



ICD-10 for Internal Medicine

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.



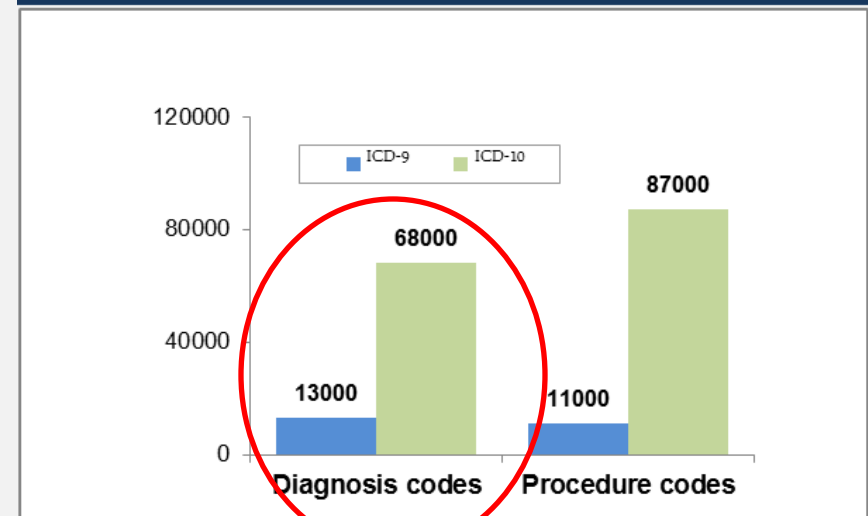
Changes to Diagnosis Codes

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

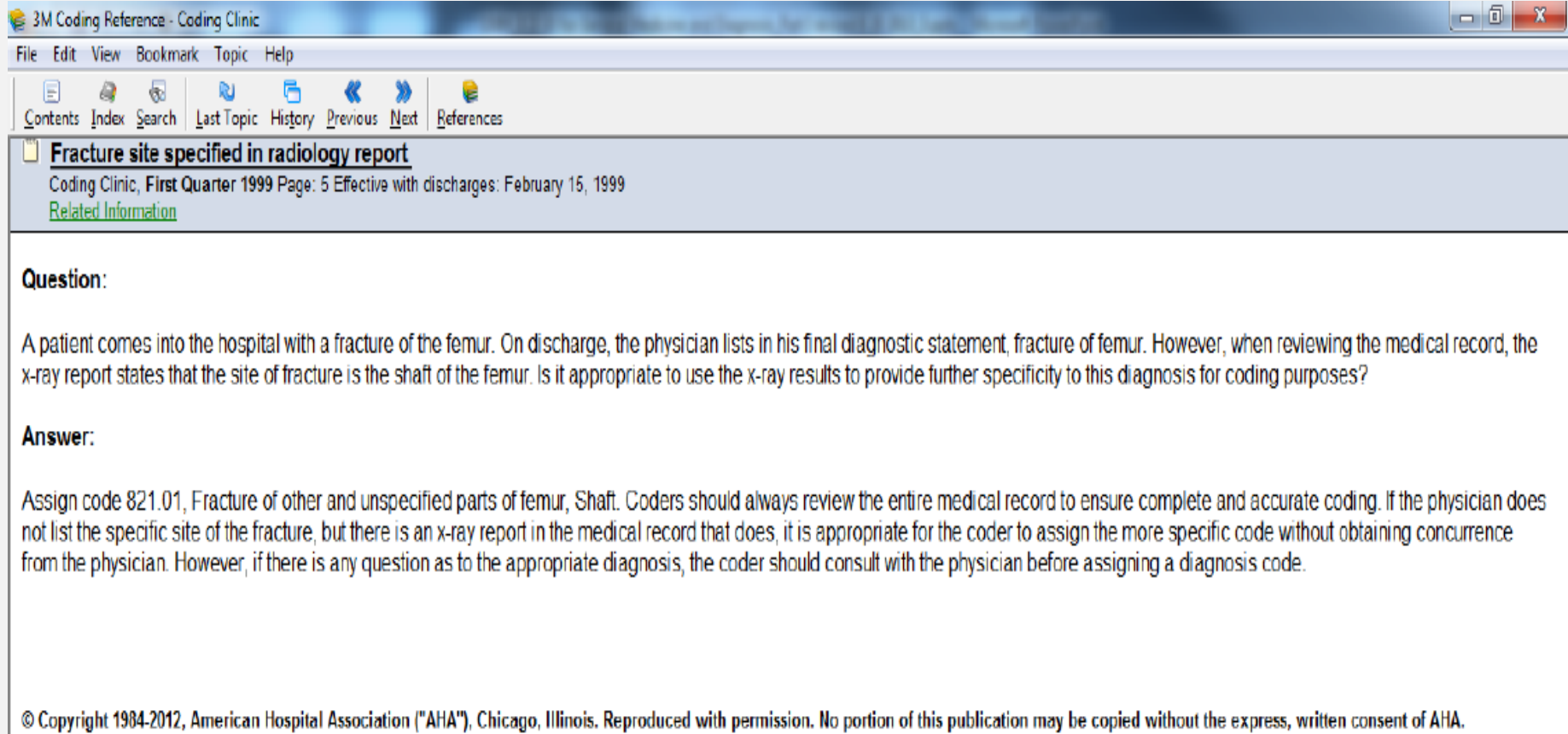
- ICD-10 requires collaboration, collaboration and more collaboration between all members of the clinical and non-clinical healthcare team:
 - Education of CDI/coder staff
 - Template revisions
 - Query revisions



