ICD-10 Documentation for Common Comorbidities
Objectives

At the completion of this lesson the learner will be able to:

• Identify common conditions and the ICD-10 changes that are associated with them

• Document the clinical findings/indicators to support the diagnosis documented

• Define documentation recommendations for each condition
Overview

While the actual number of diagnoses codes has increased from ICD-9 to ICD-10, the structure and function of coding has improved to better represent the diagnosis and acuity of patients with respiratory illness.

Standard ICD-10 Documentation Requirements

- Document causal agents as clearly as possible.
- Document the condition as acute or chronic
- Document location with as much specificity as possible
- Document the clinical findings/indicators to support the diagnosis documented
- Document related, secondary or causal illness whenever appropriate

*Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an uncommon diagnosis*
Assessment

• **Question:** What resource is available to help ensure proper documentation with complicated, hard to code cases?
Assessment

- **Answer:** Guidance on tips and recommendations for proper documentation from a Clinical Documentation Improvement Specialist is available.
Overview: Helpful Hint

To determine how to calculate the new ICD-10 code documentation requirements, think of the acronym “CALCS” (See below). While not all 5 types of documentation will be needed in each case, remembering this acronym will help you to think through the new specifications required and document the case appropriately.

• **C** - Document *causal* agents as clearly as possible
• **A** - Document the condition as *acute* or chronic
• **L** - Document *location* with as much specificity as possible
• **C** - Document the *clinical findings*/indicators to support the diagnosis documented
• **S** - Document related, *secondary* or causal illness whenever appropriate
Assessment

• **Question:** To remember what information is required for proper documentation, recall what the 5 letters in CALCS stand for?
Assessment

• **Answer:** Cause, Acuity, Location, Clinical Findings, Secondary Illnesses
Documenting Common Comorbidities

- One of the primary goals of the ICD-10 transition is to capture the most accurate and complete picture of the patient and the care the patient receives.
- Capturing complications and comorbidities is not new to ICD-10.

*Because of the expansion of codes, it is important to review some common comorbidities and be aware of the ICD-10 changes that will help to capture a more appropriate patient acuity and assist in establishing medical necessity to care provided.*

The common comorbidities that will be reviewed in this training include:
- Heart Failure
- Hypertension
- Diabetes Mellitus
- Chronic Obstructive Pulmonary Disease
- Obesity
- Hyperlipidemia
- Under-Dosing
Documenting Complications

Complications with a procedure or a device requires **the same specificity of documentation** regardless of the initial cause or patient presentation:

1. Clearly defining the complication either of procedure or device
2. Identifying the complication as causal to the patient presentation
3. Clearly identifying if this was an expected or unexpected outcome
Assessment

• **Question:** What are the different specifications required between complications of a procedure and complications of a medical device?
Assessment

• **Answer:** None. Complications with a procedure or a device requires the **same specificity of documentation** regardless of the initial cause or patient presentation.
Heart Failure

There is only one change to heart failure terminology in ICD-10:

1. The separate distinction of “congestive” goes away and diagnoses are just “heart failure”

2. There are no other terminology changes from ICD-9 to ICD-10

Documentation will continue to require a designation of “acute”, “chronic”, “acute on chronic” AND “systolic”, “diastolic”, “combined systolic and diastolic” or “left.”

It is important to document heart failure appropriately to adequately capture the severity of illness of the patient and the treatment required for appropriate patient care.
Heart Failure Documentation

Important Documentation for Heart Failure Cause

• Document **cause** of heart failure—pregnancy related, HTN, HTN with CKD, rheumatic HF will result in a more specific diagnosis code
• Identify if the failure is **systolic, diastolic, or systolic AND diastolic**
• With Systolic failure be sure Ejection Fraction is documented
• Identify the phase of treatment as **acute, chronic or acute on chronic**
• Cor Pulmonale is a separate set of diagnoses codes that requires acute or chronic designation and should include causal conditions ie. COPD, pulmonary HTN, sleep apnea
• Document if it follows **surgery or procedure**
• Document **ACE or ARB** or contraindication to these classes of medication
Heart Failure Codes

Documentation Algorithm

- Heart Failure
  - Left Ventricular Failure
    - Acute
    - Chronic
    - Acute on Chronic
  - Systolic
    - Acute
    - Chronic
    - Acute on Chronic
  - Diastolic
    - Acute
    - Chronic
    - Acute on Chronic
  - Combined
    - Acute
    - Chronic
    - Acute on Chronic

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Hypertension

- Hypertension has become streamlined with ICD-10
- There is no longer a distinction or documentation requirement for “malignant”, “benign”, or the catch all “not otherwise specified”
- Causal relationship should be stated or implied (i.e. due to hypertension)
- While descriptors are still found in some clinical settings, ICD-10 has structured hypertension to be:

**Hypertension Categories**

- **Hypertensive Heart Disease**
  - Document the presence of heart failure when appropriate
  - Document the type and acuity of heart failure

