ICD-10 Training for Outpatient Primary Care Physicians
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## Varying Changes by Clinical Areas

Changes in the number of codes

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<th>Clinical Area</th>
<th>ICD-9 Codes</th>
<th>ICD-10 Codes</th>
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<tr>
<td>Fractures</td>
<td>747</td>
<td>17099</td>
</tr>
<tr>
<td>Poisoning and toxic effects</td>
<td>244</td>
<td>4662</td>
</tr>
<tr>
<td>Pregnancy related conditions</td>
<td>1104</td>
<td>2155</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>292</td>
<td>574</td>
</tr>
<tr>
<td>Diabetes</td>
<td>69</td>
<td>239</td>
</tr>
<tr>
<td>Migraine</td>
<td>40</td>
<td>44</td>
</tr>
<tr>
<td>Bleeding disorders</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>Mood related disorders</td>
<td>78</td>
<td>71</td>
</tr>
<tr>
<td>Hypertensive Disease</td>
<td>33</td>
<td>14</td>
</tr>
<tr>
<td>End stage renal disease</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Chronic respiratory failure</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Health Data Consulting
# Comparing ICD-9-CM and ICD-10-CM

<table>
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<tr>
<th>ICD Code Structure</th>
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<tr>
<td><strong>ICD-9-CM Diagnosis Codes</strong></td>
<td><strong>ICD-10-CM Diagnosis Codes</strong></td>
</tr>
<tr>
<td>Number of codes: 14,025</td>
<td>Number of codes: 68,069</td>
</tr>
<tr>
<td>3-5 digit numeric codes</td>
<td>3-7 digit alphanumeric codes</td>
</tr>
<tr>
<td>Exception are supplemental codes, in which the first digit is alpha (E or V) or numeric; digits 2-5 are numeric</td>
<td>Digit 1 is alpha</td>
</tr>
<tr>
<td></td>
<td>Digit 2 is numeric</td>
</tr>
<tr>
<td></td>
<td>Digits 3-7 are alpha or numeric</td>
</tr>
</tbody>
</table>
ICD-9 CM Codes are numeric 3, 4 or 5 digit codes, with separate codes (V and E codes) to show other encounter data and external causes. ICD-10 CM Codes are alphanumeric with up to 7 characters, with the 7th character representing the visit encounter or sequelae for injuries and external causes.

