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.

Infectious Disease Provider Documentation Overview:

- Document causal agents as clearly as possible
- Document location with as much specificity as possible
- Document the condition as acute or chronic
- 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
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

• Document the acuity of the disease e.g. chronic, acute, etc.
• Specify the site of infection or infestation (e.g. TB of the lung)
• Document the specific cause of the infection or infestation 
  (e.g. shigellosis due to shigella boydii, post-operative wound 
  infection caused by streptococcus)
• Document any information regarding any secondary disease 
  process related to an infection e.g. syphilitic nephritis, 
  Kaposi's sarcoma, etc.
• Document the known or suspected organism associated with an infection
Whopping Cough/ Pertussis

- Document if with or without pneumonia
- Document the causative organism, if known (e.g. bordetella pertussis, bordetella bronchiseptica)
- Document any complication of pertussis and identify which condition occasioned the admission
Gonococcal Infection

- Identify the site or body system affected e.g. eye, Musculoskeletal system, etc.
- Indicate the presence or absence of periurethral and accessory gland abscess when the lower genitourinary tract is affected
- Link any associated manifestations e.g. pneumonia, sepsis, etc.
- Document information regarding health department notification
Documenting AIDS and HIV

• Document a diagnostic statement confirming diagnosis if the patient has AIDS, is HIV positive, or has a HIV related illness
• LINK HIV and any related secondary diagnosis
• Clarify when a HIV patient is admitted for a condition unrelated to HIV
• Specify when HIV is newly diagnosed
• Specify when the patient is asymptomatic or has inconclusive serology
• Specify if the HIV patient is pregnant
Documenting Post-Operative 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
Pneumonia and Respiratory Tract Infections

Documenting pneumonia / other respiratory tract infections on this information:
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)

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 never a single diagnosis—always an associated cause
- Documentation of cause and sequence of events 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.)
Diagnoses of the Digestive Track

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

1. Location - Small intestine, large intestine, peritoneum, retroperitoneum
2. Character - Acute, Chronic, Acute and Chronic
3. Cause - Identify the underlying cause or document unknown e.g. alcoholic cirrhosis, Crohn’s disease, ulcerative colitis, diverticulitis
4. Complication - 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 due to internal hemorrhoids
5. Identify the site of bleeding that is visualized or suspected
6. Document medications used e.g. NSAID
7. Tobacco use, dependence, past history, or exposure (second hand, occupational, etc.)
8. Alcohol use, Abuse, Dependence

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

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Infections of the Kidney and Urinary Tract

When documenting infections remember to document the following:

1. Identify if the problem is chronic or acute
2. Identify the presence of hematuria
3. Identify the causal organism (Candidiasis, streptococcus, staphylococcus, MRSA)
4. Document the site
5. Document if any urethritis
6. Document when hydronephrosis is accompanied by a ureteral stricture, claculus obstruction, etc.
7. Document cystitis as being acute, chronic obstructive, interstitial, trigonitis, irradiation, etc.

Example: Acute cystitis with hematuria with presence of MRSA
Viral Hepatitis

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

Fever - with or without known origin - is coded as a symptom rather than a definitive diagnosis. Additional documentation is required for determining the condition.

1. Onset—acute, chronic
2. Severity—document temperature high point and duration
3. Associated problems: malaise, chills, headache, seizure
4. Document if drug induced and identify the drug
5. Document the underlying condition and causes e.g. neutropenic fever, mosquito-borne viral fever, etc.
6. Specify if post-procedure fever or post-vaccination fever
7. Document if febrile non-hemolytic transfusion reaction

NOTE: The more precise patient presentation can be documented, coding ability to most effectively represent symptoms and severity of illness becomes. Document thoroughly and involve the CDI specialist if you have questions
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 axes
- Each axis captures an increased amount of provider documentation in respect to the service or procedure provided
### Axis 1: Starting point for coding procedures.

Provides the coder with the initial criteria to class information and narrows available codes.

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Axis 2: Body System

Body System: is the next axis for understand ICD-10 coding. As the Axes increase so does the specificity of documentation AND coding.

Depending on the section identified the axis may be:

- Body System
- Physiologic System
- Anatomic Region

Examples of Axis 2:
- Skin and breast
- Subcutaneous Tissue and Fascia
- Lymphatic and Hemic Systems
Axis 3: Root Operation

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:**

*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
Axis 3: Root Operation

Infectious Disease Examples of Axis 3-Root Operation:

Documenting for Axis 3:

- 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
Axis 4: Very specific and detailed, 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 Axis 4:

- Upper lung lobe, right
- Lower lung lobe, left
- Skin, subcutaneous tissue or fascia- which goes to specific body part e.g. shoulder, wrist, etc.
Axis 4: Body Part

Documenting for Axis 4:

- 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
Axis 5: Approach

Axis 5: 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
Axis 6: Devices left in place at the completion of a procedure require a code.

Examples include:

- Endotrachial tube
- Chest tube placement
- Catheter placement

Device Placement for Procedures:

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.
Axis 7: Qualifier

Axis 7: Defines “qualifier” or 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 axis

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

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.
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