	**0** Open	**0** Antineoplastic	**2** High-dose Interleukin-2 **3** Low-dose Interleukin-2 **5** Other Antineoplastic **M** Monoclonal Antibody **P** Clofarabine

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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?

- Coding data is incorporated into the information used by insurance companies to determine which physicians they are going to contract.

- ***Coded information is made available to consumers on various platforms, such as HealthGrades, which uses coding data as well as other information to 'rate' facility and provider service***

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?