ICD-10-CM Refresher: Mental/Behavioral, Neuro, Circulatory, Respiratory, GI System

Teresa Northcutt, BSN, RN, HCS-D, COS-C
AHIMA-Approved ICD-10-CM Trainer

Selman-Holman & Associates, LLC
Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C
Home Health Insight—Consulting, Education and Products
CoDR—Coding Done Right
CodeProUniversity
606 N. Bell Ave.
Denton, Texas 76209
214.550.1477
972.692.5908 fax
Lisa@selmanholman.com
Teresa@selmanholman.com
www.selmanholmanblog.com
www.selmanholman.com
www.CodeProU.com

CHAPTER 5 GUIDELINES
F—MENTAL AND BEHAVIORAL

F = Freud

FØ1-FØ9—Mental Disorders due to known physiological reasons
• Disorders that have an etiology in cerebral dysfunction (cerebral disease or injury)
• Can be primary or secondary
  – If there is a ‘code first’ note then these conditions must be coded secondary.

Vascular dementia F01.5-
• Being rejected as primary diagnosis in HH & hospice
• Occurs as a result of infarction of the brain due to vascular disease, including hypertensive vascular disease
  – Autoregulation may be lost in individuals with severe hypertensive arteriosclerotic vascular disease, abrupt lowering of blood pressure may lead to infarct.
Coding conventions:
• Code first the underlying physiological condition or sequelae of cerebrovascular disease. (ICD-10)
• Use additional code to identify cerebral atherosclerosis (ICD-9 instruction no longer at the code for the underlying cause)

Vascular dementia and behavioral disorders
• F01.50 Without behavioral disturbances
• F01.51 With behavioral disturbances
  – Aggressive behavior
  – Combative behavior
  – Violent behavior
  – …and wandering (use additional code)
• Besides those listed:
  – Vascular dementia with delirium
  – Vascular dementia with depression
  – Vascular dementia with delusions
Example

- Dementia post CVA, with HTN
- I69.31 Cognitive deficits following cerebral infarction
- F01.50 vascular dementia
- I10 Hypertension

FØ3.9- Unspecified Dementia

- Includes:
  - Presenile dementia, NOS
  - Presenile psychosis, NOS
  - Primary degenerative dementia, NOS
  - Senile dementia, NOS
  - Senile dementia depressed or paranoid type
  - Senile psychosis, NOS

Senile Dementia

Senile dementia is actually a group of several different diseases.
- Alzheimer’s disease,
- Vascular dementia,
- Parkinson’s disease, and
- Lewy body disease.

FØ3.9-

- FØ3.90- without behavioral disturbances
  - Dementia NOS
- FØ3.91- with behavioral disturbances
  - Unspecified dementia with aggressive behavior
  - Unspecified dementia with combative behavior
  - Unspecified dementia with violent behavior

FØ2-Dementia in other diseases classified Elsewhere

- Excludes 1- dementia with Parkinsonism (G31.83) is a problem.
- Code first the underlying physiological condition
- FØ2.80- Without behavioral disturbances
- FØ2.81- with behavioral disturbances

This code is a manifestation code and REQUIRES an etiology code

Alzheimers G30.-/F02.-

- Patient admitted for worsening dementia related to early onset Alzheimer’s, including wandering.
- M1Ø21: G3Ø.Ø Alzheimer’s disease early onset
- M1Ø23: FØ2.81 Dementia in diseases classified elsewhere with behavioral disturbances
- M1Ø23: Z91.83 Wandering in diseases classified elsewhere
Psychoactive Substance Use, Abuse And Dependence

- When the provider documentation refers to use, abuse and dependence of the same substance (e.g. alcohol, opioid, cannabis, etc.), 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.