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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Contents Index Search Last Topic History Previous Next References

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

Internal Medicine Diagnoses Documentation Examples



Top Diagnosis Codes

Internal Medicine - Diagnosis

V70.0 - ROUTINE MEDICAL EXAM
250.00 - DM W/O MENTION OF COMP,TYPE II[NIDDM]
401.9 - HYPERTENSION NOS
V04.81 - NEED FOR PROPHYLACTIC VACCINATION AND INOCULATION, INFLUENZA
401.1 - BENIGN HYPERTENSION
V06.1 - VACCIN FOR DTP
V03.82 - PROPHYLACTIC VACCINATION AGAINST STREPTOCOCCUS PNEUMONIAE
272.4 - HYPERLIPIDEMIA NEC/NOS
724.2 - LUMBAGO
311. - DEPRESSIVE DISORDER NEC
278.00 - OBESITY, UNSPECIFIED
493.90 - ASTHMA W/O STATUS ASTHM
V05.3 - NEED FOR INOCULATION AGAINST VIRAL HEPATITIS
305.1 - TOBACCO USE DISORDER
719.46 - JOINT PAIN-L/LEG
V72.84 - PRE-OPERATIVE EXAMINATION, UNSPECIFIED
782.1 - NONSPECIF SKIN ERUPT NEC
266.2 - B-COMPLEX DEFIC NEC
786.50 - CHEST PAIN NOS
300.00 - ANXIETY STATE NOS
477.9 - ALLERGIC RHINITIS NOS
789.00 - ABDOMINAL PAIN, UNSPECIFIED SITE
465.9 - ACUTE URI NOS
V74.1 - SCREENING-PULMONARY TB
530.81 - ESOPHAGEAL REFLUX



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

- 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

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

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 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

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



Clinical Examples – Documentation Improvement

Diabetes Mellitus

- Classified by “type 1 or 2” and “other specified”
- Secondary Diabetes Mellitus is further classified as:
 - Due to underlying condition
 - Drug or chemical induced
- Gestational Diabetes is further classified as:
 - Insulin controlled
 - Diet controlled
 - Puerpural
- “Other specified” complications expanded to include:
 - Neuropathic arthropathy
 - Dermatitis
 - Oral complications including periodontal disease and other oral disease



Clinical Examples – Documentation Improvement

Scenario

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

- In ICD-9-CM, 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 layer exposed, with necrosis of muscle, with necrosis of bone, unspecified severity)

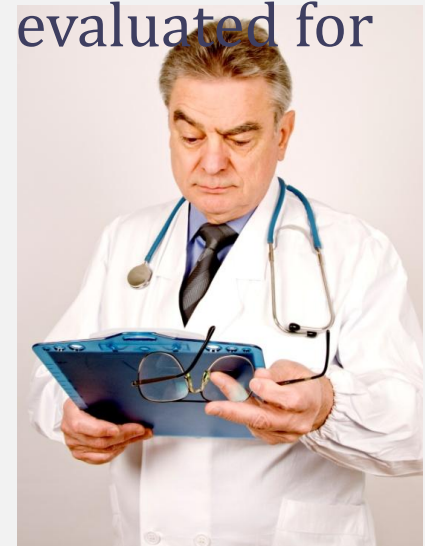




Clinical Examples – Documentation Improvement

Scenario

Patient presents with a history of diabetes mellitus type 2. The patient has been experiencing increasing leg pain and a dusky appearance to lower legs and feet. She is evaluated for PVD with a vascular scan.