<table>
<thead>
<tr>
<th>ICD-9 CM Code Format</th>
<th>ICD-10 CM Code Format</th>
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</thead>
<tbody>
<tr>
<td>Category</td>
<td>Category</td>
</tr>
<tr>
<td>Etiology, Anatomic site Manifestation</td>
<td>Etiology, Anatomic site Severity</td>
</tr>
<tr>
<td></td>
<td>Extension</td>
</tr>
<tr>
<td>ICD-9 CM Chapters</td>
<td>ICD-10 CM Chapters</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Chapter 1</strong></td>
<td>Certain infectious and parasitic diseases (A00-B99)</td>
</tr>
<tr>
<td>001-139 Infectious And Parasitic Diseases</td>
<td>Chapter 1</td>
</tr>
<tr>
<td><strong>Chapter 2</strong></td>
<td>Neoplasms (C00-D48)</td>
</tr>
<tr>
<td>140-239 Neoplasms</td>
<td>Chapter 2</td>
</tr>
<tr>
<td><strong>Chapter 3</strong></td>
<td>Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)</td>
</tr>
<tr>
<td>240-279 Endocrine, Nutritional And Metabolic Diseases, And Immunity Disorders</td>
<td>Chapter 3</td>
</tr>
<tr>
<td><strong>Chapter 4</strong></td>
<td>Endocrine, nutritional and metabolic diseases (E00-E90)</td>
</tr>
<tr>
<td>280-289 Diseases Of Blood And Blood-Forming Organs</td>
<td>Chapter 4</td>
</tr>
<tr>
<td><strong>Chapter 5</strong></td>
<td>Mental and behavioral disorders (F01-F99)</td>
</tr>
<tr>
<td>290-319 Mental Disorders</td>
<td>Chapter 5</td>
</tr>
<tr>
<td><strong>Chapter 6</strong></td>
<td>Diseases of the nervous system (G00-G99)</td>
</tr>
<tr>
<td>320-389 Diseases Of The Nervous System And Sense Organs</td>
<td>Chapter 6</td>
</tr>
<tr>
<td><strong>Chapter 7</strong></td>
<td>Diseases of the eye and adnexa (H00-H59)</td>
</tr>
<tr>
<td>390-459 Diseases Of The Circulatory System</td>
<td>Chapter 7</td>
</tr>
<tr>
<td><strong>Chapter 8</strong></td>
<td>Diseases of the ear and mastoid process (H60-H95)</td>
</tr>
<tr>
<td>460-519 Diseases Of The Respiratory System</td>
<td>Chapter 8</td>
</tr>
<tr>
<td><strong>Chapter 9</strong></td>
<td>Diseases of the circulatory system (I00-I99)</td>
</tr>
<tr>
<td>520-579 Diseases Of The Digestive System</td>
<td>Chapter 9</td>
</tr>
<tr>
<td><strong>Chapter 10</strong></td>
<td>Diseases of the respiratory system (J00-J99)</td>
</tr>
<tr>
<td>580-629 Diseases Of The Genitourinary System</td>
<td>Chapter 10</td>
</tr>
<tr>
<td>ICD-9 CM Chapters</td>
<td>ICD-10 CM Chapters</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Chapter 11: 630-677 Complications Of Pregnancy, Childbirth, And The Puerperium</td>
<td>Chapter 11: Diseases of the digestive system (K00-K93)</td>
</tr>
<tr>
<td>Chapter 12: 680-709 Diseases Of The Skin And Subcutaneous Tissue</td>
<td>Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)</td>
</tr>
<tr>
<td>Chapter 13: 710-739 Diseases Of The Musculoskeletal System And Connective Tissue</td>
<td>Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)</td>
</tr>
<tr>
<td>Chapter 14: 740-759 Congenital Anomalies</td>
<td>Chapter 14: Diseases of the genitourinary system (N00-N99)</td>
</tr>
<tr>
<td>Chapter 15: 760-779 Certain Conditions Originating In The Perinatal Period</td>
<td>Chapter 15: Pregnancy, childbirth and the puerperium (O00-O99)</td>
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<tr>
<td>Chapter 16: 780-799 Symptoms, Signs, And Ill-Defined Conditions</td>
<td>Chapter 16: Certain conditions originating in the perinatal period (P00-P96)</td>
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<tr>
<td>Chapter 17: 800-999 Injury And Poisoning</td>
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<td>ICD-9 CM Chapters</td>
<td>ICD-10 CM Chapters</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Chapter 18</td>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)</td>
</tr>
<tr>
<td>Chapter 19</td>
<td>Injury, poisoning and certain other consequences of external causes (S00-T98)</td>
</tr>
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<td>Chapter 20</td>
<td>External causes of morbidity (V01-Y99)</td>
</tr>
<tr>
<td>Chapter 21</td>
<td>Factors influencing health status and contact with health services (Z00-Z99)</td>
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Section 2: Overview Clinical Impact of ICD-10

Overview of ICD-10

Overview Clinical Impact of ICD-10

Requirements for Clinical Documentation

Appendix: General material -- Tobacco use, BMI, Wounds, Ulcers
With ICD-10, Appropriate Clinical Documentation Can:

- Enhance communication among providers, and between physician and patient by filling in the gaps in treatment and care
- Provide an accurate representation of the severity and complexity of a patient’s illness
- Improve the quality of patient care, and the patient care experience
- Connect the pieces of the medical record together for problems, assessments, procedures, and treatments
- Support and supplement provider documentation
- Help substantiate the level of specificity required within ICD-10
- Ensure we are paid for the services we provide
ICD-10 Clinical Documentation Impacts

- Timing of care
- Anatomical site specificity
- Laterality
- Disease acuity
- Combination codes with Symptoms and/or Manifestations
- Complications
- Status codes, personal and family history codes
- General – BMI, tobacco use/smoking exposure, health status
Overview

While the actual number of 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.

