ICD-10-CM – Primary Care

A Bridge to CDI
Disclaimer

The information provided within this presentation is for educational purposes only and is not intended to be considered legal advice. Opinions and commentary are solely the opinion of the speaker. Many variables affect coding decisions and any response to the limited information provided in a question is intended to provide general information only. All coding must be considered on a case-by-case basis and must be supported by appropriate documentation, medical necessity, hospital bylaws, state regulations, etc. The CPT codes that are utilized in coding are produced and copyrighted by the American Medical Association (AMA).
Agenda

• Relationship between ICD-9 and ICD-10
• Education and Training
• Communication
• Impact of Clinical Documentation Improvement
• Coding and documentation examples
Anticipated Change in Codes

17,000

BIG!

69,000
<table>
<thead>
<tr>
<th>Category</th>
<th>Chapter</th>
<th>Heading</th>
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<td>Infectious disease &amp; parasites</td>
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<td>C00-D48</td>
<td>2</td>
<td>Neoplasm</td>
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<td>D50-D89</td>
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<td>E00-E90</td>
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<td>Metabolic &amp; nutritional diseases</td>
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<td>F01-F99</td>
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<td>H60-H95</td>
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<td>Ear disease</td>
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<td>I00-I99</td>
<td>9</td>
<td>Circulatory system</td>
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<tr>
<td>J00-J99</td>
<td>10</td>
<td>Respiratory system</td>
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<td>K00-K93</td>
<td>11</td>
<td>Digestive system</td>
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<td>L00-L99</td>
<td>12</td>
<td>Skin disease</td>
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<tr>
<td>M00-M99</td>
<td>13</td>
<td>Musculoskeletal (including Dental)</td>
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<td>N00-N99</td>
<td>14</td>
<td>Genitourinary system</td>
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<td>O00-O99</td>
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<td>Pregnancy and child birth</td>
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<td>P00-P96</td>
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<td>Newborn</td>
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<td>Q00-Q99</td>
<td>17</td>
<td>Congenital, deformations, chromosomal anomalies</td>
</tr>
<tr>
<td>R00-R99</td>
<td>18</td>
<td>Signs, symptoms, &amp; abnormal lab</td>
</tr>
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<td>S00-T88</td>
<td>19</td>
<td>Injury, poisoning, complications, fractures, &amp; other external causes</td>
</tr>
<tr>
<td>V01-Y95</td>
<td>20</td>
<td>External causes of morbidity (“E” codes)</td>
</tr>
<tr>
<td>Z00-Z99</td>
<td>21</td>
<td>Health status/contact with health services (“V” codes)</td>
</tr>
<tr>
<td>ICD-10-CM Code Series</td>
<td>Category</td>
<td>Quick Reference</td>
</tr>
<tr>
<td>-----------------------</td>
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<td>-----------------------------</td>
</tr>
<tr>
<td>A00-B99</td>
<td>Infectious disease, bacteria, parasites</td>
<td>Aids and Bacteria</td>
</tr>
<tr>
<td>C00-D49</td>
<td>Neoplasm</td>
<td>Cancer</td>
</tr>
<tr>
<td>D50-D89</td>
<td>Blood diseases</td>
<td>Deficient Immune</td>
</tr>
<tr>
<td>E00-E90</td>
<td>Metabolic and nutritional diseases</td>
<td>Endocrine</td>
</tr>
<tr>
<td>F01-F99</td>
<td>Mental health</td>
<td>Freud</td>
</tr>
<tr>
<td>G00-G99</td>
<td>Nervous system diseases</td>
<td>“Gittery”</td>
</tr>
<tr>
<td>H00-H59</td>
<td>Eye</td>
<td>Hordeolum</td>
</tr>
<tr>
<td>H60-H95</td>
<td>Ears</td>
<td>Hearing</td>
</tr>
<tr>
<td>I00-I99</td>
<td>Circulatory system disorders</td>
<td>Infections</td>
</tr>
<tr>
<td>J00-J99</td>
<td>Respiratory system</td>
<td>Junk in the lungs</td>
</tr>
<tr>
<td>K00-K95</td>
<td>Digestive disorders</td>
<td>Kaopectate</td>
</tr>
</tbody>
</table>
## Quick Reference

<table>
<thead>
<tr>
<th>ICD-10-CM Code Series</th>
<th>Category</th>
<th>Quick Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>L00-L99</td>
<td>Skin disorders</td>
<td>Lesions</td>
</tr>
<tr>
<td>M00-M99</td>
<td>Musculoskeletal</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>N00-N99</td>
<td>Genitourinary</td>
<td>Nephrology</td>
</tr>
<tr>
<td>O00-O9A</td>
<td>Pregnancy and childbirth</td>
<td>OB</td>
</tr>
<tr>
<td>P00-P96</td>
<td>Newborn care</td>
<td>Perinatal care</td>
</tr>
<tr>
<td>Q00-Q99</td>
<td>Congenital anomalies</td>
<td>Quirky</td>
</tr>
<tr>
<td>R00-R99</td>
<td>Signs and Symptoms</td>
<td>Rash</td>
</tr>
<tr>
<td>S00-T88</td>
<td>Injuries, poisonings, complications</td>
<td>Sprains and Trauma</td>
</tr>
<tr>
<td>V01-Y99</td>
<td>Old “E” codes</td>
<td>Vehicle, “whoops,” exit wounds</td>
</tr>
<tr>
<td>Z00-Z99</td>
<td>Health Status codes</td>
<td>New “V” codes</td>
</tr>
</tbody>
</table>
## Comparison of Key Attributes

<table>
<thead>
<tr>
<th></th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3-5 characters</strong></td>
<td>Length of code</td>
<td>3-7 characters</td>
</tr>
<tr>
<td><strong>Approx 17,000 codes</strong></td>
<td>Number of codes</td>
<td>69,000 codes and growing</td>
</tr>
<tr>
<td><strong>1st-alpha or numeric</strong></td>
<td>Alpha or numeric digits</td>
<td>1-alpha, 2&amp;3-numeric, 4-7 alpha or numeric</td>
</tr>
<tr>
<td><strong>2-5 numeric</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No room for new codes</strong></td>
<td>Space</td>
<td>Flexible for adding</td>
</tr>
<tr>
<td><strong>Lacks</strong></td>
<td>Detail/Specificity</td>
<td>Very specific</td>
</tr>
<tr>
<td><strong>Lacks laterality</strong></td>
<td>Laterality</td>
<td>Has laterality (rt/lt)</td>
</tr>
<tr>
<td><strong>Non-specific and inadequate codes</strong></td>
<td>Accuracy</td>
<td>Much greater level of detail</td>
</tr>
<tr>
<td><strong>Not used by other countries</strong></td>
<td>Operability</td>
<td>Supports interoperability between U.S. and other countries</td>
</tr>
</tbody>
</table>
Differences in ICD-10

