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ICD-10 for Urgent Care

UConn Health

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Introduction

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

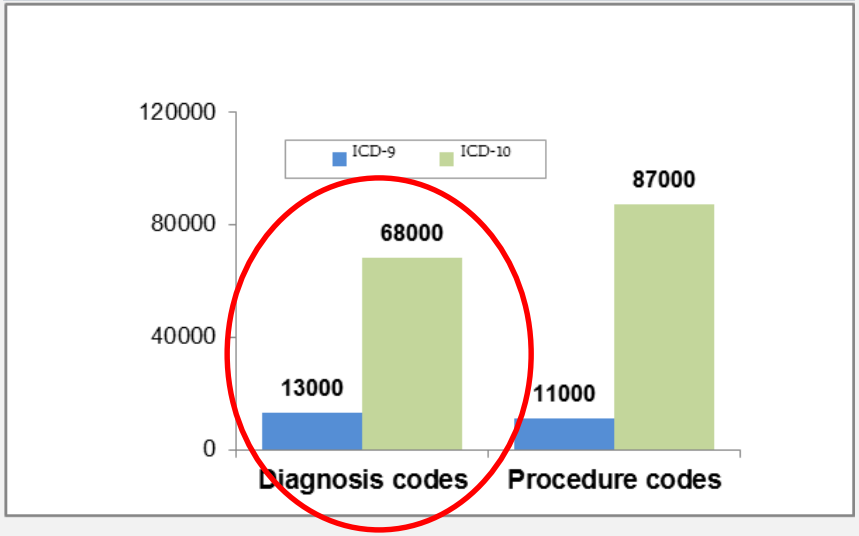
Changes to Diagnosis Codes

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***

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
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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Diagnosis Documentation Examples

Documentation Requirements – Fractures

ICD-10-CM fracture codes include greater specificity:

- Type of fracture
- Anatomical site
- Displaced or not
- Laterality
- Episode of care

Episodes of Care

ICD-10-CM relies more heavily on categorizing the episodes of care for injuries and illnesses

- **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

Fractures

- Gustilo-Anderson grade is required for long bone 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”

Gustilo-Anderson

I	Open fracture, clean wound, wound <1 cm in length
II	Open fracture, wound > 1 cm in length without extensive soft-tissue damage, flaps, avulsions
III	Open fracture with extensive soft-tissue laceration, damage, or loss or an open segmental fracture. This type also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hr prior to treatment
IIIA	Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage
IIIB	Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e. free or rotational flap)
IIIC	Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury.

Classifications of the Gustilo-Anderson scale must be documented by the physician…coders cannot select the classification based on documentation

Episodes of Care

- Sequela
  - Complications or conditions that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequela of the burn.

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

Episodes of Care w/Fractures

Fractures in ICD-10-CM:

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

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

Clinical Example: 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
  - Injuries/fractures/sprains/dislocations
  - Arthritis
  - Cancer

- 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

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Laceration- Clinical Examples

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

ICD-9-CM

- 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**

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

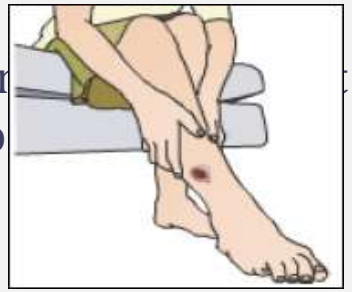
- Classified by "type 1 or 2" and "other specified"
- Secondary Diabetes Mellitus is further classified as:
  - Due to underlying condition
  - Drug or chemical induced
- Gestational Diabetes is further classified as:
  - Insulin controlled
  - Diet controlled
  - Puerpural
- "Other specified" complications 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 bo 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