Information needed

- Cannot accept “dementia” as a terminal diagnosis for hospice
- Cannot accept senile dementia or vascular dementia as a primary diagnosis for home health or hospice
- ASK: What caused the dementia?
  - Alzheimer’s early or late onset
  - Parkinson’s vs Parkinsonism

General Guidelines

- Hemiplegia/hemiparesis/Monoplegia/Monoparesis
  - When right or left is specified but dominant side is not specified
    - Default to dominant for the ambidextrous patient
    - Left side defaults to non-dominant
    - Right side defaults to dominant

G00-G09: Inflammatory Diseases of the Nervous System

- Includes Meningitis, Encephalitis, Abscesses of the CNS, Sequelae of CNS inflammatory disease
- Bacterial Meningitis (G00.0-G00.9) includes causative organism, if known
- Sequelae of inflammatory diseases of central nervous system (G09) includes conditions whose cause is classifiable to G00-G08

G10-G14: Systemic Atrophies primarily affecting the Nervous System

- Includes Huntington’s, Spinal Muscular Atrophy, Other Motor Neuron diseases, Post Polio Syndrome
- Post-Polio syndrome excludes sequelae of poliomyelitis (B91)
- Huntington’s disease includes chorea & dementia
- Hereditary ataxia include cerebellar ataxia, which are further specified as early vs. late onset or with defective DNA repair
Example

Mr. Jackson is admitted for progressive Huntington’s Chorea. He’s had several falls recently while wandering and his dementia is worsening, with behavior changes

- G10 Huntington’s Disease
- F02.81 Dementia with behaviors
- Z91.83 Wandering
- R29.6 Repeated Falls

G20-26: Extrapyramidal Movement disorders

- Includes Parkinson’s, Parkinsonism, Basal Ganglia disorders, and other movement disorders
- Dementia with Parkinson’s and Dementia with Parkinsonism remain different/separate
  - Parkinson’s excludes dementia with parkinsonism
    - G31.83 Dementia with Parkinsonism F02.80
    - G20 Parkinson’s, F02.80 Dementia without behavioral disturbance

Drug induced Neuro Conditions

Scenario- A 56 year old male patient is referred to home health for speech and occupational therapy to treat tardive dyskinesia that has begun to significantly impair his speech and self care abilities. The patient has a long-standing diagnosis of schizophrenia with use of phenothiazine class antipsychotic medications, which have resulted in the tardive dyskinesia.

- G24.01 Tardive Dyskinesia
- T43.3X5D Adverse Effect of phenothiazine
- F20.9 Schizophrenia

G35-37: Demyelinating diseases of the CNS

G40-47: Episodic and paroxysmal disorders

- G35-37 includes multiple sclerosis and other demyelinating disorders
- G40-47 includes epileptic disorders, headaches, and sleep disorders
- TIA included under G45 and is not found in the circulatory (I) chapter

Multiple Sclerosis-G35

Scenario- Mr. Parker is referred to home health for increased BLE weakness due to MS. He is no longer able to transfer to toilet or bath without assistance. PT will address gait and transfer training and strengthening, SN will provide cath changes for neurogenic bladder.

- G35- Multiple Sclerosis
- N31.9 Neurogenic Bladder
- Z46.6 Encounter for fitting/adjustment of urinary device

Seizure Example

Mr. Jones has new onset seizures and is admitted to home health for instruction, assessment and monitoring of anticonvulsants. H&P states he has idiopathic general epilepsy. His medication is still being monitored and adjusted because he continues to have seizures. G40.319- Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus

What does intractable mean?
G60-65- Polyneuropathies and other disorders of the PNS

- Includes neuropathies, polyneuropathies and other disorders.
- Causes of neuropathic conditions must be determined
  - Hereditary
  - Idiopathic
  - Drug induced
  - Inflammatory
- Do not code these when caused by diabetes! See G63

Pain Codes (Category G89)
General Guidelines

- Provide more specific info on pain in a patient when the POC is addressing pain management
  - Must be specified as Acute, Chronic, Post-Thoracotomy, Post-Procedural, or Neoplasm-related
- DO NOT assign when an underlying cause of the pain is known (i.e. a more specific, definitive dx like osteoarthritis)
- Assign when nature of pain is not part of the definitive diagnosis, i.e. acute, chronic.