- M00.111 - Pneumococcal Arthritis Right Shoulder
- O00.1 - Tubal Pregnancy
- I10 - Essential Hypertension
- T67.3xxA - Heat Exhaustion Initial Encounter
Clinical Documentation Example

No crosswalk from ICD-9 to ICD-10
Use coding book in addition to EMR decision-tree

Example-Cerumen impaction
Tool says:

380.4 Cerumen impaction =

H61.23
H61.2Ø unspecified ear
H61.21 right ear
H61.22 left ear
H61.23 bilateral
Place of Occurrence

Activity

- How it happened
- What activity
- Where it occurred
- Sequenced after the primary external cause code
External Cause Codes

ICD-10-CM

• S83.200A
  • Rt. Meniscus bucket-handle tear right knee first occurrence

• Y92.838
  • Occurred in recreation area, mountains

• Y93.23
  • Snow Skiing

Coding & Compliance Initiatives, Inc.
Documentation

• Improvement Opportunities
• Education and Preparation
• Engage Providers
Documentation

• The chart must document that the condition was:
  • Managed
  • Evaluated
  • Assessed
  • Treated
Documentation

• If providers don’t document their care and work, it can’t be captured, coded and billed
Documentation

- Patient care
- Cash flow
Documentation, Coding and Reimbursement

• The office visit note should consistently demonstrate the nature of the presenting problem(s) (i.e. chief complaint/reason for visit).

• The assessment, plan and diagnoses need to be complete and consistent with the reason for the visit.
Medical Necessity

"Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

Source: CMS Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1
Documentation

• You should always document:

  • stability of patient illness or injury
  • any complications or underlying conditions that could complicate patient’s condition
  • decision to keep patient on same medication even if no changes were made
  • your decision to obtain old/other records or films
  • any discussion of the case with another physician
  • any additional workup you are planning i.e. MRI, CT, biopsy.
Documentation and Risk

• Diagnosis and the EMR tool

  • Listing a diagnosis on a medical record problem list does not meet documentation requirements. The diagnosis must be present in the note.
Steps to Improving Documentation

• Assess your current documentation
• Implement provider education early and ongoing
• Practice documenting a more complete diagnosis
• Establish a documentation program
• Streamline clinical documentation workflow
• Evaluate EMR templates
Coding and Documentation Examples
Hypertension

There is no hypertension table in ICD-10

Hypertension alone is a simplified code - there are several combination codes

Hypertension with heart disease
  • Need to know if there is a causal relationship or an implied relationship between heart disease and hypertension

If no causal relationship exists, code both the heart condition and the hypertension
Hypertension

Hypertension with kidney disease

- ICD-10 presumes a cause and effect relationship of chronic kidney disease as hypertensive chronic kidney disease.

Must also code the stage (1-5) of chronic kidney disease

3 code choices
Hypertension

Hypertensive heart and chronic kidney disease

If heart failure exists, code that and the chronic kidney disease as a secondary code as well as the stage of disease.

When hypertensive heart and chronic kidney disease are present, code the combination code.
Hypertension

Hypertensive Cerebrovascular disease
These are not combination codes, but will report the cerebrovascular disease and hypertension separately

Hypertensive retinopathy
Code both; sequencing based on reason for encounter
Hypertension

Hypertension, secondary
Always due to an underlying condition. Two codes are required. Underlying etiology and a hypertension code

Hypertension, transient
Assign “elevated blood pressure without dx of hypertension unless patient has known hypertension

Hypertension (I10) – includes:
(arterial) (benign) (essential) (malignant) (primary) (systemic)
Hypertension

Hypertensive heart disease with heart failure – I11.0
  • Use additional code to identify type of heart failure (I50.-)

Hypertensive heart disease without heart failure – I11.9

Hypertensive CKD with stage V or ESRD – I12.0
  • Use additional code to identify the stage of chronic kidney disease (N18.5, N18.6)

Hypertensive CKD with stages I-IV or unspecified – I12.9
  • Use additional code to identify the stage of chronic kidney disease (N18.1 - N18.9)
Headaches

- R51 (only one code) – headache
- G44 (category) other headache syndromes – several choices
  - Cluster; Episodic cluster; Chronic cluster
  - Episodic paroxysmal hemicrania; Chronic paroxysmal hemicrania
  - Short lasting unilateral neuralgiform headache with conjunctival injection and tearing (SUNCT)
  - Tension type
    - Episodic
    - Chronic
  - Post-Traumatic
    - Acute
    - Chronic
  - Drug Induced
  - Complicated
Migraine

Documentation should include the type of Migraine:

- Hemiplegic
- Chronic migraines
- Persistent
- Ophthalmologic
- Menstrual migraines
- Abdominal migraines

- Intractable or not intractable
- With or without aura
## Coronary Artery Disease

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<tr>
<th>ICD-10</th>
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<th>Coding Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>I25.110 - I25.119</td>
<td>Atherosclerotic heart disease of native coronary artery with angina pectoris</td>
<td>Must document if there is unstable angina, documented spasm, other or unspecified angina pectoris.</td>
</tr>
<tr>
<td>I25.750- I25.759</td>
<td>Atherosclerosis of native coronary artery of transplanted heart with angina pectoris</td>
<td>Documentation must support if the atherosclerosis is of the native bypass graft of a transplanted heart, and if it is with unstable angina, or documented spasm, other forms, or unspecified angina pectoris.</td>
</tr>
</tbody>
</table>
## Congestive Heart Failure

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Definition</th>
<th>Coding Guidelines</th>
<th>Instructional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I50.20-</td>
<td>Systolic (congestive) heart failure</td>
<td>Must document unspecified, acute, chronic, or acute on chronic systolic congestive heart failure.</td>
<td>Excludes 1: Combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)</td>
</tr>
<tr>
<td>I50.30-</td>
<td>Diastolic (congestive) heart failure</td>
<td>Must document unspecified, acute, chronic, or acute on chronic systolic congestive heart failure.</td>
<td>Excludes 1: Combined systolic (congestive) and diastolic (congestive) heart failure (I50.4-)</td>
</tr>
<tr>
<td>150.9</td>
<td>Heart failure, unspecified</td>
<td>Congestive heart failure NOS</td>
<td>Excludes 1: Fluid overload (E87.70)</td>
</tr>
</tbody>
</table>
PVD

Documentation requires:

• Raynaud’s syndrome with or without gangrene
• Thromboangiitis obliterans (Buerger’s disease)
• Erythromelalgia
• Other specified PVD
• Unspecified PVD
Diabetes

All ICD-10 diabetes codes include:

- Type of diabetes mellitus
- Body system affected
- The complications affecting the body system

There are 125 code choices in this category

Also to be reported is long term use of insulin
Diabetes

Includes notes tell which conditions are covered under a particular type

“Code first” notes instruct on the sequencing

If multiple codes in a category are necessary to describe the condition(s), report all.

