ICD-10 Documentation Overview for HIM and Case Analysis

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Learning Objectives

- Review ICD-10 documentation requirements for various specialties
- Review The differences between ICD-9 and ICD-10 documentation requirements
- Identify Opportunities to improve documentation to maintain compliance and affect quality of care
ICD-10 Impact on Physician Documentation

- Expanded documentation to support coding
  - Specificity
  - Acuity
- All coding is dependent on physician documentation
- Revised documentation tools to capture ICD-10 requirements
  - CPOE order set
  - EHR templates
  - Physician query forms

CMS provides the following guidance:

“We highly encourage physicians and hospitals to work together to use the most specific codes that describe their patients’ conditions. Such an effort will not only result in more accurate payment by Medicare but will provide better information on the incidence of this disease in the Medicare patient population.”

Complications and Co-Morbidity Documentation

- ICD-10 coding guidelines continue to focus on the capture of complications and co-morbidities
- Secondary diagnosis codes depend on documentation. Examples:
  - Coma
  - Endocarditis
  - Encephalopathy

Complication and co-morbidity documentation tips:
- Acuity
- Document all co-morbidities that are monitored/evaluated/treated
- Indicate if “Present on Admission”
- Confirm/validate or rule out secondary Diagnoses
- Confirm discharge Diagnosis with linkage to other documentation
- Document probable causes if applicable

General Documentation Detail

- Side of dominance
  - Left
  - Right
  - Ambidextrous
- Laterality
  - All paired organs or structures
- Ordinality
  - Initial or subsequent visit?
  - Sequela of the initial event?
- Acuity
  - Acute
  - Chronic
  - Acute on chronic

- Underdosing
  - Document the relationship between a disease process and the patient’s inability or failure to take prescribed medications
- Substance identification
  - Related to adverse effects, poisoning or toxic effects
- Altered mental status
  - Document baseline mental status
  - Note age of onset
  - Some degenerative diseases require age of onset, e.g. Alzheimer’s
Coding Clinic Guidelines for Provider Documentation

- Documentation includes the chart in its entirety – it should not be based solely on one area of the record.
- Code assignment may be based on other physicians (i.e. consultants, residents, anesthesiologist, etc.) providing that there is no conflicting information from the attending, in which case the attending physician’s documentation supersedes all others.
- A procedure provided by a non-physician can be coded:
  - IVs performed by nursing staff
  - Mechanical ventilation provided by respiratory therapist
  - Debridement by physical therapy

Coding Clinic Guidelines for Provider Documentation

- Lysis of adhesions documentation:
  - Determine clinical significance
    - Do not code simply because they are listed as a procedure
    - What was the intent of the procedure?
  - Complexity of the lysis of adhesions
    - “numerous adhesions requiring a long time to take down”
    - “extensive adhesions” or “dense adhesions”
    - “extensive lysis”
    - Were the adhesions an integral part of the procedure?
    - Did the adhesions increase the complexity of the procedure?
    - Were the adhesions an incidental finding during the procedure?
Coding Clinic Guidelines for Provider Documentation

- Linking two conditions
  - Physician needs to use language linking the two conditions except in the few situations where the linkage is assumed
    - Hypertension and chronic kidney involvement
  - Just because a patient has two conditions that often occur together does not mean the conditions are related
  - If unclear, query the physician

Infectious & Parasitic Diseases Documentation
ICD-10 Diagnosis Code Assignment Requirements for Infectious and Parasitic Diseases

- Documentation that provides insight to the infectious disease
  - General appearance, color, posture, gait, facial expression
  - Alertness, orientation to person, place, and time
  - Mentation changes
  - Appearance of the skin, bone joints, nail beds, cyanosis, redness, rashes for size, shape, location, texture, drainage, pruritus
  - Lymph nodes inspected

Criteria for SIRS

- Elevated heart rate (tachycardia) >90 beats per minute at rest
- Temperature high ( > 100.4°F or 38°C) or low (<97°F or 36°C)
- Increased respiratory rate >20 breaths per minute or reduced PaCO2
- Abnormal white blood cell count (>12000 or <4000 or >10% bands [immature type of wbc])
Criteria for SIRS

Signs & Symptoms

- Multiple organ dysfunction
- Altered mental status
- Thrombocytopenia
- Disseminated intravascular coagulation (DIC)
- Hypothermia
- Hypoglycemia
- Leukopenia