Clinical Examples – Documentation Improvement

Documentation Requirements

- Physician (provider) must document if vascular disease is **associated with or caused by the diabetes mellitus. Clinical findings from labs or vascular studies are insufficient** to appropriately classify a disease without physician (provider) documentation of specific cause and effect relationship.
 - Diabetes Mellitus type 2 is how disease is classified without further documentation of relationship between vascular disease to diabetes
 - Code E11.9 – Type 2 DM without complications



Clinical Examples – Documentation Improvement

Documentation Requirements (cont'd)

- 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



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 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

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 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



Clinical Examples – Documentation Improvement

Documentation Requirements (contd)

Coders/CDI staff are not permitted to classify diseases from lung function tests only

For inpatients: possible, probable and suspected conditions are coded as though they exist

For outpatients: code only to the highest level of certainty

Atrial Fibrillation ICD-9

427.3 Atrial fibrillation and flutter

427.31 Atrial fibrillation

427.32 Atrial flutter

Atrial Fibrillation ICD-10

J48 Atrial fibrillation and flutter

J48.0 Paroxysmal atrial fibrillation

J48.1 Persistent atrial fibrillation

J48.2 Chronic atrial fibrillation

J48.3 Typical atrial flutter

J48.4 Atypical atrial flutter

J48.9 Unspecified atrial fibrillation and atrial flutter

J48.91 Unspecified atrial fibrillation

J48.92 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

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-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 persistent with rapid ventricular response. 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 nonautologous 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)



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



Long-term Use of Medications ICD-10

Z79 Long-term (L/T) (current) drug therapy

Z79.0 Long term use of anticoagulants and antithrombotics/antiplatelets

Z79.01 – Anticoagulants

Z79.02 – Antithrombotics/antiplatelets

Z79.1 – non-steroidal anti-inflammatories

Z79.2 – antibiotics

Z79.3 – hormonal contraceptives

Z79.4 – insulin

Z79.5 – steroids

Z79.51 – inhaled steroids

Z79.52 – systemic steroids



Long-term Use of Medications ICD-10

Z79 Long-term (L/T) (current) drug therapy

Z79.8 Other long term (current) drug therapy

Z79.81 – L/T use of agents affecting estrogen receptors and estrogen level

- Z79.810 – Selective estrogen receptor modulators (SERMs)
- Z79.811 – Aromatase inhibitors
- Z79.818 – Other agents affecting estrogen receptors and estrogen levels

Z79.82 – L/T use of aspirin

Z79.83 – L/T use of bisphosphonates

Z79.89 – Other L/T (current) drug therapy

- Z79.890 – Hormone replacement therapy (postmenopausal)
- Z79.891 – L/T (current) use of opiate analgesic
- Z79.899 – Other L/T (current) drug therapy

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

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

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

AKI Criteria – Acute Renal Failure

Category	GFR Criteria	Urine Output Criteria
Risk	Increased creatinine $\times 1.5$ GFR decrease $>25\%$	UO < 0.5 mL/kg/h $\times 6$ hr
Injury	Increased creatinine $\times 2$ GFR decrease $>50\%$	UO < 0.5 mL/kg/h $\times 12$ hr
Failure	Increase creatinine $\times 3$ GFR decrease $>75\%$	UO < 0.3 mL/kg/h $\times 24$ hr Anuria $\times 12$ 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

Influenza Vaccine ICD-9

V04 Need for prophylactic vaccination and inoculation 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

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

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

Cerebral Infarctions

Cerebral Infarctions

ICD-10-CM classifies cerebral infarctions by the type of occlusion as well as the specific site.

Thrombosis

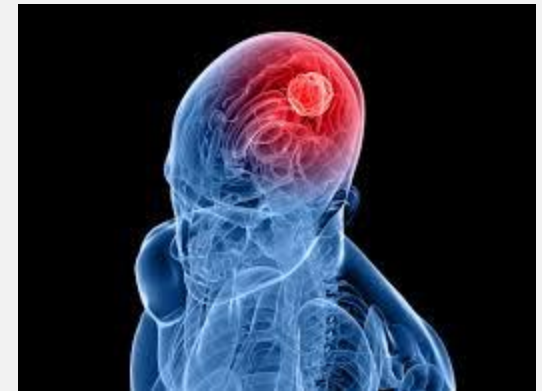
Embolism

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**

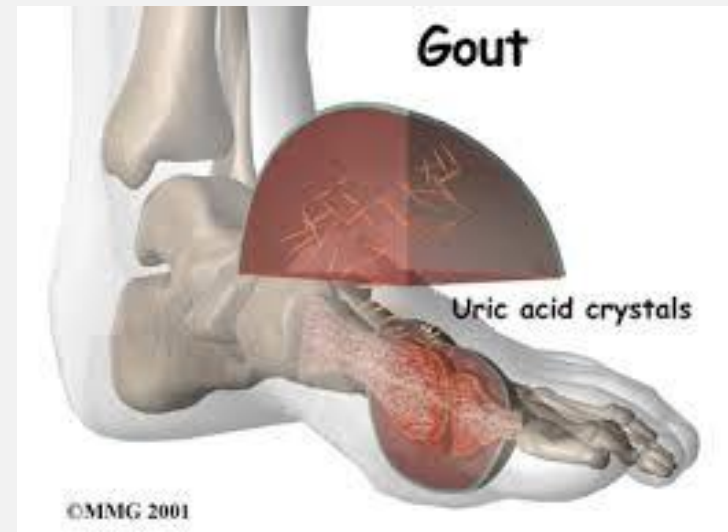
I69.354 – hemiplegia and hemiparesis following cerebral infarction affecting **left non-dominant side**