Provider Documentation Overview:

• Document social factors that influence diagnoses—BMI, smoking exposure/history, non-compliance with treatment regimen including over/under-dosing
• Document the acuity when appropriate
• 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
ICD-10-CM Examples of Documentation Specificity

- There are new ICD-10 codes identifying abnormal findings and thus separating routine preventive exams from exams that were clinically necessary for further investigation and assessment.
  - Z00.121 Encounter for routine child health examination with abnormal findings
  - Z01.01 Encounter for examination of eyes and vision with abnormal findings
  - Z01.31 Encounter for examination of blood pressure with abnormal findings
  - Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings
- For disease conditions such as asthma, bronchitis, COPD, emphysema, diseases of the ear, and hypertension ICD-10 requires that any related tobacco use, abuse, dependence, past history, or smoke exposure (e.g., second hand) be recorded
- Hearing loss is identified by laterality, rather than the location of the affected ear. You also need to delineate if hearing is different in both ears.
- ICD-9 only has one code for Alzheimer’s disease. In ICD-10, if you can distinguish that a patient’s disease is early onset or late onset, that difference can be coded.
- More specific documentation regarding laterality and anatomical location is required to identify site for medicated dressings, splints, etc.
ICD-10-CM Example of Revised Classification

• Hypertension is no longer classified by type - benign, malignant, or unspecified.
• I10 Essential (primary) hypertension replaces:
  - 401.0 Malignant essential hypertension
  - 401.1 Benign essential hypertension
  - 401.9 Unspecified essential hypertension
• The following are the available categories for hypertensive conditions in ICD-10-CM. In some cases you may need to note if heart failure is present (e.g., I11) and the type of heart failure.
  - I10, Essential (primary) hypertension;
  - I11, Hypertensive heart disease;
  - I12, Hypertensive chronic kidney disease;
  - I13, Hypertensive heart and chronic kidney disease; and
  - I15, Secondary hypertension.
• I10 is used when hypertension is not further specified/associated with/caused by another disease process such as chronic kidney disease.
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Important Note: Underdosing is a new concept for ICD-10.

Specifications and Examples

- **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
Documenting Underdosing

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:

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

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

- **Cause of Underdosing**
  - Includes:
    - Intentional
    - Unintentional
    - Financial Hardship
    - Age-related dementia

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Documenting 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 underdosing is related to an insulin pump malfunction
Documenting Diabetes (continued)

- If there are complications/manifestations of the diabetes, additional details may be necessary for the following conditions:

<table>
<thead>
<tr>
<th>Arthropyathy</th>
<th>Site of ulcer</th>
<th>Severity of retinopathy</th>
<th>With/without macular edema</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage of CKD</td>
<td>Gangrene</td>
<td>Hyperglycemia</td>
<td></td>
</tr>
</tbody>
</table>
• **Question:** What terminology for diabetes will no longer be available with ICD-10?
Assessment

• **Answer:** The descriptors of uncontrolled and controlled will no longer be available.
Documenting Heart Failure

- One of the most frequent causes of hospital admission and readmission
- Continues to have one of the highest “unspecified” code rates of all inpatient diagnoses.

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.
Documenting Heart Failure

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
Documenting Heart Failure

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
Documenting Myocardial Infarction

The changes for myocardial infarction incorporate greater specificity to both the type and location of infarct. The changes that will impact documentation include:

1. Social Factors influencing the heart including: BMI and smoking exposure/history
2. Subsequent MIs are documented along the same STEMI/NSTEMI categories as the initial event
3. Acute phase MI decreases from 8 weeks to 4 weeks following WHO definitions
4. Episodes of Care for Acute MI goes away, all encounters for an MI in the acute phase will have the same diagnosis code
5. ICD-10 will now allow for identification of an MI as a subsequent event while still being treated for an initial MI still in the acute phase

Acute MI example of STEMI of the LAD:

- **I21.02** ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery
- Replaces
  - **410.11** Acute myocardial infarction of other anterior wall, initial episode of care
  - And
  - **410.12** Acute myocardial infarction of other anterior wall, subsequent episode of care
Acute Myocardial Infarction Codes

**Important Documentation for Acute MI:**
- Smoking Exposure/History
- BMI
- Onset (acute phase is 0-4 weeks)
- Location
- STEMI vs NSTEMI
- Subsequent MI within the Acute Phase

**Documentation Algorithm**

- MI
  - NSTEMI
    - Left Main
    - LAD
  - STEMI
    - Other Anterior Wall
    - RCA
  - Subsequent STEMI
    - Other Inferior wall
  - Subsequent NSTEMI
    - L Circumflex
    - Other Site
Documenting Atherosclerosis of Coronary Vessels

• With ICD-10-CM, there are combination codes for atherosclerotic coronary artery disease and angina pectoris. A causal relationship between atherosclerosis and angina is assumed unless documentation specifically indicates that the angina is due to a condition other than atherosclerosis.