Hyperlipidemia ICD-9

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

Hyperlipidemia ICD-10

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

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

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

Smoking ICD-9

- 305 Nondependent abuse of drugs

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

Smoking ICD-10

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

Smoking ICD-10

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

Depression ICD-9

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

Depression ICD-10

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

Hypertension ICD-9

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

Hypertension ICD-10

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

Hypertension

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

Coronary Atherosclerosis ICD-9

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

CAD with Angina in ICD-10

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

CAD with Angina in ICD-10

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

CAD with Angina in ICD-10

- I25 – Chronic ischemic heart disease
  - I25.7 - ASHD of bypass grafts and coronary artery of transplanted heart with angina pectoris
    - I25.73 – ASHD of nonautologus biological bypass grafts, w/ angina pectoris
      - I25.730 – with unstable angina
      - I25.731 – with documented spasm
      - I25.738 – with other forms of angina pectoris
      - I25.739 – with unspecified angina pectoris
    - I25.75 – ASHD of native coronary artery of transplanted heart w/ angina pectoris
      - I25.750 – with unstable angina
      - I25.751 – with documented spasm
      - I25.758 – with other forms of angina pectoris
      - I25.759 – with unspecified angina pectoris
    - I25.76 – ASHD of bypass graft of transplanted heart w/angina pectoris
      - I25.760 – with unstable angina
      - I25.761 – with documented spasm
      - I25.768 – with other forms of angina pectoris
      - I25.769 – with unspecified angina pectoris

CAD with Angina in ICD-10

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

Coronary Artery Disease

- The classification of Coronary Artery Disease now includes that of:
  - Native Coronary Arteries
  - Coronary Artery Bypass Grafts
    - Autologous veins or arteries
    - Nonautologous biological
  - Transplanted heart
  - With or without angina, unstable
  - With documented spasm

Coronary Artery Disease Scenario

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

Coronary Artery Disease

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

Atrial Fibrillation ICD-9

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

Atrial Fibrillation ICD-10

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

Atrial Fibrillation ICD-9

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

Atrial Fibrillation ICD-10

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

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

Documentation Requirements

- 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 (STEMI) of unspecified site

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

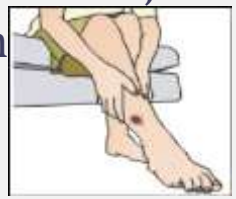
- I21.01 – ST elevation (STEMI) myocardial infarction involving **left main coronary artery**
- I21.02 – ST elevation (STEMI) myocardial infarction involving **left anterior descending** coronary artery
- I21.09 – ST elevation (STEMI) myocardial infarction involving **other** coronary artery of anterior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

Clinical Example: 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 of skin, with fat layer exposed, with necrosis of muscle, with necrosis of bon unspecified severity)



Chest Pain

Chest pain classification is further specified to ischemic or nonischemic.

Nonischemic Chest Pain ICD-9

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

Nonischemic Chest Pain ICD-10 Codes

- **R07** – Pain in throat and chest
  - **R07.0** – Pain in throat
  - **R07.1** – Chest pain on breathing
  - **R07.2** – Precordial pain
  - **R07.8** – Other chest pain
    - **R07.81** – Pleurodynia
    - **R07.82** – Intercostal pain
    - **R07.89** – Other chest pain
  - **R07.9** – Chest pain, unspecified

Ischemic Chest Pain ICD-10

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

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

Documentation Requirements (cont'd)

- 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

Heart Failure

- To properly classify heart failure in ICD-10-CM, physicians must specify **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

Heart Failure

- **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

Otitis Media

- In ICD-10-CM for otitis media the physician should specify:
  - Characteristics (i.e. effusion, suppurative, allergic, postmeasles, rupture, serous)
  - Laterality (R, L, bilateral)
  - Acuity (acute, chronic)

There are more than 90 distinct codes for otitis media in ICD-10-CM

Otitis Media ICD-9

- 382 Suppurative and unspecified otitis media
  - 382.0 Acute suppurative otitis media
  - 382.1 Chronic tubotympanic suppurative otitis media
  - 382.2 Chronic atticoantral suppurative otitis media
  - 382.3 Unspecified chronic suppurative otitis media
  - 382.4 Unspecified suppurative otitis media
  - 382.9 Unspecified otitis media