Documentation Requirements for SIRS/Sepsis

- Document the specific infection causing SIRS
  - SIRS codes to sepsis only when it is linked to an infection
  - If the SIRS is due to infection, the diagnosis “sepsis” is preferred
- Non-infectious SIRS can be the result of noninfectious disease processes
  - Document the underlying cause of SIRS
    - Trauma/burns
    - Malignant neoplasm
    - Pancreatitis
  - Two to three of the SIRS criteria are met, provided they are not due to another condition
Documentation Requirements for SIRS/Sepsis

- Documentation of sepsis to include:
  - Evidence that the patient has an infection
    - Positive culture
    - Prolonged use of antibiotics
  - Documentation that the patient is toxic in appearance or septic appearing
  - Two to three of the SIRS criteria are met, provided they are not due to another condition

Sepsis/SIRS Query

- Add clinical indicators
  - Signs and symptoms
  - Labs, radiology, and other workup performed
  - Results of the tests provided
  - Treatment initiated
  - Response to treatment
- Documentation/results/findings from all parts of the medical record must support the condition documented
HEMATOLOGY DOCUMENTATION

ICD-10-CM Anemia Documentation Requirements

- Anemia
  - Specify the cause
  - Specify the malignant disease
  - Specify any adverse effect of treatment

- Addition to blood loss queries:
  - ABLA – Acute Blood Loss Anemia
    - Documentation by provider of hematocrit and hemoglobin before and after treatment
    - Supported by lab values
    - Documentation of treatment provided
ICD-10 Diabetes Documentation Requirements

- ICD-10-CM diagnoses of diabetes are classified into one of five categories:
  - Diabetes mellitus due to underlying condition
  - Drug or chemical induced diabetes mellitus
  - Type 1 diabetes mellitus
  - Type 2 diabetes mellitus
  - Other specific diabetes mellitus

- Identify type and manifestation/complication of diabetes
  - Identify body system affected and complication affecting the body system

- ICD-10 does not require documentation of “uncontrolled” diabetes
  - Coded to applicable type of diabetes with additional code for hyperglycemia
ICD-10 Malnutrition Documentation Requirements

- The *Journal of the Academy of Nutrition and Dietetics* provides a standardized set of diagnostic characteristics to document adult malnutrition
  - Insufficient energy intake
  - Weight loss
  - Loss of muscle mass
  - Loss of subcutaneous fat
  - Localized or generalized fluid accumulation that may sometimes mask weight loss
  - Diminished functional status as measured by hand grip strength
- Malnutrition should be diagnosed when at least two or more of these characteristics are met
- Not based solely on low albumin or pre-albumin levels

Malnutrition Query

- The following clinical indicators are documented in the medical record:
  - Current BMI
  - Stress indicator – acute illness, chronic illness, social
  - Energy intake over the previous ___ days ___%
  - Amount of weight loss over ___ days ___%
  - Loss of subcutaneous fat – none, mild, moderate, severe
  - Loss of muscle – none, mild, moderate, severe
  - Fluid accumulation – none, mild, moderate, severe
  - Measurably reduced grip strength present __Yes __ No
Malnutrition Query

Please identify the diagnosis that best describes these findings:

- Cachexia without malnutrition
- Nutritional risk without malnutrition
- Malnutrition, severity unknown
- Malnutrition, non-severe (moderate)
- Malnutrition, severe, not otherwise specified
- Marasmus – severe protein-calorie malnutrition
- Kwashiorkor – severe protein malnutrition
- Another medical diagnosis
- Other – please specify
- Cannot be determined

NERVOUS SYSTEM DOCUMENTATION
Nervous System Documentation Requirements

- Document cerebrovascular accident (CVA) specifics:
  - Type of hemorrhage or infarction
  - Location of brain or artery affected
  - Laterality
  - Specify occlusion or stenosis of the artery
- Any neurologic deficit caused by a cerebrovascular accident (CVA) should be coded even if it resolves by the time the patient is discharged
  - Example: hemiplegia; hemiplegia is not inherent to an acute CVA
  - Specify dominant or non-dominant sides
- Provide documentation of the late effects of cerebrovascular disease
  - Identified as sequela of cerebrovascular disease

Nervous System Documentation Requirements

- Addition to Neurology query templates:
  - Generalized or focal seizures
    - Generalized seizures affect the whole brain:
      - Akinetic
      - Grand mal
      - Petit mal
      - Non-specified
      - General seizure documentation will require type specificity
    - Focal seizures occur when the electrical activity remains in a limited area of the brain
      - Can progress into generalized seizure
Encephalopathy Documentation Requirements