Sequencing is based on the reason for the encounter
Diabetes

E10 – is the category for Type I

E11 is the category for Type II

E10.42 – Type I DM with polyneuropathy

E11.621 – Type II DM with foot ulcer
  • Use additional code to identify the site of the ulcer – L97.4- - L97.5-
Diabetes

Diabetes of the pregnant patient

- Codes for pregnancy, childbirth, and puerperium are sequenced first
- 4th character codes from the pregnancy section indicate type 1, type 2, unspecified, or gestational.
- 5th character indicates whether the diabetes is treated during pregnancy
- 6th character indicates whether gestational diabetes is diet-controlled or insulin-controlled.
- Also report weeks of gestation of pregnancy
Hypothyroidism

Documentation is required for:

- Congenital
- Acquired
- With goiter
- Without Goiter
- Due to medicaments or other exogenous substance
  - Code first poisoning to drug or toxin if applicable
  - Use additional code for adverse effect if applicable
Hypothyroidism

E01.0 - Iodine-deficiency related diffuse (endemic) goiter

E01.1 – Iodine-deficiency related multinodular (endemic) goiter

E01.2 - Iodine-deficiency related (endemic) goiter, unspecified

E03.1 - Congenital hypothyroidism without goiter

E03.2 - Hypothyroidism due to medicaments and other exogenous substances
  • Code first poisoning due to drug or toxin, if applicable (T36-T65 with fifth or sixth character 1-4 or 6)
  • Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)
Hyperlipidemia

- Pure hypercholesterolemia – E78.0
- Pure hyperglyceridemia (hypertriglyceridemia) – E78.1
- Mixed (elevated cholesterol and triglycerides) – E78.2
- Lipoprotein deficiency – E78.6
- Hyperchylomicronemia – E78.3
- Other hyperlipidemia – E78.4
- Hyperlipidemia, unspecified – E78.5
Asthma

• Asthma coding in ICD-10 is greatly expanded
• There are 18 code choices that require the provider to document:
  • Mild intermittent
  • Mild persistent
  • Moderate persistent
  • Severe persistent
    Uncomplicated
    Exacerbation
    Status asthmaticus
• Use additional code to identify tobacco exposure, use, occupational exposure, dependence
Asthma

- J45.20 Mild intermittent asthma, uncomplicated
- J45.21 Mild intermittent asthma with (acute) exacerbation
- J45.22 Mild intermittent asthma status asthmaticus
- J45.30 Mild persistent asthma, uncomplicated
- J45.31 Mild persistent asthma with (acute) exacerbation
- J45.32 Mild persistent asthma status asthmaticus
Asthma

- J45.40 Moderate persistent asthma, uncomplicated
- J45.41 Moderate persistent asthma with (acute) exacerbation
- J45.42 Moderate persistent asthma status asthmaticus
- J45.50 Severe persistent asthma, uncomplicated
- J45.51 Severe persistent asthma with (acute) exacerbation
- J45.52 Severe persistent asthma with status asthmaticus
COPD

• Documentation must include:
  • COPD, with acute lower respiratory infection – J44.0
  • COPD, with (acute) exacerbation – J44.1
  • COPD, unspecified – J44.9
COPD

• Documentation and Coding Tips:
  • Code also any asthma, if applicable

• Use additional code to identify:
  • Exposure to environmental tobacco smoke
  • History of tobacco use
  • Occupational exposure to environmental tobacco smoke
  • Tobacco dependence
  • Tobacco use
Upper Respiratory Infection

Documentation should also include:

• Acute or chronic is required
• Specific location
• With or without obstruction

• Acute unspecified – J06.9
• Acute laryngopharyngitis – J06.0
• Chronic – J98.8
Bronchitis

Documentation should include:

• Simple chronic bronchitis – J41.0
• Mucopurulent chronic bronchitis – J41.1
• Mixed simple and mucopurulent chronic bronchitis – J41.8

• Acute Bronchitis and what it is due to (i.e. due to streptococcus) – J20.0 through J20.9
• Chronic Bronchitis – J42
Cough and Viral Infection

• There are not any additional requirements for documentation for either of these condition

• Cough – R05
• Viral Infection, unspecified – B34.9

This is a one-to-one match
Acute Pharyngitis

• Streptococcal pharyngitis – J02.0

• Acute pharyngitis due to other specified organisms – J02.8
  • Use additional code (B95-B97) to identify infectious agent

• Acute pharyngitis, unspecified – J02.9
Pharyngitis

• Acute laryngopharyngitis – J06.0
• Peritonsillar abscess – J36
• Pharyngeal abscess – J39.1
• Retropharyngeal abscess - J39.0

• Chronic
  • Chronic rhinitis – J31.0
  • Chronic nasopharyngitis – J31.1
  • Chronic pharyngitis – J31.2
Strep

Documentation should also include:

- Streptococcal pharyngitis – J02.0
- Acute streptococcal tonsillitis, unspecified – J03.00
- Acute streptococcal tonsillitis, recurrent – J03.01
Upper Respiratory Disorders Summary

• Specify the acuity (i.e. acute, chronic, or recurrent)

• Detail site (e.g. pharynx, tonsils, larynx, etc.)

