ICD-10 Documentation for Infectious Disease
Objectives

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

• List the frequently used infectious disease diagnoses
• Document the specificity required to support accurate and complete coding of diagnoses
Overview

While the actual number of infectious disease diagnoses 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.

- 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.
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
Section 1: ICD-10 Diagnosis Documentation Recommendations

ICD-10 Diagnosis Documentation Recommendations

ICD-10 Procedure Documentation Recommendations
Most Common Infectious Disease Diagnosis

This module is focused on the most frequently documented diagnoses that will have the greatest impact on the provider including:

- Sepsis and SIRS
- Viral Hepatitis
- Whooping Cough / Pertussis
- Gonococcal Infection
- AIDS and HIV
- Pneumonia
- Acute Respiratory Failure
- Mechanical Ventilation
- Abdominal Infections
- Fever of Known and Unknown Origin

Note: This training module is not intended to be an all-inclusive training tool to teach the provider every coding nuance within ICD-10
General Documentation for Infectious and Parasitic Diseases

**Examples and Specifications**

- **Causes:** shigellosis due to shigella boydii, post-operative wound infection caused by streptococcus
- **Acuity:** chronic, acute, etc.
- **Location:** TB of the lung
- **Secondary Illnesses:** syphilitic nephritis, Kaposi's sarcoma, etc.

**ICD-9 Code 004.2 Shigella Boydii**

**ICD 10 Code A03.2 Shigellosis due to Shigella Boydii**
Whooping Cough/ Pertussis

Examples and specifications
- **Cause**: e.g. bordetella pertussis, bordetella bronchiseptica
- **Clinical Findings**: With or without pneumonia
- **Secondary Illnesses**: Any complication of pertussis and identify which condition occasioned the admission

Documentation
- Cause
- Acuity
- Location
- Clinical Findings
- Secondary illnesses

ICD-9 Code 033.0: Whooping cough due to Bordetella Pertussis

ICD 10 Code A37.01: Whooping Cough due to Bordetella pertussis with pneumonia
AIDS and HIV

**Examples and Specifications**

- **Acuity:**
  - Specify when HIV is newly diagnosed
  - Specify when the patient is asymptomatic or has inconclusive serology
  - Specify if the HIV patient is pregnant

- **Clinical Findings:**
  - Diagnostic statement confirming diagnosis if the patient has AIDS, is HIV positive, or has a HIV related illness

- **Secondary illnesses:**
  - LINK HIV and any related secondary diagnosis
  - Clarify when a HIV patient is admitted for a condition unrelated to HIV

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

**ICD-9 795.71:** Nonspecific serologic evidence of human immunodeficiency virus

**ICD 10 Code R75:** Inconclusive laboratory evidence of human immunodeficiency virus
Post-Operative Complications

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

Documentation
- Cause
- Acuity
- Location
- Clinical Findings
- Secondary illnesses

Examples and Specifications
- **Cause:**
  - Identifying the complication as causal to the patient presentation
- **Clinical Findings:**
  - Clearly defining the complication either of procedure or device
- **Secondary illnesses:**
  - 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.
Pneumonia and Respiratory Tract Infections

Specifications for documenting pneumonia / other respiratory tract infections:
1. Causal agent or organism
2. Any related or underlying disease that would be complicated by pneumonia
3. Any procedural or post-procedural complication e.g. Ventilator Associated Pneumonia. Document the relationship between the condition and the procedure and the associated organism(s).

