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ICD-10 for Pulmonology

UConn Health

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Introductions

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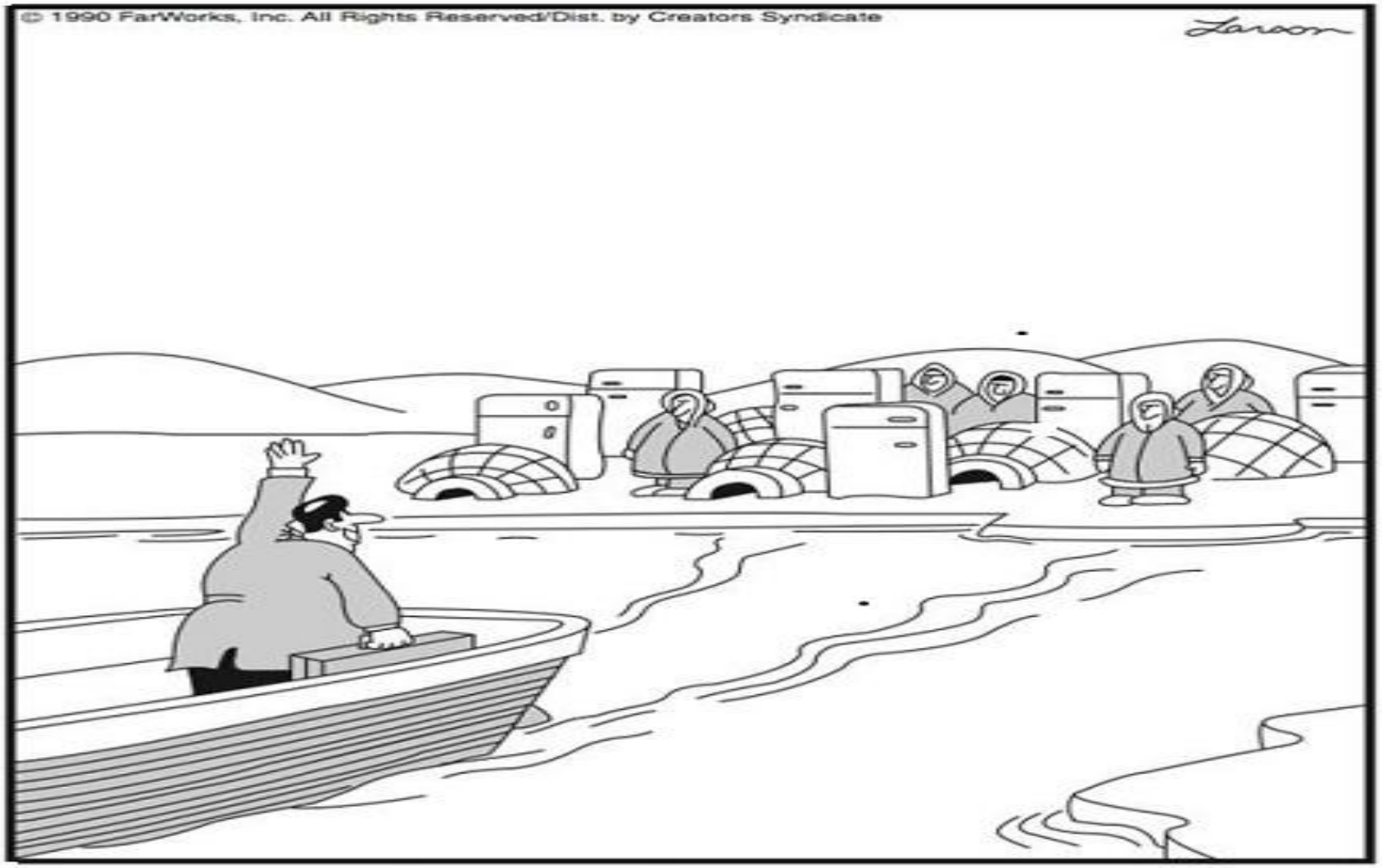
THE FAR SIDE® By GARY LARSON



Ralph Harrison, king of salespersons

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 for the most frequent diagnoses used by Pulmonology
  - Identify the importance of physician documentation and coding
  - Discuss the importance of the query writing process and physician response