More Pain Coding Specifics

- Pain codes (G89) may be used as primary when a focus of care
- Pain codes (G89) may be used in conjunction with site specific codes when pain code provides greater detail
- Sequencing is dependent on focus of care
  - If pain control is focus of care then G89 code is assigned first

Example

Mr. Smith is admitted to the agency for therapy (PT & OT) to treat a decline in mobility related to primary osteoarthritis of the bilateral knees. He has pain daily that ranges from 2-7 in the joints.
- Code only the osteoarthritis M17.0
- The pain is related to the osteoarthritis condition—will not code the pain separately

More Pain Coding Specifics

- Coding Postoperative Pain
  - Default is acute when not specified
  - Used alone when NOT associated with a post-operative complication; may use with complication code if related to complication
    - i.e.- Post-operative pain alone is not a complication
- Coding Neoplasm-Related Pain
  - Pain documented as being related, associated with or due to cancer, primary or secondary malignancy or tumor.
    - May be acute or chronic
    - May be used as a primary code if pain is focus of care

Example

Mrs. Smith fell off the porch and hurt her neck. PT and OT will treat her decreased mobility and SN will manage pain.
- M54.2 Pain in the neck
- G89.11 Acute pain due to trauma
- The pain code adds information regarding the nature and cause of the pain.
More Pain Coding Specifics

• Coding Chronic Pain (subcategory G89.2)
  – Time frame not defined, but physician must specify as “Chronic”
  – Chronic Pain Syndrome (G89.4) and Central Pain Syndrome (G89.0) require that the physician specify the syndrome.

When Pain is a Complication

• T code is used first to report the complication
• Pain is post procedural and G code is used to provide additional information
  – Default to acute
• Must use a Z code to define the presence of joint replaced
  – With complication of joint replaced, Z code may still be used if complication code doesn’t identify the joint

Scenario

• Mrs. Williams has had a bilateral knee replacement performed 6 weeks ago. She is admitted to home health for therapy and pain management. Despite orders for Percocet, she reports ongoing pain in the joints replaced of 8-10 at all times, which impairs mobility. Physician documents pain due to the prosthesis.
  – T84.84xD Pain due to internal orthopedic prosthetic devices...
  – G89.18 Other acute post-procedural pain
  – Z96.653 Presence of Artificial Knee joint, bilateral
  – Use additional code to identify the specified condition resulting from the complication (found at the beginning of the complication codes above T80).

Information needed

• Intake:
  – For meningitis, encephalitis, CNS abscess: identify infectious organism
  – For drug-induced neuro conditions, identify drug causing adverse effect
  – For seizures, identify if intractable
  – Neuralgia vs neuropathy
  – For pain, identify if acute/chronic, post-op, neoplasm related, etc.

Information needed

• Intake, con’t:
  – For neuropathies, identify cause: hereditary, drug-induced, inflammatory, idiopathic (do not code here when caused by diabetes)
• Clinician assessment:
  – For MS, identify if treating overall condition or one aspect
  – For hemiplegia/monoplegia, identify if side affected is dominant or non-dominant side

H = Hearing

CHAPTERS 7&8 GUIDELINES: H – DISEASES OF EYE AND ADNEXA, THE EAR AND MASTOID PROCESS
Diseases of the Eye and Adnexa

- Includes:
  - Vision disorders/disturbances
  - Glaucoma, retinal disorders, cataracts, lens disorders, and other ocular structure defects
  - Disorders of associated eye structures
  - Post-procedural complications
  - Optic Nerve disorders

- Excludes:
  - Complications of pregnancy, perinatal conditions, congenital malformations
  - Certain infectious and parasitic diseases
  - Diabetes-related eye conditions
  - Injury/trauma to eye and orbit
  - Neoplasms of the eye/optic nerve