Otitis Media ICD-10

- H66 Suppurative and unspecified otitis media
  - H66.0 Acute suppurative
  - H66.1 Chronic tubotympanic suppurative otitis media
  - H66.2 Chronic atticoantral suppurative otitis media
  - H66.3 Other chronic suppurative otitis media
  - H66.4 Suppurative otitis media, unspecified
  - H66.9 Otitis media, unspecified

Otitis Media ICD-10

- H66 Suppurative and unspecified otitis media
  - H66.0 Acute suppurative
    - H66.00 without spontaneous rupture of ear drum
      - H66.001 right ear
      - H66.002 left ear
      - H66.003 bilateral
      - H66.004 recurrent, right ear
      - H66.005 recurrent, left ear
      - H66.006 recurrent, bilateral
      - H66.007 recurrent, unspecified ear
      - H66.009 unspecified ear
    - H66.01 with spontaneous rupture of ear drum
      - H66.011 right ear
      - H66.012 left ear
      - H66.013 bilateral
      - H66.014 recurrent, right ear
      - H66.015 recurrent, left ear
      - H66.016 recurrent, bilateral
      - H66.017 recurrent, unspecified ear
      - H66.019 unspecified ear

Otitis Media ICD-10

- H66 Suppurative and unspecified otitis media
  - H66.0 Acute suppurative
  - H66.1 Chronic tubotympanic suppurative otitis media
  - H66.2 Chronic atticoantral suppurative otitis media
  - H66.3 Other chronic suppurative otitis media
  - H66.4 Suppurative otitis media, unspecified
  - H66.9 Otitis media, unspecified

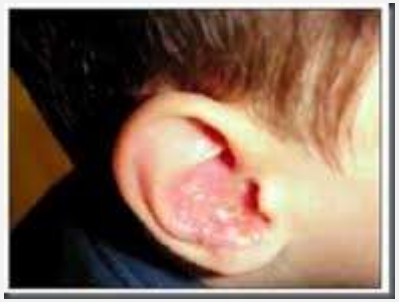
Otitis Media ICD-10

- H66 Suppurative and unspecified otitis media
  - H66.9 Otitis media, unspecified
    - Otitis media NOS
    - Acute otitis media NOS
    - Chronic otitis media NOS
    - H66.90 unspecified ear
    - H66.91 right ear
    - H66.92 left ear
    - H66.93 bilateral

Otitis Externa

Otitis externa in ICD-10-CM specifically delineates codes for cellulitis and abscess of outer ear whereas ICD-9 generally classifies "infection" of outer ear

- H60.00 Abscess of external ear, unspecified ear
- H60.01 Abscess of right external ear
- H60.02 Abscess of left external ear
- H60.03 Abscess of external ear, bilateral
- H60.10 Cellulitis of external ear, unspecified ear
- H60.11 Cellulitis of right external ear
- H60.12 Cellulitis of left external ear
- H60.13 Cellulitis of external ear, bilateral



Inflammation of Eyelids

ICD-9-CM Diagnosis

- Laterality not included in ICD9
- Upper/lower eyelid not specified in ICD-9-CM diagnosis

ICD-10-CM

- Laterality included
  - Right
  - Left
  - Unspecified
  - Bilateral

Further specified as upper and lower eyelid

Over 5,000 diagnoses have a right and left distinction.

Disorders of the Eustachian Tube

To properly classify disorders of the eustachian tube in ICD-10-CM, physicians must specify the following about the condition:

- Specific disorder
  - such as infection or obstruction
- Osseous obstruction or cartilaginous obstruction.
  - cartilaginous obstruction
    - intrinsic
    - extrinsic
- Acuity
- Laterality

Respiratory Failure

- Respiratory failure requires documentation of acuity indicating acute, chronic or acute on chronic
- "Unspecified" respiratory failure is now classified in ICD-10-CM; therefore, if acuity of respiratory failure is not documented, it defaults to "unspecified respiratory failure"
- In addition, respiratory failure requires documentation of **"with hypoxia" or "with hypercapnia"**

Acute Respiratory Failure ICD-9

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

Acute Respiratory Failure ICD-10

- J96 Respiratory failure, NEC

  Excludes respiratory arrest (RO9.2)

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

COPD ICD-9

- 490 Bronchitis
- 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

Pneumonia ICD-9

- 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

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

	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	2X per month or less	3-4X 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

Clinical Example: Documentation Improvement

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.