• Infectious agent when known (e.g. streptococcus, E. coli, influenza-A)

• List any hypertrophy or obstruction

• Document underlying or associated conditions (e.g. abscess)

• Document any exposure to tobacco smoke
Sinusitis

- Maxillary
- Frontal
- Ethmoidal
- Sphenoidal
- Pansinusitis
Sinusitis

• Acute
• Chronic
• Acute on Chronic
• Recurrent

• There is an instructional note for contributing factors:
  • Smoking
  • Exposure to tobacco
  • Current smoker
To code otitis media you must document:

- **Type**: serous, sanguinous, suppurative, mucoid, allergic
- **Infectious agent**: strep, staph, influenza, measles, mumps, scarlet fever
- **Temporal factors**: acute, chronic, subacute, recurrent
- **Side**: right, left, bilateral
- **Tympanic membrane rupture**: document if present or not
- **Secondary causes**: exposure to tobacco
Allergic Rhinitis

• Vasomotor Rhinitis – J30.0

• Allergic rhinitis
  • Due to pollen – J30.1
  • Other seasonal – J30.2
  • Due to food – J30.5
  • Due to animal hair and dander – J03.81
Influenza

Documentation should specify if the Influenza is:

• due to identified novel influenza A virus – J09.X-
• due to unidentified influenza virus – J11-
  • Influenza due to unidentified influenza virus with gastrointestinal manifestations – J11.2
• due to other identified influenza virus – J10-
• Also if there are any manifestation
Tonsillitis

Documentation should specify:

• Acute versus Chronic

• Chronic – with or without adenoiditis

• Acute
  • Recurrent or not
  • Streptococcal
  • Due to other specified organisms
Fever

• Document the following:
  • When the origin is unknown
  • Drug induced (identify drug)
  • Underlying conditions and causes (e.g. neutropenic fever, heat, etc.)

• Post-procedure or post-vaccination
• Febrile nonhemolytic transfusion reaction
Otalgia

Documentation should outline laterality

- Bilateral – H92.03
- Right ear – H92.01
- Left ear – H92.02
- Unspecified ear – H92.09
Conjunctivitis

- Right, left or bilateral

- Acute
  - Atopic
  - Other mucopurulent conjunctivitis
  - Follicular
  - Toxic
  - Serous conjunctivitis, except viral

- Chronic
  - Follicular
  - Chronic giant papillary conjunctivitis
  - Simple chronic conjunctivitis
Glaucoma

• Bilateral glaucoma with same type and stage: Report only the code for the type of glaucoma, bilateral, with the seventh character for the stage.

• Bilateral glaucoma stage with different types or stages: Assign the appropriate code for each eye rather than the code for bilateral glaucoma.

• Patient admitted with glaucoma and stage evolves during the admission: Assign the code for highest stage documented.

• Indeterminate stage glaucoma: Assignment of the seventh character "4" for "indeterminate stage stage" should be based on clinical documentation.
## Glaucoma

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<tr>
<th>ICD-10</th>
<th>Definition</th>
<th>Instructional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H40.10</td>
<td>Unspecified open-angle glaucoma</td>
<td>Extension Alert (requires an &quot;X&quot; in 6th character)</td>
</tr>
<tr>
<td>H40.11</td>
<td>Primary open-angle glaucoma</td>
<td>Also these codes require a 7th character in addition to the “X”</td>
</tr>
<tr>
<td>H40.20</td>
<td>Unspecified primary angle-closure glaucoma</td>
<td>0 = stage unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 = mild stage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 = moderate stage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = severe stage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = indeterminate stage</td>
</tr>
<tr>
<td>H40.40-</td>
<td>Glaucoma secondary to eye inflammation</td>
<td>Extension Alert (requires an &quot;X&quot; in 6th character)</td>
</tr>
<tr>
<td>to H40.43-</td>
<td></td>
<td>– also these codes require a 7th characters in addition to the “X”</td>
</tr>
</tbody>
</table>
Tobacco Use Disorder

The type of nicotine must be documented

- Cigarettes
- Chewing tobacco
- Other products
- Unspecified

Documentation must also include:

- Uncomplicated
- Remission
- Withdrawal
- Dependence unspecified with unspecified nicotine induced disorders
Tobacco Use Disorder

F17.210 - Nicotine dependence, cigarettes, uncomplicated

F17.211 - Nicotine dependence, cigarettes, in remission

F17.213 - Nicotine dependence, cigarettes, with withdrawal

F17.218 - Nicotine dependence, cigarettes, with other nicotine induced disorders

F17.219 - Nicotine dependence, cigarettes, with unspecified nicotine induced disorders
Atrial Fibrillation and Flutter

• Documentation must specify:
  • Paroxysmal atrial fibrillation – I48.0
  • Persistent atrial fibrillation – I48.1
  • Chronic atrial fibrillation – I48.2
  • Typical atrial flutter – I48.3
  • Atypical atrial flutter – I48.4
  • Unspecified atrial fibrillation – I48.91
  • Unspecified atrial flutter – I48.92
Iron Deficiency Anemia Secondary to Blood Loss

• There is one code is ICD-10-CM

• D50.0 - Iron deficiency anemia secondary to blood loss (chronic)
Other Anemias

• There are dozens of conditions that are anemia related and include:
  • Nutritional
  • Hemolytic

• Medical record documentation must be specific to type, acuity, etc.
B12 Deficiency

• Documentation must include the reason when known:
  • Due to intrinsic factor deficiency
  • Due to selective vitamin B12 malabsorption with proteinuria
  • Transcobalamin II deficiency
  • Other dietary vitamin B12 deficiency
  • Other vitamin B12 deficiency
  • Unspecified
Abdominal

- Pain
- Tenderness
- Rebound

- Specific location:
  - right, left
  - upper, lower
  - epigastric, periumbilical
Crohn’s

• Small intestine
• Large intestine

• without complication
• with rectal bleeding
• with obstruction
• with fistula
• with abscess
• with other complication
• with unspecified complications
Diverticular Disease

• Documentation must outline:
  • Diverticulosis or Diverticulitis
  • without perforation or abscess without bleeding
  • with bleeding
  • without bleeding
Constipation

• Document the following:

  • Slow transit – K59.01
  • Outlet dysfunction – K59.02
  • Other constipation – K59.09
  • Unspecified – K59.00
Vomiting

- Bilious - R11.14
- Projectile - R11.12
- With (R11.2) or without nausea (R11.11)
- Fecal matter - R11.13
- Unspecified – R11.10
Gastroesophageal Reflux

• Documentation must specify:
  • With or without esophagitis
  • K21.0 – with esophagitis
  • K21.9 – without esophagitis
Barrett’s Esophagitis

• Documentation must specify:
  • Without dysplasia
  • With low grade dysplasia
  • With high grade dysplasia
  • With unspecified grade of dysplasia
Urinary Tract Infection

• No additional documentation
  • N39.0 - UTI site not specified

• Personal history of urinary (tract) infections – Z87.440
Hematuria

- Documentation should specify:
  - Gross hematuria – R31.0
  - Benign essential microscopic hematuria – R31.1
  - Other microscopic hematuria – R31.2
  - Unspecified – R31.9
Incontinence