Chapter 7 General Guidelines

- Laterality – identify affected eye
  - Right
  - Left
  - Bilateral
  - Unspecified
- If bilateral code is not available, assign separate codes for left and right, unless otherwise directed (ex: glaucoma guidelines)

Glaucoma Guidelines

- Assign as many codes from Category H40, Glaucoma, as needed to identify the type of glaucoma, affected eye, and glaucoma stage
- Laterality
- Documentation of specific glaucoma info:
  - Type
  - Stage
  - Affected eye

- Glaucoma Stages (7th character)
  - 0=stage unspecified
  - 1=mild stage
  - 2=moderate stage
  - 3=severe stage
  - 4=indeterminate stage
- If stage evolves during episode, assign code for highest stage documented
Glaucoma Guidelines

- Bilateral Glaucoma with same type and stage in both eyes:
  - If there is a code available for bilateral, assign the code for the type of glaucoma, bilateral, with the 7th character for the stage
  - If no bilateral code is available (H40.10, H40.11, H40.20), assign only one code for the type of glaucoma with the 7th character for the stage

- Bilateral glaucoma with different types, different stages in each eye:
  - DO NOT ASSIGN CODE FOR BILATERAL
  - If the classification distinguishes laterality, assign the appropriate code for each eye
  - If code does not distinguish laterality (H40.10, H40.11, H40.20), assign one code for each type with appropriate 7th character for the stage in each eye

- Bilateral glaucoma, same type, different stages:
  - If the classification distinguishes laterality, assign the appropriate code for each eye
  - If the classification does not distinguish laterality, assign a code for the type of glaucoma for each eye, with the 7th character for the specific glaucoma stage documented for each eye

H53-54: Visual Disturbances and Blindness

- Includes diplopia, color vision deficits, visual field deficits, amblyopia, blindness, and other vision loss
- V54 Blindness and low vision codes: code first any associated underlying cause of the blindness (e.g. macular degeneration, cataract, etc.)
- Note that “Legal Blindness” when specified is coded to H54.8

Diseases of Ear and Mastoid

- Includes:
  - Disorders of external ear
  - Disorders of middle ear and mastoid
  - Disorders of inner ear
  - Other disorders of the ear
  - Intraoperative and post-procedural complications
  - Disorders of the ear NEC

- Excludes:
  - Complications of pregnancy, perinatal conditions, congenital malformations
  - Certain infectious and parasitic diseases
  - Metabolic and endocrine-related conditions
  - Injury/trauma to ear and mastoid process
  - Neoplasms of the ear
Chapter 8 General Guidelines

- None at present; reserved for future guidance
- Laterality applies to most conditions
- Note applies to all conditions in chapter 8:
  - Use an external cause code following the code for the ear condition, if applicable, to identify the cause of the ear condition.

Notes for H65-H66 Otitis Media

- Use additional code for any associated perforated tympanic membrane
- Use additional code to identify any tobacco exposure or history of tobacco use/dependence:
  - Exposure to environmental tobacco smoke
  - Exposure to tobacco smoke in perinatal period
  - History of tobacco use
  - Occupational exposure to environmental tobacco
  - Tobacco dependence
  - Tobacco use

CHAPTER 9 GUIDELINES
I—CIRCULATORY SYSTEM

Hypertension

- Includes Essential Hypertension, Hypertensive Heart Disease, Hypertensive Chronic Kidney disease, and secondary hypertension
- No Hypertension table in ICD-10
  - No distinction between malignant and benign hypertension in ICD-10
- Guidelines are unchanged from ICD-9-CM

Hypertension

- I10 Essential hypertension
- I11 Hypertensive heart disease
  - I11.0 with heart failure
  - I11.9 without heart failure
- I12 Hypertensive chronic kidney disease
  - I12.0 with stage 5 or ESRD
  - I12.9 with stage 1-4 or unspecified
- I13 Hypertensive heart and chronic kidney disease
  - I13.0-I13.2 Variety with or without heart failure and stage of CKD