• Specify the type of angina pectoris, e.g., angina, unstable angina, angina with documented spasm.
  – Terminology change -- intermediate coronary syndrome has been updated and is now called unstable angina

• When documenting atherosclerosis of coronary vessels or a coronary artery bypass graft, document by type, such as
  – native coronary artery
  – autologous vein or autologous artery bypass graft
  – nonautologous biological bypass graft
  – unspecified
Documenting Atherosclerosis of Non-Coronal Vessels

When documenting atherosclerosis of non-coronal vessels:

**Cause/Type:**
State if the affected vessel is a native or a bypass graft

**Location:**
Identify the site(s) affected including laterality

**Clinical Findings:**
Document and support any complication(s) such as rest pain, ulceration, intermittent claudication
Documenting 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” hyperglycemias instead of combining “other specified” with “unspecified”

**Documentation Requirements:**
Providers must continue to document specifically:
• Triglycerides
• Lipids
• Cholesterol
Types of Hyperlipidemia

- Hyperlipidemias are also classified according to which types of lipids are elevated, that is hypercholesterolemia, hypertriglyceridemia or both in combined hyperlipidemia
  - **Pure Hypercholesterolemia (Group A)** Includes: Fredickson’s hyperlipoproteinemia, type IIa; hyperbetalipoproteinemia; low-density-lipoprotein-type [LDL] hyperlipoproteinemia
  - **Pure Hyperglyceridemia (Group B)** Includes: pure hyperglyceridemia; elevated fasting triglycerides; endogenous hyperglyceridemia; Fredickson’s hyperlipoproteinemia, type IV; hyperprebetalipoproteinemia; very-low-density-lipoprotein-type [VLDL] hyperlipoproteinemia
  - **Mixed Hyperlipidemia (Group C)** Includes: broad- or floating-betalipoproteinemia; combined hyperlipidemia NOS; elevated cholesterol with elevated triglycerides NEC; Fredrickson’s hyperlipoproteinemia, type IIb or III; hyperbetalipoproteinemia with prebetalipoproteinemia; hypercholesteremia with endogenous hyperglyceridemia; tubo-eruptive xanthoma; xanthoma tuberosum
  - **Hyperchylomicronemia (Group D)** Includes: hyperchylomicronemia; mixed hyperglyceridemia; chylomicron retention disease; Fredickson’s hyperlipoproteinemia, type I and V
  - **Other Hyperlipidemia Include:** Familial combined hyperlipidemia
  - Hyperlipidemia, unspecified
Assessment

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

• **Answer:** Providers must continue documenting a patients’ triglycerides, lipids, and cholesterol.
Documenting Arrhythmia/Dysrhythmia

Specifications and Examples

**Cause:**
Underlying cause (e.g., hyperkalemia, hypertension, alcohol consumption, digoxin, amiodarone, verapamil HCl)
Rhythm name (e.g. flutter, fibrillation, type 1 atrial flutter, long QT syndrome, sick sinus syndrome, etc.)

**Acuity:** Document the acuity (e.g. acute, chronic, etc.) of the case

**Location:** Document the location with greater specificity (e.g. atrial, ventricular, supraventricular, etc.)
Documenting Injuries

Specifications and Examples

- **Cause:**
  - Type of the injury
  - Description of the circumstances – timeframe, how, where, when the injury or accident occurred
  - If relevant, what was the patient doing at the time of the injury or accident (e.g. sports, motor vehicle crash, pedestrian, slip and fall)

- **Acuity:** Severity of the injury

- **Location:** Anatomical site of the injury, including laterality with appropriate anatomical landmarks

- **Clinical Findings:** Is infection present?