• Documentation requires:
  • Stress – N39.3
  • Urge incontinence – N39.41
  • Incontinence without sensory awareness – N39.42
  • Post-void dribbling – N39.43
  • Continuous leakage – N39.45
  • Nocturnal enuresis – N39.44
  • Mixed incontinence – N39.46
  • Overflow incontinence – N39.490
  • Other specified urinary incontinence (which include total incontinence and reflex) – N39.498
Vaginitis and Vulvitis

• Documentation must include the location and severity
  • N76.0 Acute vaginitis
  • N76.1 Subacute and chronic vaginitis
  • N76.2 Acute vulvitis
  • N76.3 Subacute and chronic vulvitis
  • N76.4 Abscess of vulva
  • N76.5 Ulceration of vagina
  • N76.6 Ulceration of vulva
  • N76.81 Mucositis (ulcerative) of vagina and vulva
  • N76.89 Other specified inflammation of vagina and vulva
Vaginal/Uterine Bleeding

- **Location & Cause** need to be documented
- Excessive and frequent menstruation
  - N92.0- with regular cycle
  - N92.1- with irregular cycle
  - N92.2- at puberty
  - N92.3- Ovulation bleeding
  - N92.4- in the premenopausal period
  - N92.5- Other specified irregular
  - N92.6- Unspecified irregular
  - N93.0- Postcoital and contact bleeding
  - N93.8- Other uterine & vaginal
  - N93.9- Abnormal uterine & vaginal
# Postmenopausal Bleeding

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient presents with complaints of post-menopausal bleeding.</td>
<td>Includes menopausal disorder due to naturally occurring age related menopause</td>
</tr>
<tr>
<td>627.1</td>
<td>N95.0-Postmenopausal bleeding</td>
</tr>
</tbody>
</table>

One to one code crossover
Symptomatic Menopausal or Female Climacteric State

• Documentation must specify:
  • N95.0 - Postmenopausal bleeding
  • N95.1 - Menopausal and female climacteric state
  • N95.2 - Postmenopausal atrophic vaginitis
  • N95.8 - Other specified menopausal and perimenopausal disorders

• Use additional code for associated symptoms:
  • Eg. Flushing
  • Lack of concentration
  • Headache
  • Sleepiness
Infrequent Menstruation (Hypomenorrhea, Oligomenorrhea)

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient presents with complaints of scanty monthly periods.</td>
<td></td>
</tr>
<tr>
<td>• 626.1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Amenorrhea or Oligomenorrhea</td>
</tr>
<tr>
<td>• N91.0 - Primary amenorrhea</td>
</tr>
<tr>
<td>• N91.1 - Secondary amenorrhea</td>
</tr>
<tr>
<td>• N91.2 - Amenorrhea, unspec</td>
</tr>
<tr>
<td>• N91.3 - Primary oligomenorrhea</td>
</tr>
<tr>
<td>• N91.4 - Secondary oligomenorrhea</td>
</tr>
<tr>
<td>• N91.5 - Oligomenorrhea, unspec. (hypomenorrhea)</td>
</tr>
</tbody>
</table>
Dysplasia of the Cervix

• Documentation must specify:
  
  • Mild (CIN I) – N87.0
  • Moderate (CIN II) – N87.1
  • Severe
    
    D06.9 Carcinoma in situ of cervix, unspecified
    D06.0 Carcinoma in situ of endocervix
    D06.1 Carcinoma in situ of exocervix
    D06.7 Carcinoma in situ of other parts of cervix
  
  • Unspecified – N87.0
Other non-inflammatory disorders of Vagina

- Vaginal dysplasia
  - Mild
  - Moderate
  - Severe
  - Unspecified
- Leukoplakia of vagina
- Stricture and atresia of vagina
- Tight hymenal ring
- Other
Candidiasis

ICD-9-CM
• Patients presents with vaginal itching. Lab tests confirm the patient has vaginal candidiasis
• 112.1- Candidiasis

ICD-10-CM
• Candidiasis of vulva and vagina
  • B37.3

One to one code crossover
Trichomoniasis

Documentation must specify the detail:

- A59.00 - Urogenital trichomoniasis, unspecified
- A59.01 - Trichomonal vulvovaginitis
- A59.03 - Trichomonal cystitis and urethritis
- A59.09 - Other urogenital trichomoniasis (trichomonas cervicitis)
- A59.8 - Other sites
- A59.9 - Unspecified
Herpes

• Documentation must specify:

  • Anogenital

    • Urogenital (unspecified)
    • Penis
    • Male genital organs

    • Cervicitis
    • Vulvovaginitis
    • Other urogenital tract
    • Perianal skin and rectum
Herpes

• Documentation must specify:

  • Other
    • Eczema herpeticum
    • Vesicular dermatitis
    • Gingivostomatitis and pharyngotonsillitis

  • Ocular
    • Iridocyclitis
    • Keratitis
    • Conjunctivitis
    • Other

• Herpes simplex infection NOS
Other Sexually Transmitted Chlamydial Diseases

- Lower genitourinary tract
  - Cystitis and urethritis
  - Vulvovaginitis
  - Other chlamydial infection of lower genitourinary tract
- Pelviperitoneum and other genitourinary organs
  - Chlamydial female pelvic inflammatory disease
  - Other genitourinary infection
- Chlamydial infection of genitourinary tract, unspecified
- Anus and rectum
- Pharynx
- Other sites
Intrauterine Contraceptive Device

- Documentation must include:
  - Routine checking – Z30.431
  - Insertion – Z30.430
  - Removal – Z30.432
  - Removal and reinsertion – Z30.433
Papanicolaou Smear of Cervix

• Documentation must include the type:
  • Atypical
    • R87.610 – undetermined significance - ASC-US
    • R87.611 – high grade - ASC-H
  • Squamous intraepithelial
    • R87.612 – low grade – LGSIL
    • R87.613 – high grade – HGSIL
Papanicolaou Smear of Cervix - cont’d.

- Cytologic evidence of malignancy on smear of cervix – R87.614
- Unsatisfactory smear – R87.615
- Satisfactory but lacking transformational zone – R87.616
- Other abnormal cytological fining on specimens – R87.618
- Unspecified abnormal cytological findings – R87.619
HPV

• Documentation must include:
  • High risk versus low risk
  • Cervical
  • Vaginal
Breast Disorders

• Documentation must specify the type of breast disorder when known.