General Guidelines
Hypertensive Heart Disease

- Heart conditions classified to I50.- or I51.4-I51.9 are assigned to a code from I11 when a causal relationship is STATED or IMPLIED
  - Physician MUST state or imply relationship
  - I51.4-I51.9 are included however use an additional code for heart failure, if present.
  - Specific sequencing required
- For patients who do NOT have a stated or implied relationship between the same heart conditions (I50-, I51.4-I51.9) and hypertension, the conditions are coded separately (no specific sequencing required with hypertension and the heart disease)
  - I10 Essential Hypertension OR
  - I12.- Hypertensive Chronic Kidney Disease (if CKD present)
General Guidelines
Hypertensive Chronic Kidney Disease

- May assume a relationship between hypertension and chronic kidney disease
- Code to I12.
  - Stage 5 or ESRD with hypertension I12.0
  - Stage 1-4 or unspecified CKD with hypertension I12.9
  - Specific sequencing required with CKD

General Guidelines
Hypertensive Heart and CKD

- I13—combination code when hypertensive heart disease is verified (I11) and the patient also has CKD (I12).
  - Use additional code for heart failure when present.
  - Use additional code for CKD stage.

Name that category

- Hypertension and ESRD
- Hypertension and CHF
- Systolic heart failure due to hypertension
- Malignant hypertension
- Patient has CKD and hypertensive cardiomegaly

Answers

- Hypertension and ESRD I12.0, N18.6
- Hypertension and CHF I10, I50.9 or I50.9, I10
- Systolic heart failure due to hypertension I11.0, I50.20
- Malignant hypertension I10
- Patient has CKD and hypertensive cardiomegaly I13.10, N18.9

Heart Failure

When the right side of the heart starts to fail, fluid collects in the feet and lower legs. As the heart failure becomes worse, the upper legs swell and eventually the abdomen collects fluid (ascites). Weight gain accompanies the fluid retention. Systolic HF: pumping action of the heart is reduced or weakened measured by the left ventricular ejection fraction (LVEF); typically, systolic heart failure has a decreased ejection fraction of less than 50%. Diastolic HF: heart can contract normally but is stiff and less able to relax and fill with blood. This impedes blood flow into heart chambers, produces backup into the lungs and CHF symptoms. Diastolic heart failure is more common in patients older than 75 years, especially in women with high blood pressure. LVEF is normal.

Heart Failure

428.0 = congestive heart failure, unspecified (I50.9)
428.1 = I50.1 = left ventricular heart failure
428.2 = I50.2 = systolic HF (includes CHF in ICD-10)
428.3 = I50.3 = diastolic HF (includes CHF in ICD-10)
428.4 = I50.4 = combined HF (includes CHF in ICD-10) means systolic and diastolic
428.9 = I50.9 = HF unspecified
429.0 = I51.4 = myocarditis unspecified
429.1 = I51.5 = myocardial degeneration
429.3 = I51.7 = cardiomegaly
429.9 = I51.9 = heart disease, unspecified
What about this?

• The patient has a history of CHF and now is documented as having acute systolic failure.
• 2 codes OR
• 1 code??

I20-25 Ischemic heart disease

• Angina is considered integral to ASHD unless otherwise noted
  — Angina alone = I20.
  — Angina with dx of ASHD = I25.
• Post infarction angina is considered a complication of the MI if specifically documented in medical record

MI I21 vs. I22

• Initial MI coded to I21 for 4 weeks
• Any subsequent MI within the same 4 weeks is coded to I22
  — Sequencing by plan of care
  — Site is more important than STEMI/non-STEMI
  — Care setting does not change code
• Old MIs not requiring further care—code to I25.2

I21 vs. I22 Defaults

• I21.3 STEMI of unspecified site (also AMI NOS)
• I21.4 non-STEMI of unspecified site
• I22.2 Subsequent non-STEMI
• I22.9 Subsequent STEMI of unspecified site (Subsequent MI NOS)

Scenarios

Michael Isaac was referred to the agency 3 weeks after he was diagnosed with an inferior wall MI.
Mr. Isaac has a diagnosis of post infarction angina
Mr. Isaac was resumed after hospitalization 2 days later with another inferior wall MI.
Codes for inpatient diagnoses (M1011)?