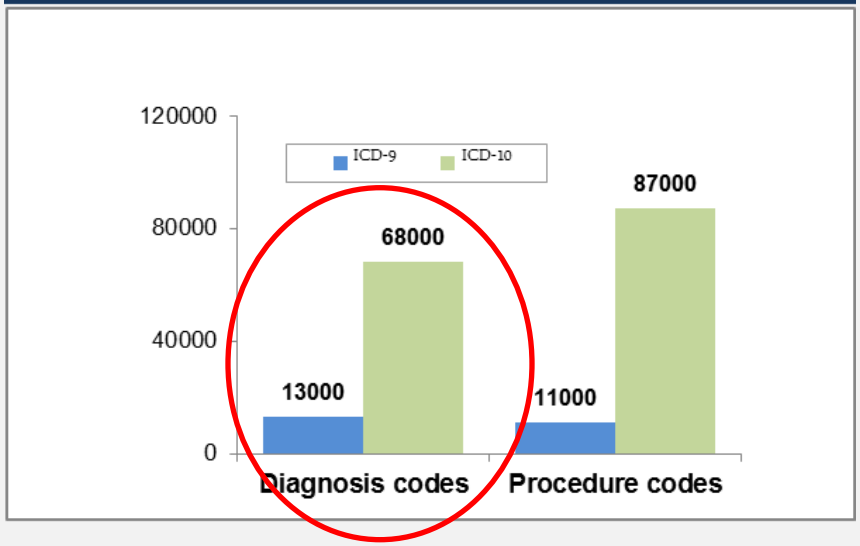
Changes to Diagnosis Codes

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

- ***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***

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.

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 Diagnoses

Requirements for Detailed Documentation for Diagnoses	
Acuity	Acute, chronic or both
Specific site	Sigmoid colon, wrist, upper forearm
Laterality	Right, left, bilateral Left upper lobe Left vocal cord
Specific type of condition	Acute blood loss anemia, type 2 diabetes with hyperglycemia
Etiology of diagnosis	Chest pain due to gastroesophageal reflux, anxiety due to alcohol abuse
Link must be established between manifestations and underlying diseases	Hypertension due to cardiovascular disease, vascular insufficiency secondary to diabetic PVD
Complications of care	Intraoperative, postoperative, mechanical malfunctions, infections
Degree of severity	Mild, moderate, severe, e.g., malnutrition: mild, moderate, severe

Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses	
Stages (I, II, III, IV)	Stage IV decubitus ulcer
Injury details	Place of occurrence, activity causing the injury
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)
Cerebral and myocardial infarctions	Site and artery specificity
Non-pressure skin ulcers	Site, laterality and depth of tissue involvement

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Pulmonology Diagnosis Documentation Examples

Top Pulmonology Diagnosis Codes

327.23 - OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
496. - CHR AIRWAY OBSTRUCT NEC
786.09 - RESPIRATORY ABNORM NEC
493.90 - ASTHMA W/O STATUS ASTHM
786.2 - COUGH
516.31 - IDIOPATHIC PULMONARY FIBROSIS
135. - SARCOIDOSIS
710.1 - SYSTEMIC SCLEROSIS
786.05 - SHORTNESS OF BREATH
494.0 - BRONCHIECTASIS WITHOUT ACUTE EXACERBATION
793.19 - OTHER NONSPECIFIC ABNORMAL FINDING OF LUNG FIELD
416.0 - PRIM PULM HYPERTENSION
162.9 - MAL NEO BRONCH/LUNG NOS
793.11 - SOLITARY PULMONARY NODULE
799.02 - HYPOXEMIA
282.60 - SICKLE-CELL ANEMIA NOS
486. - PNEUMONIA, ORGANISM NOS
517.3 - ACUTE CHEST SYNDROME
477.9 - ALLERGIC RHINITIS NOS
511.9 - PLEURAL EFFUSION NOS
416.8 - CHR PULMON HEART DIS NEC
518.81 - RESPIRATORY FAILURE
786.6 - CHEST SWELLING/MASS/LUMP
305.1 - TOBACCO USE DISORDER
327.20 - ORGANIC SLEEP APNEA, UNSPECIFIED

COPD ICD-9

- 490 Bronchitis
- 491 Chronic bronchitis
- 492 Emphysema
- 493 Asthma
- 494 Bronchiectasis
- 495 Extrinsic allergic alveolitis
- 496 Chronic airway obstruction, NEC
  - NOTE: Excludes COPD specified with
    - Allergic alveolitis
    - Asthma
    - Bronchiectasis
    - Bronchitis
    - Decompensated
    - Emphysema

COPD

Chronic lower respiratory diseases (J40-J47)

- J40 Bronchitis
- 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

- 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

Dyspnea ICD-9

- 786.0 Dyspnea and respiratory abnormalities
  - 786.00 Respiratory abnormality, unspecified
  - 786.01 Hyperventilation
  - 786.02 Orthopnea
  - 786.03 Apnea
  - 786.04 Cheyne-Stokes respiration
  - 786.05 Shortness of breath
  - 786.06 Tachypnea
  - 786.07 Wheezing
  - 786.09 Other respiratory distress, insufficiency

Dyspnea

R06 Abnormalities of breathing

- R06.0 Dyspnea
  - R06.00 Dyspnea, unspecified
  - R06.01 Orthopnea
  - R06.02 Shortness of breath
  - R06.09 Other forms of dyspnea

Dyspnea ICD-10 cont'd.