- **Episode of care** (e.g. Initial, subsequent, sequelae). Initial encounters may also require, where appropriate, intent (e.g. unintentional or accidental, self-harm, etc.), and status (e.g. civilian, military, etc.)
Assessment

• **Question:** In addition to the standard documenting requirements that can be remembered through the “CALCS” acronym, what information needs to be recorded to accurately code an injury?
Assessment

- **Answer:** A classification of the encounter or instance as initial, subsequent, or sequelae needs to be documented.
Documenting Osteoporosis

Specifications and Examples

**Cause**: Identify whether osteoporosis is age-related vs. other specific cause (e.g., chronic steroid use, vitamin deficiency)

**Location**: Name the bone fractured and laterality, as appropriate

**Clinical Findings**: Identify whether it is with or without current pathological fracture and history of pathological fracture
Documenting Arthritis

Specifications and Examples

**Cause**: Clarify type (rheumatoid, juvenile, osteo, etc..), joint and any manifestations especially if rheumatoid.

**Secondary Illnesses**: Further specify any rheumatoid associated conditions such as rheumatoid lung, vasculitis, heart, polyneuropathy, fever etc..
Documenting Pregnancy

If a female patient is pregnant, the following documentation should be included:

• In ICD-10-CM, antepartum encounters are classified by the trimester of the pregnancy at the time of the encounter

• **Document weeks of gestation**

• The definition of a complication remains the same as under ICD-9-CM. Examples include asthma, smoking, obesity, gestational diabetes, pre-existing hypertension, etc.
Documentation for Gynecological Conditions

- Documentation for gynecological conditions is relatively unchanged, except for addition of laterality
- Vaginitis is further classified as either vaginitis or vulvitis and includes the specification of acute or subacute and chronic
- Delineation of a high risk screening mammogram is not available
Specifications and Examples

**Cause:** Identify the deficit such as aphasia, dysphagia, monoplegia, hemiparesis
Inquire about any alcohol, drug, or tobacco use, abuse, or dependence. Identify tobacco exposure (e.g., second hand, occupational, etc.)

**Location:** Determine if dominant or non-dominant side is affected for hemiplegia/monoplegia cases
Documenting Asthma

Specifications and Examples

- **Cause:**
  - Detail external forces that will assist in establishing a cause and effect relationship (e.g., asthma due to dusts, exercise-induced bronchospasm, allergic rhinitis with asthma, etc.)
  - Include any exposure to tobacco smoke
- **Acuity:**
  - Describe the severity as mild, moderate, or severe
  - List the frequency as intermittent or persistent
- **Clinical Findings:** Note if there is an exacerbation, and whether or not it is uncomplicated, acute, or status asthmaticus
- **Secondary Illnesses:** Further specify any rheumatoid associated conditions such as rheumatoid lung, vasculitis, heart, polyneuropathy, fever etc..
Documenting Pneumonia

Documentation of cause or organism is key:

• Viral pneumonia –
  – Clarify type of virus when known.
  – Clarify bronchopneumonia due to viruses other than influenza viruses, Pneumonia due to SARS-associated coronavirus, and Severe acute respiratory syndrome when appropriate to assure accurate code assignment.

• Bacterial pneumonia –
  – Clarify between gram negative and gram positive pneumonia and whether empirical treatment is being rendered.
  – Furthermore, clinicians should specify Methicillin susceptible vs. Methicillin resistant Staphylococcus aureus when known.
  – All of this differentiation is key to assuring severity of illness and risk of mortality data integrity. One does not need a positive sputum culture to render this diagnosis due to variables such as previous use of antibiotics or difficulty getting a good specimen.

• Other pneumonias –
  – Aspiration, drug-induced interstitial lung disorder, and pneumonitis due to fumes and vapors. If due to a medications or other exogenous substance, the clinician should clarify the substance and whether it is a side effect of the drug versus the drug being taken inappropriately.
Documenting Influenza

• **Cause:**
  – Document the type of influenza when known (i.e. A influenza vs. other flu strains vs. unidentified strains)
  – For all types of influenza, documentation should indicate the associated manifestations.

• **Secondary Illnesses:**
  – Document presence of influenza with lower respiratory infections
  – Possible respiratory manifestations include sinusitis, pneumonia, lung abscess, pleural effusion, laryngitis, pharyngitis, upper respiratory symptoms.
  – Other non respiratory manifestations such as gastroenteritis, encephalopathy, myocarditis, and otitis media should be documented when clinically appropriate.
Documenting Otitis Media

When documenting otitis media, include the following:

- **Type** e.g., Serous, sanguinious, suppurative, allergic, mucoid
- **Infectious agent** e.g., Strep, Staph, Scarlet Fever, Influenza, Measles, Mumps
- **Secondary causes** e.g. tobacco smoke
- **Temporal factors** Acute, subacute, chronic, recurrent
- **Side** e.g. Left, right, or both ears
- **Tympanic membrane rupture** Note whether this is present
Documenting Depression