  • Fissure and fistula of nipple
  • Fat necrosis of breast
  • Atrophy of breast
  • Galactorrhea not associated with childbirth
  • Mastodynia
  • Induration of breast
  • Nipple discharge
  • Retraction of nipple
  • Ptosis of breast
  • Hypoplasia of breast
  • Other specified breast disorder
Limb Pain

• Right, left or bilateral
• Arm
• Hand and/or fingers
• Leg
• Foot and/or toes
Back Pain

- Lumbago with or without sciatica
  - If with – right or left
- Radiculopathy
  - Occipito-atlanto-axial region
  - Cervical region
  - Cervicothoracic region
  - Thoracic region
  - Thoracolumbar region
  - Lumbar region
  - Lumbosacral region
  - Sacral and sacrococcygeal region
Joint Pain

• The documentation should include:
  • Specific joint
  • Right
  • Left
  • Bilateral
Joint Pain

**ICD-9-CM**

- 719.4_ “Pain in Joint”
  - 0 = unspecified site
  - 1 = shoulder region
  - 2 = upper arm
  - 3 = forearm
  - 4 = hand
  - 5 = pelvic region
  - 6 = lower leg
  - 7 = ankle and foot
  - 8 = other sites
  - 9 = multiple sites

**ICD-10-CM**

- M25.5 _ _ Pain in joint
  - Codes for left or right
    - Shoulder
    - Elbow
    - Wrist
    - Hip
    - Knee
    - Ankle & joints of foot
- M79.64_
  - Codes for left or right
    - Hand
    - finger
# Joint Pain in Leg

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
<th>ICD-10</th>
<th>Description</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>719.46</td>
<td>Pain in joint, lower leg</td>
<td>M25.561</td>
<td>Pain in right knee</td>
<td>left, right, or unspecified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M25.562</td>
<td>Pain in left knee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M25.569</td>
<td>Pain in unspecified knee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M25.571</td>
<td>Pain in ankle &amp; joints of right foot</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M25.572</td>
<td>Pain in ankle &amp; joints of left foot</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M25.579</td>
<td>Pain in ankle &amp; joints of unspecified foot</td>
<td></td>
</tr>
</tbody>
</table>
Obesity

Documentation to include:
- Due to excessive calories
- Morbid (severe)
- Other
- Drug induced - code drug also
- Overweight
- Other
- Unspecified

Must also code the BMI
Osteoarthritis

- Primary osteoarthritis
  - Normal wear and tear
  - Most common type

- Secondary osteoarthritis
  - Caused by injury, heredity, obesity, or some other condition
Fractures

- Laterality
- Open or closed
- Displaced or non-displaced
- Fracture type (2, 3, or 4 part)
- What kind (greenstick, comminuted, transverse)
- Routine healing, non-healing, delayed healing
- Malunion, nonunion
Fractures

- 7th character extensions:
  - A Initial encounter for closed fracture
  - B Initial encounter for open fracture
  - D Subsequent encounter for fracture with routine healing
  - G Subsequent encounter for fracture with delayed healing
  - K Subsequent encounter for fracture with nonunion
  - P Subsequent encounter for fracture with malunion
  - S Sequelae
Acne

• Documentation should specify the type of acne:
  • Vulgaris – L70.0
  • Conglobata – L70.1
  • Varioliformis – L70.2
  • Tropica – L70.3
  • Infantile acne – L70.4
  • Acne excoriee des jeunes filles – L70.5
  • Other – L70.8
  • Unspecified – L70.9
Dermatitis

• Documentation should specify the type of dermatitis:

  • Atopic
  • Seborrheic
  • Allergic contact
  • Irritant contact
  • Other
  • Unspecified
Atopic

• Documentation should specify:

  • Atopic neurodermatitis – L20.81
  • Flexural eczema – L20.82
  • Infantile (acute) (chronic) eczema – L20.83
  • Intrinsic (allergic) eczema – L20.84
  • Other – L20.89
  • Unspecified – L20.9
  • Diaper rash – L22
Seborrheic

• Documentation should specify:

  • Seborrhea capitis – L21.0
  • Seborrheic infantile dermatitis – L21.1
  • Other – L21.8
  • Unspecified – L21.9
Allergic and Irritant

• Documentation should specify what it is due to:

  • Metal
  • Adhesives
  • Cosmetics
  • Drugs in contact with skin
  • Dyes
  • Chemical products
  • Food in contact with the skin
  • Plants
  • Animal dander
  • Other agents
  • Unspecified
Viral Warts

• Documentation should specify the type of viral wart:
  • Plantar wart – B07.0
    • Verruca
  • Other viral warts – B07.8
    • Flat
    • Common
    • Verruca plana
  • Unspecified viral warts – B07.9
Cellulitis

• Documentation should specify the exact location
  • Cellulitis
  • Lymphangitis
  • Laterality
Ulcers

- Documentation must include:
  - Specific anatomical location
  - Stage of the ulcer or if unstageable or unspecified stage
- Pressure ulcer are **combination codes** that identify the site of the pressure ulcer as well as the stage of the ulcer.
- If the ulcer is a diabetic ulcer – we report the diabetes followed by the appropriate ulcer code
- If there is gangrene with the ulcer – code the gangrene first
<table>
<thead>
<tr>
<th><strong>Patients admitted with pressure ulcers documented as healed</strong>: No code is assigned if the documentation states the pressure ulcer is completely healed.</th>
</tr>
</thead>
</table>

**Patients admitted with pressure ulcers documented as healing**: Should be assigned based on the documentation in the medical record. If the documentation does not provide information about the stage of the healing pressure ulcer, assign the appropriate code for unspecified stage. If the documentation is unclear as to whether the patient has a current (new) pressure ulcer or if the patient is being treated for a healing pressure ulcer, query the provider. |

**Patient admitted with pressure ulcers evolving into another stage** during the admission: Assign the code for highest stage reported for that site.
<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Definition</th>
<th>Coding Guidelines</th>
<th>Instructional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>L89.010-L89.019</td>
<td>Pressure ulcer of right elbow</td>
<td>Must document the stage of the ulcer or if unstageable or unspecified stage of right elbow.</td>
<td></td>
</tr>
<tr>
<td>L89.120-L89.129</td>
<td>Pressure ulcer of left upper back</td>
<td>Must document the stage of the ulcer or if unstageable or unspecified stage of left upper back.</td>
<td></td>
</tr>
<tr>
<td>I83.011-I83.229</td>
<td>Varicose veins of lower extremities</td>
<td>Must document if the ulcer is of the thigh, calf, ankle, heel and midfoot, other part of foot, or unspecified site of the right, left, or unspecified varicose vein of lower extremity.</td>
<td>Excludes 1: Varicose veins complicating pregnancy (O22.0-), Varicose veins complication the puerperium (O87.4) Use additional code to identify severity of ulcer (L97.-).</td>
</tr>
</tbody>
</table>
Anxiety