R06 Abnormalities of breathing

- R06.1 Stridor
- R06.2 Wheezing
- R06.3 Periodic breathing
- R06.4 Hyperventilation
- R06.5 Mouth breathing
- R06.6 Hiccough
- R06.7 Sneezing
- R06.8 Other abnormality of breathing
- R06.9 Unspecified abnormalities of breathing

Hypoxemia ICD-9

- 799.0 Asphyxia and hypoxemia
  - 799.01 Asphyxia
  - 799.02 Hypoxemia

Hypoxemia

- R09.0 Asphyxia and hypoxemia
  - R09.01 Asphyxia
  - R09.02 Hypoxemia

Cough ICD-9

- 786 Symptoms involving respiratory system and other chest symptoms
  - 786.0 Dyspnea and respiratory abnormalities
  - 786.1 Stridor
  - 786.2 Cough
  - 786.3 Hemoptysis
  - 786.4 Abnormal sputum
  - 786.5 Chest pain
  - 786.6 Swelling, mass, or lump in chest
  - 786.7 Abnormal chest sounds
  - 786.8 Hiccough
  - 786.9 Other symptoms involving respiratory system and chest

Cough

Symptoms and signs involving the circulatory and respiratory systems (R00-R09)

- R05 Cough

Fatigue ICD-9

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

Fatigue

- 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

Sinusitis

Documentation must indicate the **anatomy involved and specify whether the condition is acute, chronic, or both**. What seems to be a rather straightforward diagnosis can become difficult to code if documentation is not detailed enough for ICD-10-CM.

Physicians must document the infectious agent, if known.

Smoking ICD-9

- 305 Nondependent abuse of drugs
  - 305.0 Alcohol abuse
  - 305.1 Tobacco use disorder
  - 305.2 Cannabis abuse…..

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.

Smoking

- 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

Acute Respiratory Failure ICD-9

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

Acute Respiratory Failure

- 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”)

Pneumococcal Pneumonia ICD-9

- 481 Pneumococcal pneumonia
- 486 Pneumonia, organism unspecified

Pneumonia

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

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

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

Pneumoconiosis

To properly classify **pneumoconiosis** in ICD-10-CM, **Physicians must specify the cause**. These new classifications are listed below:

- **Talc dust** – inhalation of talc usually occurring during talc mining or milling
- **Aluminosis** – exposure to aluminum particles
- **Bauxite fibrosis** – exposure to bauxite fumes which contain aluminum and silica particulates
- **Berylliosis** – exposure to beryllium and its compounds associated with beryllium mining or manufacturing of fluorescent light bulbs (which used to contain beryllium compounds in their internal phosphor coating)

Pneumoconiosis

- **Graphite fibrosis** – inhalation of graphite dust, which often contains up to 10% silicon dioxide
- **Siderosis** – exposure to iron oxide present in welding material, foundries, and iron ore mining. This is also known as welder's lung or silver polisher's lung and caused by inhaling iron particles.
- **Stannosis** – exposure to tin oxide and is very rare. It is considered to belong to the category of 'benign' pneumoconiosis, such as siderosis or baritosis.

Sinusitis

- ICD-10-CM instructional notes tell you to use an additional code (when applicable) to identify:
  - Exposure to environmental tobacco smoke
  - Exposure to tobacco smoke in the perinatal period
  - History of tobacco use
  - Occupational exposure to environmental tobacco smoke
  - Tobacco dependence
  - Tobacco use

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Sinusitis

- The codes for documented chronic sinusitis begin with category J32. A fourth character is required to indicate the sinus(es) affected.

  For example:

  - J32 Chronic sinusitis
    - J32.0 Chronic maxillary sinusitis
    - J32.1 Chronic frontal sinusitis

Physicians must document the infectious agent, if known.