Answers

Michael Isaac was referred to the agency 3 weeks after he was diagnosed with an inferior wall MI. Code? I21.19
Mr. Isaac has a diagnosis of post infarction angina. I23.7, I21.19
Mr. Isaac was resumed after hospitalization 2 days later with another inferior wall MI.
Codes for inpatient diagnoses (M1011)? I23.7, I21.19, I22.1
Category I69, Sequelae of Cerebrovascular disease

- Category I69 is used to indicate conditions classifiable to categories I60-I67 as the causes of sequela (neurologic deficits).
- The neurologic deficits, or “late effects” caused by cerebrovascular disease may be present from the onset or may arise at any time after the onset of the condition.
- Personal history of transient ischemic attack (TIA) and cerebral infarction (286.73)

Sequelae of I60-67

- Non-traumatic subarachnoid hemorrhage requires identification of laterality (right and left) and the specific artery for acute CVAs. (I69.0)
- Non-traumatic intracerebral hemorrhage requires identification of the site to assist in choosing a more specific sequela code (I69.1):
  - Subcortical hemisphere
  - Cortical hemisphere
  - Brain stem, Cerebellum, Ventricle, Multiple or specified locations

Sequelae of I60-67

- Cerebral and precerebral infarctions, occlusion, and stenosis require identification of cause (thrombosis, embolism, unspecified), laterality (right and left) and specific artery (If bleed, I69.2, otherwise I69.3)
- Do NOT choose I69.9 for sequela of CVAs!!!
- Sequela require documentation of the residual deficits

Scenario

- Mr. Jarvis was referred to home care after a stroke for right sided hemiplegia, dysphasia and cognitive changes.
- I69.351 Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side
- I69.321 Dysphasia following cerebral infarction
- I69.31 Cognitive deficits following cerebral infarction

Sequela of Strokes

- I69.3-
  - Which ones require more info?
  - Other paralytic syndrome
  - Dysphagia
  - Seizures
  - Muscle weakness

Extremity Circulatory Disorders

- Atherosclerosis is coded with or without complications, such as ulceration:
  - I70.2- requires identification of artery affected, native or graft, site of ulcer, and depth of tissue damage
- Venous stasis disease, insufficiency, chronic venous hypertension, varicose veins, with or without ulceration
  - I87.- requires site, depth of ulcer
Information needed

• Intake:
  – For HTN and heart disease, identify if related and if heart failure present
  – For HTN and CKD, identify CKD stage
  – For heart failure, identify type of HF
    • CHF? Query if systolic/diastolic
  – For AMI, identify date, site of infarction, STEMI or NSTEMI

• CHF? Query if systolic/diastolic

• For AMI, identify date, site of infarction, STEMI or NSTEMI

Information needed

• Intake, con’t:
  – For ASHD, identify if native coronary artery or graft, if angina present
  – For CVA, identify specific artery affected, site of infarction, cause (bleed, thrombosis, embolism), and the residual deficit present
  – Etiology of any circulatory ulcerations

Information needed

• Clinician assessment:
  – Any angina present
  – For CVA, any residual deficits present, if patient is left or right side dominant
  – For CVA with dysphagia, identify type of dysphagia
  – Depth of tissue damage for any non-pressure ulcers

Information needed

• Clinician assessment:
  – Any angina present
  – For CVA, any residual deficits present, if patient is left or right side dominant
  – For CVA with dysphagia, identify type of dysphagia
  – Depth of tissue damage for any non-pressure ulcers