Altered Mental Status – any degenerative disorder of the brain. The AHA Coding Clinic for ICD-9, 4th Quarter 1993, states that toxic or metabolic encephalopathy denotes delirium, which, according to Coding Clinic for ICD-9, 4th Quarter 2003, always has an underlying cause, such as:

- brain tumor
- brain metastasis
- cerebral infarction or hemorrhage
- cerebral ischemia
- uremia
- poisoning
- systemic infection
- or other illnesses

Encephalopathy Documentation Requirements

Altered Mental Status (AMS) presents as:

- Confusion
- Lethargy
- Often documented with or due to:
  - Underlying infection
    - Pneumonia
    - Sepsis
    - Urinary tract infection
  - Medication
Encephalopathy Documentation Requirements

Common types of encephalopathy

- Metabolic encephalopathy
  - Electrolyte derangement
    - Sustained hypoglycemia
    - Hyponatremia
  - Liver failure
  - Thiamine deficiency
  - Nutritional disorders

- Toxic encephalopathy
  - Toxic elements – solvents, drugs, radiation, paints, industrial chemical and certain metals
  - Exogenous toxins, including carbon monoxide and cyanide
  - Drug overdose

Toxic-Metabolic Encephalopathy Documentation Requirements

- Tests performed
  - Blood tests
  - Spinal fluid examination
  - Imaging studies
  - EEG
  - Similar studies to differentiate the various causes of encephalopathy

- Acute to sub-acute course meaning hours to days
- Ask the physician to be specific of the nature of the AMS (acute/chronic)
### Toxic-Metabolic Encephalopathy Documentation Requirements

- Ask the physician to document the underlying cause
  - Neurodegenerative disease (i.e. Alzheimers, Lewy body dementia)
  - Psychiatric illnesses (i.e. mood disorders, schizophrenia, chemical dependencies, including drug withdrawal syndrome)
  - AMS caused by a focal structural problem with the brain (seizure, concussion, TIA/CVA, or tumor)
  - AMS caused by global dysfunction of the brain = encephalopathy, specified by the type:
    - Toxic
    - Septic
    - Metabolic
    - Hypertensive
    - Hepatic

### Toxic-Metabolic Encephalopathy Query

Query for encephalopathy
- If the patient has AMS with no underlying structural problem
- Identify the nature of the AMS
  - Delirium, dementia, obtundation, stupor, coma, other, unable to determine
- Identify the chronicity of the AMS
  - Acute, chronic, acute on chronic, other, unable to determine
- Develop query with multiple choice checklist with clinically credible options as well as “other” and “unable to determine”
ICD-10 Heart Failure Acuity Documentation

Document findings and treatment

**Specify Findings**
- Edema
- Acute shortness of breath
- Abnormal echo findings
- Abnormal labs
- Abnormal chest x-ray findings

**Heart Failure Treatment**
- Fluid boluses
- IV diuretics
- Surgical patients receiving large volume of fluids
Heart Failure Documentation

- New terms have been used for heart failure patients:
  - HFpEF – heart failure with preserved ejection fraction
  - Heart failure with preserved systolic function
  - HFrEF – heart failure with reduced ejection fraction
  - Heart failure with low ejection fraction
  - Heart failure with reduced systolic function

- A coder cannot assume either systolic or diastolic failure or a combination of both, based on these terms

Query the physician

Myocardial Infarction Documentation

- Acute myocardial infarction (AMI)
  - Document STEMI vs. NSTEMI
  - Document MI age using weeks, not days or months
  - Document the anatomic location
    - Anterior wall
      - Left main coronary artery
      - Left anterior descending coronary artery
      - Other coronary artery of anterior wall
    - Inferior wall
      - Right coronary artery
      - Other coronary artery of inferior wall
  - Subsequent MI – acute MI occurring within four weeks (28 days) of a previous MI, regardless of site
Complication of MI

Document any consequences or complications of the AMI

- Hemopericardium
- Atrial septal defect
- Ventricular septal defect
- Rupture of cardiac wall
- Rupture of chordae tendinea
- Rupture of papillary muscle
- Thrombosis of atrium
- Post infarction angina
- Other complication