- **Hypertensive Chronic Kidney Disease**
  - Document Stage of Kidney Disease
  - Diagnoses codes are divided by Stage 1-4

- **Secondary HTN**
  - Document the primary cause:
    - Renovascular HTN
    - Secondary to other renal disorders
    - Secondary to endocrine disorders
    - Other secondary

- **Hypertensive Heart and Chronic Kidney Disease**
  - Document the presence of heart failure
  - Type and acuity of the heart failure
  - Document the stage of kidney Disease by stage 1-4

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Diabetes Mellitus

- Biggest changes for diabetes documentation → elimination of controlled/uncontrolled
- Documenting the patient presentation allows coder to capture the necessary information to fully code the patient’s condition
- IMPORTANT: Document a LINK between DM and manifestations or complications
- Think of the diabetes codes in building blocks, building from one block to the next for complete documentation:

**Diabetes Mellitus**

**Cause or Type**
- Secondary to Underlying Condition
- Drug or Chemical Induced
- Type 1
- Type 2
- Other

**Presence of Manifestations or Complications**
- Examples:
  - Kidney
  - Neuro
  - Circulatory

**Specific Complications**
- Examples:
  - Polyneuropathy
  - Hyperglycemia with coma
  - Cataract

**Insulin Dependence**
- NIDDM
- IDDM

Note: Document if insulin overdosing or under dosing is related to an insulin pump malfunction
Chronic Obstructive Pulmonary Disease (COPD)

- Roughly the same number of codes as in ICD-9 but documentation requirements are streamlined.

Chronic Obstructive Pulmonary Disease

- Includes:
  - Chronic Obstructive Bronchitis
  - Chronic bronchitis with airway obstruction
  - Chronic bronchitis with emphysema
  - Chronic Obstructive Tracheobronchitis
  - Asthma with COPD
  - Asthma is classified as: Mild intermittent, mild persistent, moderate persistent and severe persistent

COPD with Acute Lower Respiratory Infection

- Document the type of infection

COPD with Exacerbation

- Coding will include any documentation of “decompensated COPD”
- Indicate if with respiratory failure and its severity
- Document if oxygen dependent
- Document any tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
Hyperlipidemia

- **Coding** for hyperlipidemia has changed slightly with ICD-10
- **Documentation** for hyperlipidemia has not changed
- Document if there is a relationship between other conditions and Hyperlipidemia e.g. CAD, DM
- **Document the type:**
  - Group A- Pure Hypercholesterolemia
  - Group B- Pure Hyperglyceridemia
  - Group C- Mixed Hyperlipidemia
  - Group D- Hyperchylomicronemia
  - Group E - Familial combined Hyperlipidemia
  - Group F - Unspecified Hyperlipidemia

**Restructure** of codes will provide a better picture of patients that have “other specified” hyperglycemics instead of combining “other specified” with “unspecified”

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Assessment

• **Question:** What three attributes of hyperlipidemia should providers continue to document?
Assessment

- **Answer:** Providers must continue documenting a patients’ triglycerides, lipids, and cholesterol.
**Important Note:** Underdosing is a new concept for ICD-10. Ability to capture and report the detail around these complications can have a big impact.

### Specifications and Examples

**Documentation**
- **Cause**
- **Acuity**
- **Location**
- **Clinical Findings**
- **Secondary Illnesses**

**Cause:**
- Document the cause of underdosing
- Reason code explains why the patient is not taking the medication

**Clinical Findings:** Document the outcome of underdosing

**Secondary Illness:** *The components of underdosing codes include:*
- Medical condition is sequenced first.
- Under-dosing code is listed as a secondary diagnosis.
- Reason code explains why the patient is not taking the medication
Assessment

• **Question:** Is underdosing a primary or secondary diagnosis?
Assessment

- **Answer:** Underdosing is a secondary diagnosis, but still requires the documentation of cause and the patients outcome. The primary diagnosis is listed first when the instance is coded and the code will also include the reason for underdoing.
If a patient presents with a condition that is related to under-dosing, it is important to document the condition and a LINK to the medication:

### Underdosing

**Medical Condition**
- Infection
- Hyperglycemia
- Hypertension
- Seizure
- Mania

**Identification of Underdosing as Cause**
- Antibiotic
- Antidiabetic
- Hormonal agents
- Anti-epileptic
- Antihypertensive

**Cause of Underdosing**
- Intentional
- Unintentional
- Financial Hardship
- Age-related dementia
Comorbidities are prevalent in most hospitalized patients. Every patient is unique and even common conditions have a wide range of impact on patient conditions, but there are commonalities when documenting:

- Document **cause and social factors** that influence cardiac diagnoses—(Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)), weight, non-compliance with treatment regimen including over/under-dosing, and any corresponding diagnosis
- Document **comorbidities** with detail that will show their **impact on patient condition** even if it is not the primary problem
- Document a clear **LINK between underlying condition and related, secondary, or causal illness** whenever appropriate

*Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, or are documenting an uncommon diagnosis.*