Documentation requires details including:

- Agoraphobia
- Social phobia
- Animal
- Natural environment
- Blood, injection, injury
- Situational
- Other
- Unspecified
Anxiety

F40.00 - Agoraphobia, unspecified
F40.01 - Agoraphobia with panic disorder
F40.02 – Agoraphobia without panic disorder

F40.10 - Social phobia, unspecified
F40.11 - Social phobia, generalized

F40.210 – Arachnophobia
F40.218 - Other animal type phobia

F40.220 - Fear of thunderstorms
F40.228 - Other natural environment type phobia

F40.230 - Fear of blood
F40.231 - Fear of injections and transfusions
F40.232 - Fear of other medical care
F40.233 - Fear of injury
Anxiety

F41.0 - Panic disorder [episodic paroxysmal anxiety] without agoraphobia

F41.1 - Generalized anxiety disorder

F41.3 – Other mixed anxiety disorders

F41.8 – Other specified anxiety disorders

F41.9 – Anxiety disorder, unspecified
Attention Deficit Disorder

• Documentation should include:
  • With or without hyperactivity
  • Combined type
  • Inattentive type
  • Other specified type
## Alzheimer’s

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>G30.0</td>
<td>Alzheimer's disease with early onset</td>
</tr>
<tr>
<td>G30.1</td>
<td>Alzheimer's disease with late onset</td>
</tr>
<tr>
<td>G30.8</td>
<td>Other Alzheimer's disease</td>
</tr>
<tr>
<td>G30.9</td>
<td>Alzheimer's disease, unspecified</td>
</tr>
</tbody>
</table>

Includes: Alzheimer's dementia senile and presenile forms

Use additional code to identify: delirium, if applicable (F05), dementia: with behavioral disturbance (F02.81), without behavioral disturbance (F02.80)

Excludes 1: Senile degeneration of brain NEC (G31.1), Senile dementia NOS (F03), Senility NOS (R41.81)

Edit symbol: A = These diagnosis are intended for patients between the age 15 to 124 years.
## Parkinson’s

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Definition</th>
<th>Coding Guidelines</th>
<th>Instructional Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>G20</td>
<td>Parkinson's disease</td>
<td></td>
<td>Excludes 1: Dementia with Parkinsonism (G31.83)</td>
</tr>
<tr>
<td>G21.0- G21.9 Secondary Parkinsonism</td>
<td>Must document if it is malignant neuroleptic syndrome, other drug-induced, due to external agents, postencephalitic, vascular, other, or unspecified secondary parkinsonism.</td>
<td>Excludes 1: Dementia with Parkinsonism (G31.83), Huntington's disease (G10), Shy-Drager syndrome (G90.3), Syphilitic Parkinsonism (A52.19)</td>
<td></td>
</tr>
<tr>
<td>G21.2 Secondary parkinsonism due to other external agents</td>
<td>Use additional code for adverse effect, if applicable, to identify drug (T43.3X5, T43.4X5, T43.505, T43.595)</td>
<td>Code first (T51-T65) to identify external agent</td>
<td></td>
</tr>
</tbody>
</table>
Psychoactive Substance Use, Abuse And Dependence

• When the provider documentation refers to use, abuse and dependence of the same substance, only one code should be assigned to identify the pattern of use based on the following hierarchy:
  • If both use and abuse are documented, assign only the code for abuse
  • If both abuse and dependence are documented, assign only the code for dependence
  • If use, abuse and dependence are all documented, assign only the code for dependence
  • If both use and dependence are documented, assign only the code for dependence.
Opioid Dependence

• Must document whether the use is:
  • Abuse
    • Uncomplicated
    • With intoxication
    • With delirium
    • With perceptual disturbance
    • With mood disorder
    • Hallucinations
    • Sexual dysfunction
Opioid Dependence

• Dependence
  • Uncomplicated
  • In remission
  • Intoxication
  • With perceptual disturbance
  • Withdrawal
  • Opioid induced mood disorder
  • Delusions
  • Hallucinations
  • Sexual dysfunction
  • Sleep disorder

• Opioid use Unspecified
  • Uncomplicated
  • With intoxication
  • With delirium
  • With perceptual disturbance
  • Withdrawal
  • Psychotic disorder
Cannabis - Abuse

• Must document whether the Abuse is:
  • Uncomplicated
  • With intoxication uncomplicated
  • With intoxication delirium
  • With perceptual disturbance
  • With intoxication, unspecified

• If they have abuse with psychotic disorder
  • With delusions
  • With hallucination
  • Unspecified
Cannabis - Abuse

• Abuse
  • With other cannabis-induced anxiety disorder
  • With other cannabis-induced disorder
  • With unspecified cannabis-induced disorder
Cannabis - Dependence

- Must document whether the Dependence is:
  - Uncomplicated
  - In remission
  - Dependence with intoxication
    - Uncomplicated
    - Delirium
    - With perceptual disturbance
    - Unspecified
Cannabis - Dependence

• Must document:
  • Dependence with psychotic disorder
    • With delusions
    • With hallucination
    • Unspecified

• Dependence
  • With other cannabis-induced anxiety disorder
  • With other cannabis-induced disorder
  • With unspecified cannabis-induced disorder
Cannabis - Use

• Must document whether the Use is:
  • Uncomplicated
  • With intoxication uncomplicated
  • With intoxication delirium
  • With perceptual disturbance
  • With intoxication, unspecified
• If they have use with psychotic disorder
  • With delusions
  • With hallucination
  • Unspecified
Cannabis - Use

• Use
  • With other cannabis-induced anxiety disorder
  • With other cannabis-induced disorder
  • With unspecified cannabis-induced disorder
Alcohol

- Alcohol
  - abuse
  - dependence
  - unspecified
- Uncomplicated
- With intoxication
- With withdrawal
- With alcohol-induced psychotic disorder
- With alcohol-induced persisting amnestic disorder
- With alcohol-induced persisting dementia
- With other alcohol-induced disorder
- With unspecified alcohol-induced disorder
Depressive Disorder

• Documentation must indicate:
  • Single episode vs. recurrent
  • Major Depressive
  • Mild/Moderate/Severe
  • With or without Psychotic behavior
  • Partial remission vs. full remission
Adjustment Disorder

• Adjustment disorder with depressed mood
• Prolonged depressive reaction
• Predominant disturbance of other emotions as adjustment reaction
  • Separation anxiety disorder
  • Emancipation disorder of adolescence and early adult life
  • Specific academic or work inhibition
  • Adjustment disorder with anxiety
  • Adjustment disorder with mixed anxiety and depressed mood
  • Other
Adjustment Disorder