Example Cause & Secondary Illness Documentation

Define Type of Pneumonia:
- Viral
- Bacterial
- Aspiration

Document Causal Agent:
- Streptococcus, group B
- H. Influenzae
- RSV
- Klebsiella

Document Related Disease:
- Rheumatic Fever
- Measles
- Rubella
- Salmonella
- Whooping Cough

Complication Related:
- VAP
- Aspiration
Respiratory Failure

• Respiratory Failure is never a single diagnosis—always an associated cause
• Documentation of cause and sequence of events is vital to assigning the correct codes:
  • Is respiratory failure the reason the patient was admitted secondary to another cause?
    – Patient with myasthenia gravis presents to the ED with acute exacerbation and respiratory failure
  • Did the patient present with a problem that after the admission resulted in respiratory failure?
    – Patient with acute on chronic combined heart failure required mechanical ventilation following hospitalization for sepsis and aggressive fluid resuscitation that resulted in respiratory failure

Documenting Respiratory Failure:
1. Diagnosis does not require mechanical ventilation
2. Must document as acute, chronic, or acute and chronic
3. Must be defined as hypercapnic or hypoxic
4. If respiratory failure is post-procedural, specify if this is a complication or an expected outcome of the surgery and specify the etiology (aspiration, radiation, pneumonia, etc.)
5. Document any tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
Fever - with or without known origin - is coded as a symptom rather than a definitive diagnosis. Additional documentation is required for determining the condition.

### Examples and Specifications

- **Cause:**
  - Document if drug induced and identify the drug
  - Document the underlying condition and causes e.g. neutropenic fever, mosquito-borne viral fever, etc.

- **Acuity:**
  - acute, chronic at the onset
  - Severity—document temperature high point and duration

- **Secondary Illnesses:**
  - Associated problems: malaise, chills, headache, seizure
  - Specify if post-procedure fever or post-vaccination fever
  - Document if febrile non-hemolytic transfusion reaction

### Documentation
- **Cause**
- **Acuity**
- **Location**
- **Clinical Findings**
- **Secondary illnesses**
Assessment

• **Question:** True or False: Fever may be used as diagnosis by itself. No further documentation is required.
Assessment

- **Answer:** False.
Diagnoses of the Digestive Track

Diagnoses of the small and large intestines follow the same principles of documentation:

**Specifications**

- **Cause:**
  - Identify the underlying cause or document unknown e.g. alcoholic cirrhosis, Crohn’s disease, ulcerative colitis, diverticulitis
  - Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
  - Alcohol use, Abuse, Dependence
- **Acuity:** Acute, Chronic, Acute and Chronic
- **Location:**
  - Small intestine, large intestine, peritoneum, retroperitoneum
  - Identify the site of bleeding that is visualized or suspected
- **Clinical Findings:** Document medications used e.g. NSAID
- **Secondary Illnesses:** Complications, obstruction, bleeding, perforation, with abscess, without perforation, with diarrhea, state abnormal test/lab findings or link them to a related diagnosis e.g. positive guaiac stool

**Examples:**

- Diverticulosis of the small intestine without perforation or abscess
- Allergic gastroenteritis and colitis
- Crohn’s disease of the small intestine with fistula
- IBS with diarrhea
- Postprocedural peritoneal adhesion
Infections of the Kidney and Urinary Tract

Examples and Specifications

- **Cause:** Identify the causal organism (Candidiasis, streptococcus, staphylococcus, MRSA)
- **Acuity:**
  - Identify if the problem is chronic or acute
  - Document cystitis as being acute, chronic obstructive, interstitial, trigonitis, irradiation, etc.
- **Location:** Document the site
- **Clinical Findings:** Identify the presence of hematuria
- **Secondary Illnesses:**
  - Document if any urethritis
  - Document when hydronephrosis is accompanied by a ureteral stricture, claculus obstruction, etc.