Asthma

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 Example: 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

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 Code Examples

J45.0 – Asthma (examples)

- **J45.2 –** Mild intermittent asthma
  - **J45.20** – Mild intermittent asthma, uncomplicated
  - **J45.21 –** Mild intermittent asthma with (acute) exacerbation
  - **J45.22** – Mild intermittent asthma with status asthmaticus
- **J45.3** – Mild persistent asthma
  - **J45.30** – Mild persistent asthma, uncomplicated
  - **J45.31** – Mild persistent asthma with (acute) exacerbation
  - **J45.32**- Mild persistent asthma with status asthmaticus
- **J45.4 –** Moderate persistent asthma
  - **J45.40 –** Moderate persistent asthma, uncomplicated
  - **J45.41 –** Moderate persistent asthma with (acute) exacerbation
  - **J45.42** – Moderate persistent asthma with status asthmaticus
- **J45.5** – Severe persistent asthma
  - **J45.50-** Severe persistent asthma, uncomplicated
  - **J45.51** – Severe persistent asthma with (acute) exacerbation
  - **J45.52 –** Severe persistent asthma with status asthmaticus

Asthma ICD-10

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

Sepsis

- Sepsis requires documentation of associated organ dysfunction
- Documentation of the relationship between organ dysfunction and sepsis will be critical in ICD-10-CM for appropriate reflection of patient acuity and outcomes
- The classification differences between ICD-9-CM Diagnosis and ICD-10-CM require that physician documentation be specific. In ICD-10-CM, the R65.2X codes are only utilized when organ dysfunction is documented as secondary or due to sepsis
  - R65.20 – Severe sepsis without septic shock
  - R65.21 – Severe sepsis with septic shock

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

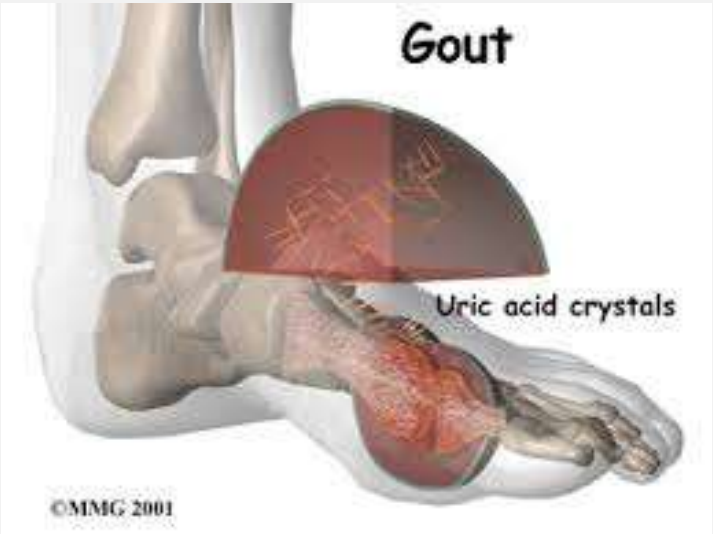
Septicemia ICD-10

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

Gout – Documentation Improvement

- Physician (provider) must document the type and site of the gout in order to get the most specific classification



Clinical Example: 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
      - ***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

Clinical Example: 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 Example: 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 Example: 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

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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 Example: Documentation Improvement

Glascow Coma Scale

- In ICD-10-CM, clinicians may use the Glasgow coma scale codes that follow in conjunction with traumatic brain injury codes or sequelae of cerebrovascular accident codes. ***At a minimum, facilities must report the initial score documented on presentation at the facility***. This may be a score from the emergency medicine technician (EMT) or in the ED.
- **One code from each of the three subcategories** (R40.21-, R40.22-, and R40.23-) **is needed to complete the scale**. Therefore, the clinician must document
  - visual
  - verbal
  - motor status

- The clinician must also **document the time in which the coma scale is recorded** in order to assign the appropriate seventh character

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Clinical Example: Documentation Improvement

Catheter Complications

Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure.