RESPIRATORY SYSTEM DOCUMENTATION
Respiratory Failure

- Respiratory failure is a syndrome in which the respiratory system fails in one or both of its gas exchange functions:
  - Oxygenation – hypoxemic respiratory failure
  - Carbon dioxide elimination – hypercapnic respiratory failure
- Hypoxemic respiratory failure
  - PaO2 - <60mm Hg
  - Symptoms – confusion, somnolence
- Hypercapnic respiratory failure
  - PaCO2 - >50mm Hg
  - Hypoxemia is common in patients with hypercapnic respiratory failure who are breathing room air

Respiratory Failure

- Respiratory failure in COPD patients
  - sudden increase in PaCO2 of > five degrees of change (10-15 points from normal)
  - pH is lower than 7.35
Respiratory Failure

- Documentation must indicate the patient is having trouble breathing and has an abnormal reading on either blood gas or pulse oximetry
  - How do you tell if it’s hypoxia or hypoxic respiratory failure?
    - Use of accessory muscles of respiration
    - May have inability to speak more than two or three words at a time
    - There may be tachypnea in the range of 24-30 or above
  - A single reading of arterial oxygen does not tell if this is acute or chronic

Respiratory Failure Query

- Incorporate the following severity indicators into documentation templates or queries for respiratory failure:
  - Identify the severity as:
    - Acute
    - Chronic
    - Unspecified
  - Identify the respiratory failure as:
    - Hypoxic
    - Hypercapnic
Asthma

• ICD-10 combines intrinsic or extrinsic asthma into one category so this will no longer be differentiated
• New codes are based on severity of asthma:
  ■ Intermittent (mild)
  ■ Mild persistent
  ■ Moderate persistent
  ■ Severe persistent asthma
  ■ All with:
    o Acute exacerbation
    o Status asthmaticus
• Focus documentation on relationship between asthma and other diseases, i.e. COPD

Asthma Classification

• Intermittent asthma symptoms, without any treatment
  ■ Difficulty breathing, wheezing, chest tightness, coughing
  ■ Occurs on fewer than 2 days a week
  ■ Nighttime symptoms occur on fewer than 2 days a month
  ■ Lung Function Tests are normal when person is not having an attack
• Mild persistent asthma
  ■ Symptoms occur more than 2 days a week, but not everyday
  ■ Attacks interfere with daily activities
  ■ Nighttime symptoms occur 3 to 4 times a month
  ■ Lung Function Tests are normal when person is not having an attack
• Moderate persistent asthma
  ■ Symptoms occur daily; asthma medication is used every day
  ■ Symptoms interfere with daily activities
  ■ Nighttime symptoms occur more than once a week, but not everyday
  ■ Lung Function Tests are abnormal, 60-80% of expected value
• Severe persistent asthma
  ■ Symptoms occur throughout each day
  ■ Severely limit daily physical activities
  ■ Nighttime symptoms occur often, sometimes every night
  ■ Lung Function Tests are abnormal, 60% or less of expected value
Query for Asthma

- Incorporate the following severity indicators into documentation templates or queries for asthma:
  - National Heart, Lung, and Blood Institute (NHLBI) asthma severity classification scale
    - Intermittent (mild)
    - Mild persistent
    - Moderate persistent
    - Severe persistent
  - Relationship to other diseases when applicable

SKIN, SUBCUTANEOUS TISSUE & BREAST DOCUMENTATION
Documentation of Pressure Ulcers

In ICD-10-CM pressure ulcer codes are combining both the location and the stage of the pressure ulcer:

- Location includes laterality per anatomical site
- Stage of pressure ulcer notation is allowed based on non-provider documentation – as long as the provider has documented the presence of the pressure ulcer
- Pressure ulcers should be coded to the highest degree of specificity per anatomical site

Pressure Ulcer Query

- Documentation should focus on:
  - Site
  - Laterality
  - Stage
  - Associated conditions when noted (to be coded in addition)
    - Gangrene
- Extensive ulcers may require multiple codes or a single code for certain contiguous sites as directed in the index
ICD-10 Fracture Code Documentation Requirements

- Fracture codes in ICD-10 identify the following specificity:
  - Fracture type
  - Specific anatomical site
  - Displacement status
    - Open
    - Closed
  - Laterality
  - Routine vs. delayed healing (type of encounter)
  - Nonunion or malunion
### ICD-10 Fracture Code Documentation Requirements

- **Documentation efforts:**
  - Type
  - Laterality
  - Type of encounter
  - Gustilo Open Fracture Classification
    - I
    - II
    - IIIA
    - IIIB
    - IIIC