- Like ICD-9-CM, in ICD-10-CM, depression is coded by type. Recall with in ICD-9-CM, the “fifth digit” of the assigned code signifies severity, chronicity, or status within applicable code categories. In ICD-10-CM there is no fifth digit list.
- The ICD-9 code for unspecified depression, ICD-9-CM 311 Depressive disorder NOS, includes the clinical terms “depressive state” and “depression.” In ICD-10-CM, there is no unique code for “depression” without any further detail. Unqualified use of the word depression in the medical record is classified to major depression in ICD-10.
- ICD-10 categorizes postpartum mental disorders as puerperal, but only if they cannot otherwise be classified.
Documenting Depression (continued)

• If a patient is not formally diagnosed, consider potentially using a signs or symptom code. See as examples
  – F53 Puerperal psychosis
  – R45.2 Unhappiness
  – R45.3 Demoralization and apathy
  – R45.4 Irritability and anger
  – R45.7 State of emotional shock and stress, unspecified
    Note “and” means “and/or”
  – O90.6 Postpartum mood disturbance (for postpartum blues, postpartum dysphoria, postpartum sadness)
• If relevant, list any late effects or current injuries related to past events (e.g., fall from dizziness secondary to lithium level)
• List any alcohol or drug use, abuse or dependence
Documenting Anxiety

• There is an unspecified anxiety code in ICD-10-CM, but there are potentially new codes in places other than the mental health chapter that may provide a better picture of the patient’s situation. See examples
  – Z56.1 Change of job
  – Z60.0 Problems of adjustment to life-cycle transitions

• Potential use of symptom codes when patient has not been formally diagnosed. See examples
  – R45.0 Nervousness
  – R45.1 Restlessness and agitation
  – R45.82 Worries
Assessment

• **Question**: In some instances with depression and anxiety, if a patient is not formally diagnosed with the condition what code(s) could accurately represent the case?
Assessment

• **Answer:** consider potentially using a signs or symptom code and remember that for hard to code cases, guidance is available from the Clinical Documentation Improvement Specialists.
Documenting Attention Deficit Disorder

- Revised terminology: ICD-9-CM code category 314 classifies it as **hyperactivity, development delay, conduct disorder, and other specified manifestation**
- With ICD-10-CM, you need to indicate if condition is predominantly inattentive, hyperactive, or combined
Documenting Adverse effects, Poisonings, or Toxic effects

- List all complications or manifestations the substance causes (e.g., cardiac arrest, convulsions, arrhythmias, etc.)
- Supply the name of the substance causing the complications or manifestations (e.g., Prednisone, shellfish, Digoxin, latex, detergent, etc.)
- Specify any abuse of or dependence on the substance
- Specify any external causes (e.g., malfunction of insulin pump)
- Provide information regarding the circumstances surrounding the event, or the mindset of the patient:
  - Accidental (i.e., unintentional).
  - Intentional (i.e., self-harm).
  - Assault
  - Undetermined (only use this when it is impossible to determine the intent)
Documenting Migraines

- Migraine headaches frequently are accompanied by autonomic nervous system symptoms, such as nausea, vomiting, and sensitivity to light and/or sound. The neurological disorder also can result in symptoms other than a headache, such as prolonged visual aura, atypical auras, confusion, abdominal pain, cyclic vomiting, vertigo, etc.

- In ICD-10-CM, migraines are classified to category G43, with 12 subcategories:
  - G43.0- Migraine without aura
  - G43.1- Migraine with aura
  - G43.4- Hemiplegic migraine
  - G43.5- Persistent migraine aura without cerebral infarction
  - G43.6- Persistent migraine aura with cerebral infarction
  - G43.7- Chronic migraine without aura
  - G43.A- Cyclical vomiting
  - G43.B- Ophthalmoplegic migraine
  - G43.C- Periodic headache syndromes in child or adult
  - G43.D- Abdominal migraine
  - G43.8- Other migraine
  - G43.9- Migraine unspecified
• Migraine codes have fifth characters that further differentiate the condition as not intractable or intractable. The following terms are considered to be “equivalent” to intractable: pharmacoresistant, pharmacologically resistant, treatment resistant, refractory, medically refractory, and poorly controlled.