- ***Physicians must document any relationship between a current condition and an indwelling catheter***

There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication.

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Alcohol Abuse/Use

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

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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**

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

STD- Documentation Improvement

ICD-10-CM has created a range of codes to identify infections with a predominantly Sexual mode of transmission (A50-A64).

- Physician (provider) must document the type of STD and infection.
- It is important to note that human immunodeficiency ***virus (HIV) disease is excluded from this range of codes***.
  - A56.11 Disease, diseased, sexually transmitted, chlamydial

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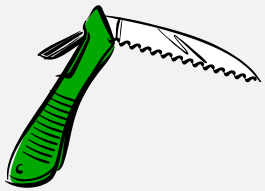
Clinical Example: Documentation Improvement

Domestic Violence Coding

- ICD-10-CM has *multiple codes each describing type of assault instrument as well as type of encounter such as:*
  - ICD-9 : Example: ICD-9-CM E code=E966=Assault by cutting and piercing instrument
  - X99.0xxA = Assault by sharp glass, initial encounter;
  - X99.0xxD = Assault by sharp glass, subsequent encounter;
  - X99.1xxA = Assault by knife, initial encounter;
  - X99.1xxD = Assault by knife, subsequent encounter



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Clinical Example: Documentation Improvement

Domestic Violence Coding

- ICD-10-CM *includes whether the maltreatment was suspected or confirmed and also details if the encounter was initial or subsequent*
- *I10 also includes the terminology of "abandonment"*
  - T74.91xA Unspecified adult maltreatment, confirmed, initial encounter;
  - T74.91xD Unspecified adult maltreatment, confirmed, subsequent encounter
  - T76.91xA Unspecified adult maltreatment, suspected, initial encounter
  - T76.91xD Unspecified adult maltreatment, suspected, subsequent encounter

Overweight and Obesity 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.

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.

Backache ICD-9

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

Backache ICD-10

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

Dysuria ICD-9

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

Dysuria ICD-10

- R30 Pain associated with micturition
  - R30.0 Dysuria
  - R30.1 Vesical tenesmus (feeling of incomplete emptying after urination)
  - R30.9 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.

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

Depression ICD-9

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

Depression ICD-10

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

Epigastric 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

Epigastric Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.1 Pain localized to upper abdomen
    - R10.10 Upper abdominal pain, unspecified
    - R10.11 Right upper quadrant pain
    - R10.12 Left upper quadrant pain
    - R10.13 Epigastric pain
      - Dyspepsia NOS
      - Excludes functional dyspepsia (K30)
        - » Indigestion

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 dyserythyropoietic anemia
  - D64.8 Other specified anemias
  - D64.9 Anemia, unspecified

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 esphagostomy
  - 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

Underdosing

New concept in ICD-10

- Taking less of a medication than prescribed by physician or manufacturer's instruction
  - Intentional underdosing
    - Due to financial hardship
    - Other reasons
  - Unintentional underdosing
    - Age-related debility
    - Other reasons

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

Separate "Z" code 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).

Underdosing / Poisoning ICD-10 Examples

T45.5 – Poisoning by, adverse effect of and underdosing of anticoagulants

- T45.511 – Poisoning by anticoagulants, accidental (unintentional)
- T45.512 – Poisoning by anticoagulants, intentional self-harm
- T45.513 – Poisoning by anticoagulants, assault
- T45.514 – Poisoning by anticoagulants, undetermined
- T45.515 – Adverse effect of anticoagulants
- T45.516 – **Underdosing** of anticoagulants