ICD-10 Code N30.01: Acute cystitis with hematuria (with presence of MRSA)

ICD-9  595 Acute Cystitis
Viral Hepatitis

Examples and Specifications

- **Cause:** the underlying cause e.g. alcohol and the manifestation e.g. hepatic coma
- **Acuity:** Specify the acuity e.g. acute, subacute, chronic
- **Clinical Findings:**
  - Document any associated medication or drug use and the purpose of its use e.g. methotrexate for RA
  - Document the type of Hepatitis: Type A, Type B with and without delta agent, Type C, Type E
- **Secondary Illnesses:** information regarding any related disease e.g. cirrhosis

ICD-9 070.20 Viral hepatitis B with hepatic coma, acute or unspecified, without mention of hepatitis delta

ICD 10 Code B15.9 Acute Hepatitis B without delta agent with hepatic coma
Section 2: ICD-10 Procedure Documentation Recommendations

| ICD-10 Diagnosis Documentation Recommendations |
| ICD-10 Procedure Documentation Recommendations |
Review of ICD-10 Procedure Code Structure

ICD-10 Procedure documentation: More granular and precise

Focus for Providers: Understand concepts coders capture rather than memorize every detail

- Procedure documentation can be thought of on multiple characters
- Each character captures an increased amount of provider documentation in respect to the service or procedure provided
Assessment

• **Question:** What are the 7 different characteristics to remember when coding a procedure?
Assessment

• **Answer:** Section, Body System, Root Operation, Body Part, Approach, Device, Qualifier
# Section

Starting point for coding procedures. Provides the coder with the initial criteria to class information and narrows available codes.

<table>
<thead>
<tr>
<th>Medical and Surgical - Biopsy of Skin</th>
<th>Chiropractic</th>
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</thead>
<tbody>
<tr>
<td>Obstetrics</td>
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<tr>
<td>Placement</td>
<td>Nuclear Medicine</td>
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<td>Administration</td>
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<td>Physical Rehabilitation and Diagnostic</td>
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<tr>
<td>Other Procedures</td>
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Body System requires increased specificity of documentation AND coding.

Depending on the section identified the character may be:

- Body System
- Physiologic System
- Anatomic Region

Examples of Body System:

- Skin and breast
- Subcutaneous Tissue and Fascia
- Lymphatic and Hemic Systems
**Root Operation** determines the purpose of a procedure. There are 31 specific types of root operations that are in 9 groups:

1. Procedures that take out some or all of a **body part**
2. Procedures that take out **solids/fluids/gases** from a body part
3. Procedures involving **cutting or separating** only
4. Procedures that **put in/put back** or **move** some/all of a body part
5. Procedures that **alter the diameter/route of a tubular body part** – can be performed only on tubular body parts
6. Procedures that always involve a **device**
7. Procedures involving **examination only**
8. Procedures that **define other repairs**
9. Procedures that **define other objectives**

**Examples of Root Operation:**
- Drainage- Taking or letting out fluids and/or gases from a body part
- Excision- Cutting out or off, without replacement, a portion of a body part
Documenting for Root Operation:

- Don’t attempt to memorize the coding verbiage for each root operation

- Ensure documentation of the procedure has a clear objective/purpose

- Ensure one of the 9 groupings of operations can be identified
Body Part is very specific and detailed. The procedure dictates the specificity of documentation:

- A body part
- Some of a body part
- Area around a body part
- In or on a body part
- Conduction mechanism (brain or heart)

**Examples of Body Part**
- Upper lung lobe, right
- Lower lung lobe, left
- Skin, subcutaneous tissue or fascia- which goes to specific body part e.g. shoulder, wrist, etc.
Documenting for Body Part:

- Be as specific as the body part and procedure allow
- If there is laterality, capture right, left or bilateral
- If there is distance, capture proximal and distal
- Multiple procedures in the same organ or vessel need to have clear documentation
Approach is based on access location, method and types of instrumentation used:

- **Open**- Cutting through the (skin/mucous membrane/other body layers) to expose the site of the procedure
- **Open Endoscopic**- Instrumentation to reach and visualize the procedure site
- **Open with Percutaneous Endoscopic Assistance**- Instruments used to assist with procedure
- **Percutaneous**- Entry, by puncture or minor incision, of instrumentation through the (skin/mucous membrane/other body layers) to reach procedure site
- **Percutaneous Endoscopic**- Instrumentation to reach and visualize the procedure site
- **Via Natural or Artificial Opening**- Entry of instrumentation through a natural or artificial external opening to reach the procedure site
- **Via Natural or Artificial Opening Endoscopic**- Instrumentation to reach and visualize the procedure site
- **External**- Performed directly on the skin or mucous membrane
Assessment

• **Question:** What are the 3 determinants for coding an “approach”?
Assessment

• **Answer:** Location, method, instrumentation
**Device.** Devices left in place **at the completion of a procedure** require a code.