General Guidelines

• ICD-10 removes instructions related to the classification of COPD
  – All components covered under J44.
• For infectious disease processes, coder is to include infectious organism
  – Use additional code for the causative microorganism if known

General Guidelines

• COPD J44.
  – ICD-10 coding broken up into exacerbated, not otherwise specified, and with acute lower respiratory infection
  – Extremely important to note the excludes 1 and excludes 2 notes
Acute exacerbation of chronic obstructive bronchitis and asthma

- An acute exacerbation is a worsening or a decompensation of a chronic condition. An acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.
- See difference between J44.0 and J44.1

Scenario
Mrs. Winston is admitted for IV antibiotic and PICC line care to treat pneumonia due to MRSA. She also has a history of COPD with chronic obstructive bronchitis, and is oxygen dependent.

Scenario Coded
- J44.0 COPD with lower respiratory infection
- J15.212 MRSA pneumonia
- Z99.81 Oxygen dependence
- Z45.2 Fitting and adjustment of vascular catheter
- Z79.2 Long term current use of antibiotic medication
- COPD code used indicates presence of lower respiratory infection
  - Note sequencing instruction at J44.0

Other Notes
- A patient with COPD (of any type) who also has a lower respiratory infection is not assumed exacerbated. If Mrs. Winston is also documented as exacerbated, then:
  - J44.0 COPD with lower respiratory infection
  - J15.212 MRSA pneumonia
  - J44.1 Exacerbation of COPD
    - See Excludes 2 note

Use additional code...
- Exposure to environmental tobacco smoke (Z77.22)
- Exposure to tobacco smoke in the perinatal period (P96.81)
- History of tobacco use (Z87.891)
- Occupational exposure to environmental tobacco smoke (Z57.31)
- Tobacco dependence (F17.~)
- Tobacco use (Z72.0)
Information needed

• Intake:
  – For infectious processes, identify causative organism
  – Any exacerbation
  – For asthma and bronchitis, identify type
  – Tobacco abuse or dependence
• Clinician assessment:
  – If s/sx, query for exacerbation
  – Any tobacco use or exposure
  – Any supplemental oxygen

CHAPTER 11 GUIDELINES
K - DIGESTIVE

Guidelines

• General guidelines for this chapter are reserved for future expansion
• Hernias are coded by site, type, and laterality, and presence of obstruction and gangrene. If both are documented, code to the gangrene.
• Ulcers are coded by site, with or without hemorrhage and perforation

Examples

• Patient admitted to home health with a diagnosis of GERD with esophagitis for teaching and observation and assessment.
K21.Ø-GERD with esophagitis
• Patient was admitted to home health with acute gastric ulcer with perforation which resulted in bleeding and SN to monitor for continued bleeding and teach s/s of exacerbation and medication teaching.
K25.2-Acute gastric ulcer with both hemorrhage and perforation

Complications of artificial openings of the digestive system K94.-

• K94.Ø- Colostomy complications
• K94.1- Enterostomy complications
• K94.2- Gastrostomy complications
• K94.3- Esophagostomy complications

Complications of Bariatric Procedures (K95.-)

• K95.0- Complications of gastric band procedure
  – K95.01: Infection due to gastric band
  – Infection: use additional code to specify type of infection or organism, (bacterial and viral infectious agents) (B95-. B96)
  – Cellulitis of abdominal wall (LØ3.311)
  – Sepsis (A4Ø.-, A41.-)
• K95.8- Complications of other bariatric procedures
Information needed

• Intake:
  – Identify site or part of GI tract affected
  – Identify any bleeding, obstruction, perforation, infection
• Clinical assessment:
  – Any s/sx bleeding or obstruction

What questions do you have?

Lisa@selmanholman.com
Teresa@selmanholman.com

• Selman-Holman & Associates, LLC
  • Home Health Insight
• CoDR—Coding Done Right—home health and hospice outsource for coding and coding audits
• CodeProUniversity—role based comprehensive online ICD-10-CM training for home health and hospice