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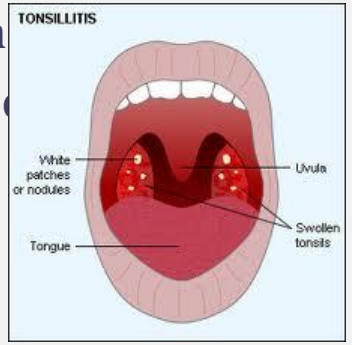
Tonsillitis

Acute tonsillitis in ICD-10-CM has been expanded at the fourth and fifth characters. **The fourth character identifies the organism and fifth character level indicates whether the condition is acute or recurrent.** The fifth character "1" identifies recurrent tonsillitis.

Tonsillitis

For example:

- J03 Acute tonsillitis
  - J03.0 Streptococcal tonsillitis
    - J03.00 Acute streptococcal tonsillitis, unspecified
    - J03.01 Acute recurrent streptococcal tonsillitis
  - J03.8 Acute tonsillitis due to other specified organisms
    - J03.80 Acute tonsillitis due to other specified orga
    - J03.81 Acute recurrent tonsillitis due to other spe organisms



Tonisillitis

A patient was seen by his family physician and diagnosed with acute tonsillitis. The patient had a previous acute bout of tonsillitis six months ago and this is the second occurrence in six months.

ICD-9-CM

- 463 Acute tonsillitis

ICD-10-CM

- J03.91 Acute ***recurrent*** tonsillitis, unspecified

In ICD-9-CM there is not a code to report recurrent tonsillitis.

Acute pharyngitis

In ICD-10-CM, acute pharyngitis has expanded to delineate the causative organism.

ICD-9-CM

- 462 Acute pharyngitis

ICD-10-CM

- J02 Acute pharyngitis
  - J02.0 Streptococcal pharyngitis
  - J02.8 Acute pharyngitis due to other specified organism
  - J02.9 Acute pharyngitis, 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

- 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

- 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

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

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 that point 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

Hypertension

- 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

- 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

Obesity ICD-9

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

Obesity

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

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

- 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

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

- 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

- 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

Depression ICD-9

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

Depression

- 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

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

- 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

- 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

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

- 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

- 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

- 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

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

- 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

- 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

- 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

- 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.

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)

Sequela

- Complication or condition that arises as a direct result of an injury or disease, such as scar formation after a burn. The scar is a sequela of the burn.

Sequela is the new terminology in ICD-10-CM replacing "late effects"

Overweight and Obesity

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.

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

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

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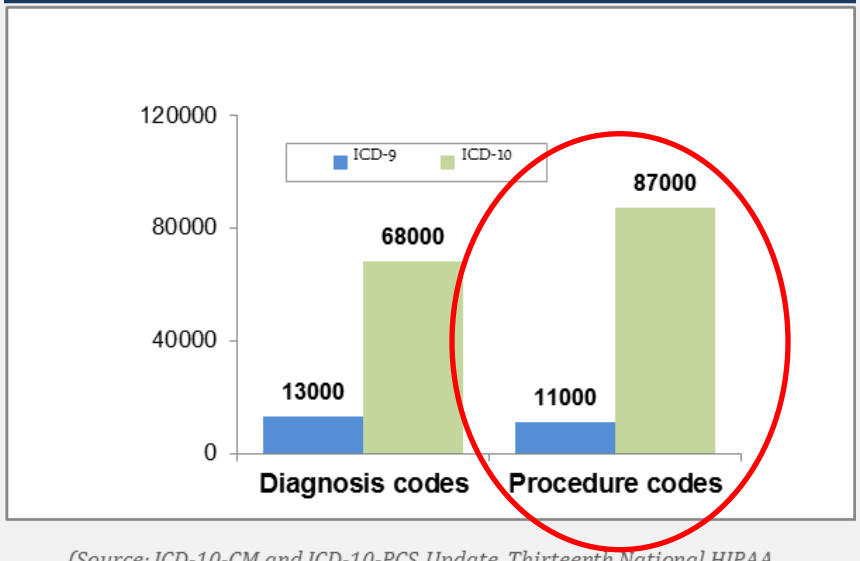
Pulmonology Procedure Documentation Examples

Changes to procedure codes

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

Overview of ICD-10-PCS

- PCS stands for **Procedure Classification System**
- It is a multiaxial system with a 7 character alphanumeric code classification providing a **unique code** for all substantially different procedures and with **easy expandability**, incorporating new procedures, technologies and devices utilized in medical/surgical procedures
- The classification for the procedures has undergone significant revision focusing primarily on **section, body system, root operation, body part, approach, device and qualifier.**