**Important Note:**

*It is important to document specifically what *type of device* is placed, and also *how it is placed*. Qualifying codes will often capture additional details about a device placement.*

**Examples of Device:**
- Endotrachial tube
- Chest tube placement
- Catheter placement
Assessment

• Question: What devices require documentation to accurately code the procedure under ICD-10?
Assessment

- **Answer:** Devices that are left in the body after the procedure require documentation.
Assessment

• **Question:** What specifics need to be provided about these devices?
Assessment

• **Answer:** The type of device and its placement
**Qualifier:** Defines an additional attribute of the procedure when appropriate.

- **Not all procedure codes require qualifiers**
- Data adds specific, clarifying information that is not contained in another character

**Examples of Qualifiers:**

- Procedures including biopsy for diagnostic purposes
- Identifies source of tissue if placed during a procedure: autologous, non-autologous
- Identifies source of blood product: frozen vs. fresh
Putting It All Together:

Skin Biopsy- Scalp:

- 0JB03ZX- Excision of Scalp Subcutaneous Tissue and Fascia, Percutaneous Approach, Diagnostic
- 0JB03ZZ- Excision of Scalp Subcutaneous Tissue and Fascia, Percutaneous Approach, No Qualifier
- 0JB00ZX- Excision of Scalp Subcutaneous Tissue and Fascia, Open Approach, Diagnostic
- 0JB00ZZ- Excision of Scalp Subcutaneous Tissue and Fascia, Open Approach, No Qualifier
Blood Transfusions

The single data point captured in ICD-9 for blood transfusion was the occurrence of the transfusion. With ICD-10 there are multiple data points that will be captured:

1. Type of cells transfused (RBC or Frozen RBC)
2. Document location or infusion site (Peripheral artery, Peripheral vein, Central Vein, Central Artery)
3. Document the approach
4. Specify if Autologous or non-Autologous

**Important Note:**
The receipt of transfusions has to be acknowledged by the provider.
Mechanical Ventilation

New Concepts for Mechanical Ventilation in ICD-10:

1. Respiratory Assistance vs. Respiratory Performance
   - Assistance is respiratory support delivered via mask or non-invasive device (CPAP, BiPAP)
   - Performance is respiratory support delivered via invasive ETT device (nasal, oral, trach)

2. Duration of Ventilator support
   - less than 24 hours
   - 24-96 hours
   - more than 96 hours

3. Capture of detail of support
   - Continuous Positive Airway Pressure
   - Intermittent Positive Airway Pressure
   - Continuous Negative Airway Pressure
   - Intermittent Negative Airway Pressure

**Important Note:**
Respiratory Arrest:
- Is not a diagnosis
- Is a clinical finding for which a more definitive diagnosis should be determined
- Is appropriate to describe an initial finding
Biopsy

• Document the root operation e.g. excision, resection, etc.
• Document specific site and laterality (if applicable)
• Document approach e.g. open, percutaneous endoscopic, etc.
Conclusion

While the actual number of infectious disease diagnoses 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.

Infectious Disease Provider Documentation Overview:

- Document a clear LINK between underlying condition and related, secondary or causal illness whenever appropriate
- Document comorbidities with detail that will show their impact on patient condition even if it is not the primary problem
- Document causal agents as clearly as possible
- Document location with as much specificity as possible
- Document the condition as acute or chronic
- 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*