I69.359 – hemiplegia and hemiparesis following cerebral infarction affecting **unspecified side**



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

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

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 – up to 15 EOC encounter codes (characters)

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



Fractures/Injuries – General Rule

Documentation of the initial injury must be consistent for each visit with episode of care information including hospital, skilled nursing or rehab, physician office/clinic with appropriate 7th character representing episode of care:

- Each record must stand on its own.

- Documentation from previous records will not be used / must be re-iterated in current note.

- No aftercare or follow-up classification for fractures or injuries (V codes in ICD-9-CM Diagnosis)- in ICD-10-CM use “subsequent” code.

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 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

Scenario

Patient presents with a known history of Crohn's disease. He is experiencing abdominal pain and some bloating. A CT scan and colonoscopy are performed to evaluate for obstruction.



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**



Clinical Examples – Documentation Improvement

To properly classify **kidney disease** in ICD-10-CM, physicians must specify if the *renal failure is acute and then the location of necrosis or chronic and then the stage.*

Acute renal failure

With tubular necrosis

With acute cortical necrosis

With medullary necrosis

Other)/Unspecified

Chronic kidney disease (CKD)

Stage 1

Stage 2 (mild)

Stage 3 (moderate)

Stage 4 (severe)

Stage 5

End stage renal disease

Unspecified

Unspecified kidney failure



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 of 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.

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

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

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)

ICD-10-CM Opportunities

Atrial Fibrillation

- Type specificity
- Chronic, paroxysmal, persistent

Cerebral Infarction and Myocardial Infarction

- Artery specificity
- Site specificity
- AMI acuity timeframe

Cellulitis

- Abscess
- Furuncle
- Acute Lymphangitis
- Site specificity
- Laterality

ICD-10-CM Opportunities

Pelvic Pain

- Symptom code
- Underlying cause
- Potential MS-DRG impact – symptom code classified to GI system

Pregnancy

- Trimester documentation impacts code assignment
- Fetus specificity if multiple gestations for some OB conditions

Urinary Tract Infection

- No classification for urosepsis
- Query will always be required if “urosepsis” is documented by providers

Diabetes Mellitus

- Linkage of manifestation to disease
- Type

Internal Medicine Procedure Documentation Examples



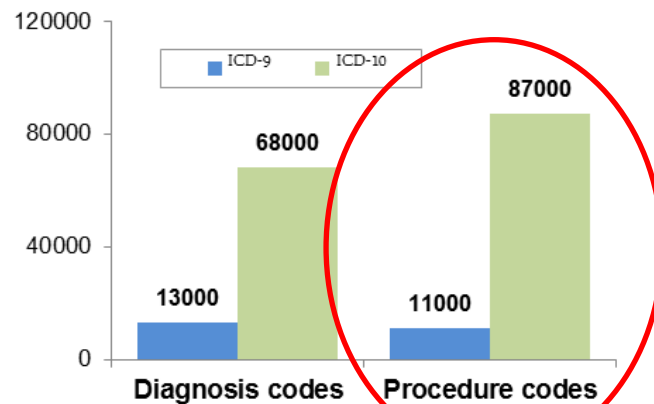
Overview of ICD-10-PCS

- 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 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	0 Open	Z No Device	X Diagnostic	
G Optic Nerve	3 Percutaneous		Z No Qualifier	
H Oculomotor Nerve	4 Percutaneous Endoscopic			
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				

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

<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

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		
<i>Body System / Region</i>	<i>Approach</i>	<i>Substance</i>	<i>Qualifier</i>
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



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.



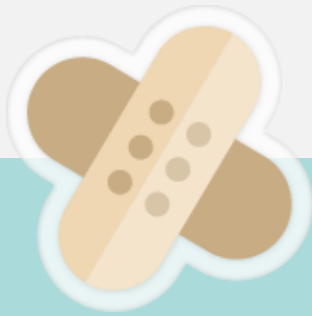
- ***A. signature alone on a generated query does not fulfill this requirement***

Query... answer how?

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?