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ICD-10-PCS Laryngoscopy

Patient presents for laryngoscopy

ICD-10-PCS

0CJS8ZZ

- Inspection of Larynx, Via Natural or Artificial Opening Endoscopic

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ICD-10-PCS Table

Section	**0**	Medical and Surgical
Body System	**C**	Mouth and Throat
Operation	**J**	Inspection: Visually and/or manually exploring a body part

Body Part	*Approach*	*Device*	*Qualifier*
A Salivary Gland	**0** Open **3** Percutaneous **X** External	**Z** No Device	**Z** No Qualifier
S Larynx **Y** Mouth and Throat	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic **X** External	**Z** No Device	**Z** No Qualifier

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ICD-10-PCS Laryngoscopy

1st	2nd	3rd	4th	5th	6th	7th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	C	J	S	8	Z	Z

The ICD-10-PCS code structure tells a story

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ICD-10-PCS Nasal Polyp Biopsy

Patient presents for nasal polyp biopsy of the left ethmoid sinus

ICD-10-PCS

09BV4ZX

- Excision of Left Ethmoid Sinus, Percutaneous Endoscopic Approach, Diagnostic

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ICD-10-PCS Table

Section	**0**	Medical and Surgical
Body System	**9**	Ear, Nose, Sinus
Operation	**B**	Excision: Cutting out or off, without replacement, a portion of a body part

Body Part	*Approach*	*Device*	*Qualifier*
0 External Ear, Right **1** External Ear, Left **K** Nose	**3** Percutaneous **4** Percutaneous Endoscopic **X** External	**Z** No Device	**X** Diagnostic **Z** No Qualifier
3 External Auditory Canal, Right **4** External Auditory Canal, Left	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic **X** External	**Z** No Device	**X** Diagnostic **Z** No Qualifier
5 Middle Ear, Right **6** Middle Ear, Left **9** Auditory Ossicle, Right **A** Auditory Ossicle, Left **D** Inner Ear, Right **E** Inner Ear, Left	**0** Open	**Z** No Device	**X** Diagnostic **Z** No Qualifier
7 Tympanic Membrane, Right **8** Tympanic Membrane, Left **F** Eustachian Tube, Right **G** Eustachian Tube, Left **L** Nasal Turbinate **N** Nasopharynx	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier
B Mastoid Sinus, Right **C** Mastoid Sinus, Left **M** Nasal Septum **P** Accessory Sinus **Q** Maxillary Sinus, Right **R** Maxillary Sinus, Left **S** Frontal Sinus, Right **T** Frontal Sinus, Left **U** Ethmoid Sinus, Right **V** Ethmoid Sinus, Left **W** Sphenoid Sinus, Right **X** Sphenoid Sinus, Left	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier

ICD-10-PCS Nasal Polyp Biopsy

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

The ICD-10-PCS code structure tells a story

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ICD-10-PCS Pharyngoplasty

Patient presents for lysis of pharyngeal adhesions

ICD-10-PCS

0CNM8ZZ

- Release Pharynx, Via Natural or Artificial Opening Endoscopic

ICD-10-PCS Table

Section	**0**	Medical and Surgical
Body System	**C**	Mouth and Throat
Operation	**N**	Release: Freeing a body part from an abnormal physical constraint by cutting or by the use of force

Body Part	*Approach*	*Device*	*Qualifier*
0 Upper Lip **1** Lower Lip **2** Hard Palate **3** Soft Palate **4** Buccal Mucosa **5** Upper Gingiva **6** Lower Gingiva **7** Tongue **N** Uvula **P** Tonsils **Q** Adenoids	**0** Open **3** Percutaneous **X** External	**Z** No Device	**Z** No Qualifier
8 Parotid Gland, Right **9** Parotid Gland, Left **B** Parotid Duct, Right **C** Parotid Duct, Left **D** Sublingual Gland, Right **F** Sublingual Gland, Left **G** Submaxillary Gland, Right **H** Submaxillary Gland, Left **J** Minor Salivary Gland	**0** Open **3** Percutaneous	**Z** No Device	**Z** No Qualifier
M Pharynx **R** Epiglottis **S** Larynx **T** Vocal Cord, Right **V** Vocal Cord, Left	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**Z** No Qualifier
W Upper Tooth **X** Lower Tooth	**0** Open **X** External	**Z** No Device	**0** Single **1** Multiple **2** All

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ICD-10-PCS Pharyngoplasty

1st	2nd	3rd	4th	5th	6th	7th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	C	N	M	8	Z	Z

The ICD-10-PCS code structure tells a story

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Summary

The transition to ICD-10 classification systems on October 1, 2015 will have a significant impact on physician documentation requirements.

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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?