• Migraine codes can also have a sixth character that identifies the migraine as occurring with status migrainosus or without status migrainosus. Status migrainosus refers to a migraine that has lasted more than 72 hours.

• If the terms lower-half migraine and migrainous neuralgia are used they map to cluster headache syndrome.

• Conditions that may cause or be associated with migraines should be reported. Migraines can represent an adverse effect of some drugs; drugs that are known to trigger migraines include nitroglycerine and oral contraceptives.

• Migraines with aura rarely may be complicated by a seizure. According to the International Headache Society, for a diagnosis of migraine seizure, the seizure must occur within one hour of the onset of the aura.

• For menstrual migraines, an additional code is required for associated premenstrual tension syndrome.
Documenting Anemia

• **Cause:**
  – Identify the type of anemia
    • e.g., nutritional, hemolytic, aplastic, blood loss, etc.
  – Describe hemolytic anemias as being hereditary, acquired, enzyme disorders, autoimmune, or non-autoimmune
  – Detail the underlying cause or provide a statement indicating “unknown cause”
    • e.g., chronic kidney disease, trauma, ulcer, chemotherapy, etc.
  – List the name and purpose of substances causing anemia
    e.g., medications
  – Provide the name of the deficient vitamin(s) and/or mineral(s) for nutritional anemias
    • e.g., low vitamin B12 level to pernicious anemia

• **Acuity:** Specify the acuity of the disease
  – i.e., acute or chronic

• **Clinical Findings:** Link any laboratory findings to a related diagnosis
Documenting Sleep Disorders

• Specify the type (e.g., insomnia, sleep apnea, etc.).
• Note if there is a definitional change. For example, ICD-10 guidelines define insomnia as
  – Difficulty falling asleep
  – Difficulty maintaining sleep, or
  – Non-refreshing sleep

happening **three or more times a week** for longer than a month, and causing distress to the patient or interfering with the patient’s daily life. The main difference is that ICD-10-CM quantifies the symptoms with a frequency of three or more times a week; that qualifier does not exist in either of the two current use classifications for insomnia.

• List other underlying or related conditions (e.g., nightmares, sleepwalking, obesity, morbid obesity)
• Detail any contribution alcohol or drug use, abuse, or dependence has on the condition
• Specify the drug by name
Diagnoses of the Thyroid

Documentation of thyroid disorders requires:

- **Cause**: Identify the problem: thyrotoxicosis, thyroiditis, goiter, hypothyroidism
- Detail the type of hypothyroidism (e.g., congenital, due to medicine or other substances, post-infectious, atrophy, etc.)
- **Acuity**: Designate the problem as acute or chronic
- **Clinical Findings**:
  - Indicate any iodine deficiencies
  - Detail the type of congenital iodine-deficiency syndrome (e.g., neurological, myxedematous, mixed)
  - List the presence or absence of a diffuse goiter
  - List the acuity of thyroiditis (e.g., acute, subacute, chronic)
- **Secondary Illnesses**:
  - Identify associated complications: thyrotoxic crisis/storm, transient thyrotoxicosis, myxedema.
  - Report any post-surgical hypothyroidism
  - Specify the presence or absence of a thyrotoxic crisis, storm, or goiter with hyperthyroidism
  - State the type of goiter associated with iodine-deficiency thyroid disorders (e.g., diffuse, multinodular)

**Examples**:
- Drug-induced thyroiditis
- Congenital hypothyroidism without goiter
- Iodine-deficiency related diffuse goiter
- Thyrotoxicosis with toxic multinodular goiter with toxic storm
Appendicitis

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

Examples and Specifications
- **Acuity**: acute, chronic/recurrent
- **Secondary Illnesses**: Presence of peritonitis and if the peritonitis is localized or generalized

Examples
*Acute appendicitis with localized peritonitis*
*Acute appendicitis with generalized peritonitis*
Documenting Complications of Care

- Complications of care are based solely on the provider’s documentation of the relationship between the condition and the care or procedure.
- The provider must state the condition as a complication.
- Assist in inquiring if there appears to be a cause-and-effect relationship between the care provided and the condition.
Appendix - General Materials: Tobacco Use, BMI, Wounds & Ulcers

Clinical Impact of ICD-10

Requirements for Clinical Documentation

Appendix - General Materials: Tobacco Use, BMI, Wounds, Ulcers
Tobacco Use Documentation Changes