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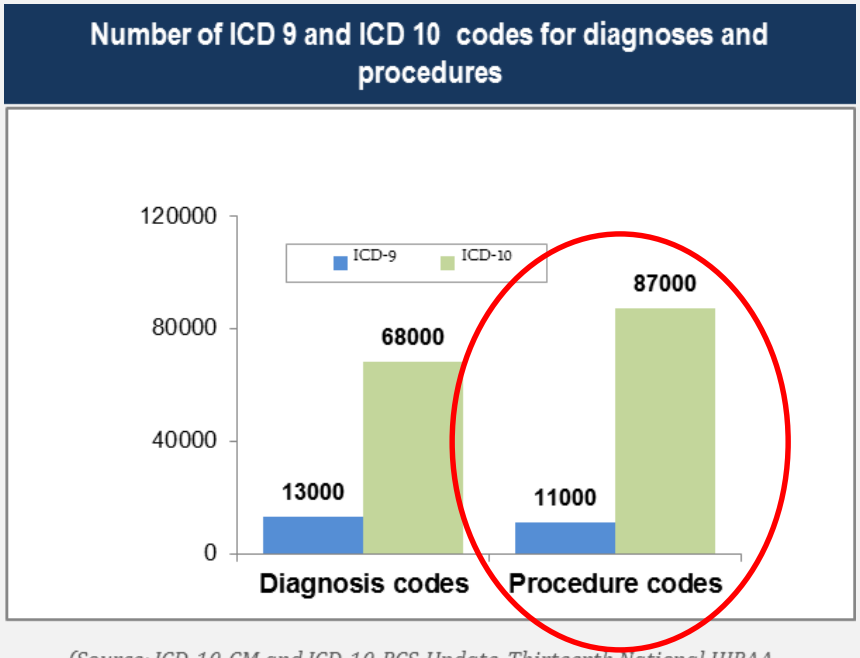
Procedure Documentation Examples

Changes to procedure codes



(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 general surgery procedures has undergone significant revision focusing primarily on section, body system, root operation, body part, approach, device and qualifier.

Catheter Insertion

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

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

Clinical Example: Documentation Improvement

Catheter complications (cont'd.)

For Example:

Patient presents with E.coli UTI and indwelling foley catheter.

Physician must document the relationship between the two conditions if present

- E.Coli UTI **due to** indwelling foley catheter – *indicating a relationship*
- E.Coli UTI **and** indwelling foley catheter – *indicating no relationship*

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Clinical Example: Catheter complications

Failure to document the relationship between catheters and current conditions will prompt a coder to query for clarification.

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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 02HV33Z Insertion, superior vena cava, percutaneous, infusion device

Infusion of substances

- Procedures require documentation of:
  - *Body part where infusion took place*
    - Peripheral vein/artery
    - Central vein/artery
  - *Approach*
    - Open
    - percutaneous
  - *Substance*

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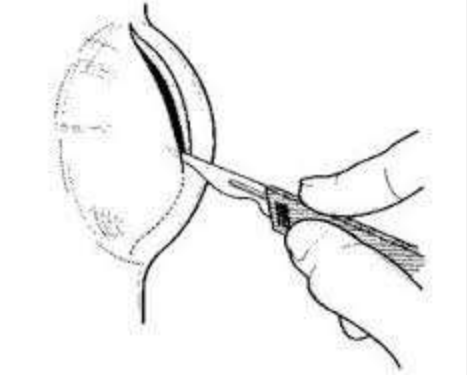
Incision and Drainage

- Procedures require documentation of:
  - *Body part*
  - *Level of tissue incised*
    - Skin
    - Subcutaneous tissue and fascia



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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!

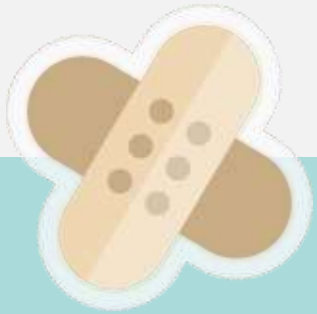
Query…answer how?

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 ord and ***cannot code a diagnosis*** that is ***not d y the Provider.***

Summary

- The transition to ICD-10 classification systems on October 1, 201 will have a significant impact on physician documentation requirements.
- Please let us know areas or items that you would like to see further addressed in more detail.



Questions?