- Adjustment disorder with disturbance of conduct
- Adjustment disorder with mixed disturbance of emotions and conduct
- Other specified adjustment reactions
  - Post traumatic stress disorder
  - Adjustment reaction with physical symptoms
  - Adjustment reaction with withdrawal
  - Other
  - Unspecified
Mood Affective Disorder

- Manic episode
- Bipolar disorder
- Major depressive disorder
- Persistent mood (affective) disorder
- Other
Severity

- Mild
- Moderate
- Severe
- With psychotic symptoms
- Without psychotic symptoms
Remission Status

• Currently in remission
• In partial remission
• Full remission
Dementia

• Documentation should include:
  • Vascular dementia
    • With or without behavioral disturbance
  • Dementia in diseases classified elsewhere
    • With or without behavioral disturbance
    • Must specify the underlying physiological condition and it must be coded first
  • Unspecified dementia
    • With or without behavioral disturbances
Conduct Disorders

- Conduct disorder confined to family context
- Conduct disorder, childhood-onset type
- Conduct disorder, adolescent-onset type
- Oppositional defiant disorder
- Other conduct disorders
- Unspecified
Eating disorders

• Anorexia nervosa
• Bulimia nervosa
• Other eating disorder
PTSD

• Documentation must include
  • Acute – F43.11
  • Chronic – F43.12
  • Unspecified – F43.10
Bipolar – F31.-

• Current episode
  • Hypomaniac
  • Manic without psychotic features
  • Depressed
  • Mixed

• In remission
  • Hypomaniac
  • Manic
  • Depressed
  • Mixed
Schizophrenia

• Documentation must include the type:
  • Paranoid
  • Disorganized
  • Catatonic
  • Undifferentiated
  • Residual
  • Other
  • Unspecified

• Schizotypal disorder
• Delusional disorders
• Brief psychotic disorder
• Shared psychotic disorder
Schizoaffective Disorder

• ICD-9
  • 295.70 Schizoaffective disorder, unspecified
  • 295.71 Schizoaffective disorder, subchronic
  • 295.72 Schizoaffective disorder, chronic
  • 295.75 Schizoaffective disorder, in remission
  • 295.74 Schizoaffective disorder, chronic with acute exacerbation
  • 295.73 Schizoaffective disorder, subchronic with acute exacerbation

• ICD-10
  • F25.9 Schizoaffective disorder, unspecified
  • F25.8 Other schizoaffective disorders
  • F25.0 Schizoaffective disorder, bipolar type
  • F25.1 Schizoaffective disorder, depressive type
Inhalant related disorders

• Documentation should include:
  • Abuse
  • Dependence
  • Use
Inhalant related disorders - Abuse

- Uncomplicated
- With intoxication
  - Uncomplicated
  - Delirium
  - Unspecified
- With inhalant-induced mood disorder
- With inhalant-induced psychotic disorder
  - With delusions
  - Hallucination
  - Unspecified
- With inhalant-induced dementia
- With other inhalant-induced disorder
  - With anxiety disorder
Inhalant related disorders - Dependence

- Uncomplicated
- In remission
- With intoxication
  - Uncomplicated
  - Delirium
  - Unspecified
- With inhalant-induced mood disorder
- With inhalant-induced psychotic disorder
  - With delusions
  - Hallucination
  - Unspecified
- With inhalant-induced dementia
- With other inhalant-induced disorder
  - With anxiety disorder
Inhalant related disorders - Use

• Uncomplicated
• With intoxication
  • Uncomplicated
  • Delirium
  • Unspecified
• With inhalant-induced mood disorder
• With inhalant-induced psychotic disorder
  • With delusions
  • Hallucination
  • Unspecified
• With inhalant-induced persisting dementia
• With other inhalant-induced disorder
  • With anxiety disorder
Immunization

Z23 – Encounter for immunization
Encounter for newborn, infant and child health examinations

• Health examination for newborn under 8 days old – Z00.110

• Health examination for newborn 8 to 28 days old – Z00.111

• Encounter for routine child health examination (over 28 days old)
  • With abnormal findings – Z00.121
  • Without abnormal findings – Z00.129
Wellness Visit

The documentation must include:

• With abnormal findings
• Without abnormal findings

• Z00.00 - Encounter for general adult medical examination without abnormal findings
• Z00.01 - Encounter for general adult medical examination with abnormal findings
Well Woman Exam

Documentation must indicate if there are any abnormal findings

In Addition:

- Use additional code for screening of HPV
- Use additional code for screening vaginal pap smear
- Use additional code to identify acquired absence of the uterus if applicable
Counseling on Contraception

Documentation must indicate:

- Encounter for initial prescription of contraceptives
  - Contraceptive pills
  - Emergency contraception
  - Injectable contraceptive
  - Intrauterine contraceptive device
  - Other
- Encounter for surveillance of contraceptives
  - Contraceptive pills
  - Injectable contraceptive
Counseling on Contraception

- Encounter for surveillance of intrauterine contraceptive device
  - Insertion
  - Routine checking
  - Removal
  - Removal and reinsertion

- Encounter for other general counseling and advice on contraception
- Encounter for sterilization
Supervision of Pregnancy

Documentation must include:

• which pregnancy
• weeks of gestation
• any high risk issues
• complications, etc.
Special Screening Neoplasm Colon

Documentation must include the specific location for screening:

- Colon – Z12.11
- Intestinal tract – Z12.10
- Rectum – Z12.12
- Small intestine – Z12.13
Underdosing

• Document that the patient is noncompliant with his medication.

• Document if there is a medical condition linked to the underdosing that is relevant to the encounter, and ensure the connection is clearly made.

• Intentional or unintentional

• Financial hardship or Age related dementia
Underdosing

Underdosing of other antihypertensive drugs, initial encounter – T46.5X6A

Underdosing of other antihypertensive drugs, subsequent encounter – T46.5XD

Patient's intentional underdosing of medication regimen due to financial hardship – Z91.120

Patient's intentional underdosing of medication regimen for other reason - Z91.128

Patient's unintentional underdosing of medication regimen due to age-related debility – Z91.130

Patient's unintentional underdosing of medication regimen for other reason - Z91.138
Coding Summary

Suggest starting with the top 5 codes you use and begin to document details of those encounters

- Continue with more codes until you have up to 25 codes used

Create the templates in the EMR that will facilitate necessary documentation

Review the decision tree methodology in the EMR to insure it compliments templates
Contact

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Social Media Content

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