• ICD-10 documentation requires a **terminology change for the capture of tobacco use**
  – Current tobacco use documentation changes to nicotine use documentation
  – Documentation must also include tobacco use and types of second hand tobacco smoke (e.g., from parent, at work, perinatal) including, but not limited to:
    • History of nicotine dependence
    • Problems related to lifestyle, tobacco use NOS
    • Problems related to physical environment, exposure to environmental tobacco smoke (acute, chronic)
  – **Type of nicotine needs to be documented** (cigarette, chewing tobacco, other tobacco product)

**Note:** The physician must determine and document a patient’s:
  – Tobacco abuse/dependence
  – Whether tobacco use status is in remission/withdrawal/uncomplicated
Body Mass Index

Many quality measures as well as ICD-10 diagnoses require documentation of weight status

BMI categories include:
- $\leq 19$
- 20-40 (each whole number)
- 40-44
- 45-49
- 50-60
- $\geq 70$

**Important Note:**
Who can Document BMI?
- Coding guidelines allow any clinician to capture and record a patient’s BMI
- However, the provider is ultimately responsible for the completeness of diagnosis documentation
- Find where BMI is routinely captured at your facility and partner with other clinicians to ensure this is properly documented

**NOTE:** In pediatric patients, document their weight percentile
Overweight/Obesity

Overweight → should be accompanied by documentation of BMI

Obesity → Is further subdivided into three groups:

- **From Excess Calorie Intake**
  - Severe
  - Morbid

- **Drug Induced**
  - Identify causal agent

- **With Alveolar**
  - Hypoventilation
Wound Care Documentation Requirements, Specific to Debridement

- Debridement descriptors have increased and require descriptive documentation
  - Condition requiring debridement (e.g., ulcer, fracture)
  - Type of debridement (e.g., excisional, non-excisional, hydro, dressing)
  - Location, size and characteristics of the wound
  - Depth of the wound debrided
  - Specific type of tissue removed (e.g., skin, muscle)
  - Instruments used to remove tissue (e.g., scalpel, scissors)
  - Patient tolerance
  - Dressing applied and treatment plan
Pressure Ulcer Documentation Requirements

Includes ulcers described as bed sore, decubitus ulcer, plaster ulcer, or pressure sores. While underlying diagnosis (obesity, overweight, pressure ulcer) must be captured by the provider, details of ‘healing’ pressure ulcers can be captured from other clinician documentation:

- Specificity has increased—you must capture laterality and location site
- The severity of the pressure ulcer is reported using the National Pressure Ulcer Advisory Panel (NPUAP) stages 1-4 and unstageable. Unspecified is an option but is not part of the NPUAP classification. Staging is more specific:
  - **Stage I:** Pressure pre-ulcer skin changes limited to persistent focal edema
  - **Stage II:** Pressure ulcer with abrasion, blister, partial thickness skin loss involving epidermis and/or dermis
  - **Stage III:** Pressure ulcer with full thickness skin loss involving damage or necrosis if subcutaneous tissue
  - **Stage IV:** Pressure ulcer with necrosis of soft tissues through to underlying muscle, tendon, or bone
  - **Unstageable:** Based on clinical documentation pressure ulcers are those “whose stage cannot be clinically determined (e.g., the ulcer is covered by eschar or has been treated with a skin or muscle graft) and pressure ulcers that are documented as deep tissue injury but not documented as due to trauma.”

- Multiple ulcers need to be documented distinctly to location and stage
Non-Pressure Ulcer Documentation

• In ICD-10-CM, clinicians will also need to document arterial ulcers, venous ulcers, and ulcers caused by diabetic neuropathic disease

• Documentation for non-pressure ulcers must include anatomic location and laterality, when applicable

• Documentation for non-pressure ulcers must also capture depth, specifically:
  – Limited to breakdown of skin
  – With fat layer exposed
  – With necrosis of muscle
  – With necrosis of bone
Documentation and coding of diagnoses have greater alignment with ICD-10.

Following these documentation recommendations will assist in meeting the greater specificity demands of ICD-10:

- Document **causal** agents as clearly as possible. This includes the type and a LINK to the underlying condition.
- 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. This include a clear LINK to the cause and documenting comorbidities with detail that will show their impact on patient condition even if it is not the primary problem.

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