- Coders can review the radiology reports to determine specificity of the fracture

### Fracture Queries

- Incorporate into musculoskeletal queries exact:
  - Location
  - Side of dominance
  - Laterality
  - If condition is due to underlying disease, document the causative disease process (pathological fracture)
ICD-10 Acute Kidney Failure Documentation Requirements

- Documentation inconsistencies:
  - Acute renal failure (ARF)
  - Acute kidney injury (AKI)
  - Acute kidney insufficiency (AKI)

- A concept was developed by the National Kidney Foundation known as the RIFLE model:
  - Risk-Urine output, GFR, serum creatinine
  - Injury-(48 hour abrupt event)
  - Failure
  - Loss-(four weeks without recovery)
  - ESRD
Chronic Kidney Disease Documentation

- Incorporate the following severity indicators into documentation templates for chronic kidney disease:
  - Stage 1, Stage 2, Stage 3, Stage 4, Stage 5
  - End Stage Renal Disease (ESRD) should be documented as such, not as a stage, e.g. Stage 6
  - Supported by lab values for:
    - BUN
    - Creatinine – blood
    - Creatinine clearance
    - Creatinine – urine
    - GFR – glomerular filtration rate

Renal Failure Query

- Incorporate into acute renal failure queries:
  - Signs/symptoms
  - Results of lab tests to show kidney function
  - Treatment initiated/medications
  - Monitoring of condition
  - Patient’s response to treatment
  - Allow physician to select correct diagnosis:
    - Acute renal failure
    - Chronic renal failure
    - Chronic renal insufficiency
    - Other diagnosis
ICD-10 Pregnancy Documentation Requirements

- The pregnancy codes have a 7th character identifying the trimester of pregnancy in which the condition occurred
  - Not all conditions include codes for all three trimesters
  - Certain conditions only occur during certain trimesters
- Code Z3A – weeks of gestation to identify the specific week of the pregnancy
  - Count from the first day of the last menstrual period
  - Used only on the maternal record
- Greater specification on complications related to multiple gestations
  - Ability to identify the fetus for which the complication applies, if possible
Pregnancy Queries

- Addition to obstetrics query templates:
  - Trimester of pregnancy
    - 1st trimester – less than 14 weeks, 0 days
    - 2nd trimester – 14 weeks 0 days to less than 28 weeks 0 days
    - 3rd trimester – 28 weeks 0 days until delivery
  - Default to the trimester when the complication occurred, not the discharge trimester when an admission crosses trimesters

- Weeks of gestation
ICD-10 Documentation Requirements for Injuries

- Specific documentation requirements for injuries:
  - Specific injury
    - Laceration
    - Puncture
    - Avulsion
    - Bite
    - Foreign body
    - Superficial vs. open
    - Intracranial injury with or without concussion and/or loss of consciousness
      - Length of time of loss of consciousness
  - Location
  - Laterality
  - Type of encounter
    - Initial
    - Subsequent
    - Sequela of injury

- Documentation concerning Injuries should include:
  - Glasgow Coma Scale, if applicable:
    - A score from each of the following assessment areas is needed:
      - Eye opening
      - Verbal response
      - Motor response
    - Code assignment is based on the components
    - 7th character identifies when the scale was recorded
      - In the field
      - Upon arrival to the emergency department
      - At hospital admission
      - 24 or more hours after admission
ICD-10 Diagnosis Code Requirements and Sequencing

Include importance of secondary code assignments

The value of reporting secondary codes further emphasizes the complexity of the patient and increased patient care required to successfully treat the patient. The definition of “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay or increased nursing care and/or monitoring. Secondary diagnoses identify all conditions that coexist at the time of admission, develop after admission, or affect the treatment received and/or the length of stay. Reporting of secondary diagnoses additionally supports Severity of Illness (SOI) and Risk of Mortality (ROM) for all patients, further justifying their need for treatment and hospitalization.
When and How to Query

- Documentation in the medical record prompts a query in the following situations:
  - The documentation is conflicting, imprecise, incomplete, illegible, ambiguous or inconsistent
  - Documentation describes clinical indicators without a definitive relationship to an underlying diagnosis
  - Documentation states clinical indicators, diagnostic evaluation and/or treatment not related to a specific condition or procedure
  - A diagnosis is documented without underlying clinical support
  - It is unclear if the condition was Present on Admission (POA)
Query Process Consideration

The 2013 ACDIS/AHIMA guidance also added the use of **Yes/No** queries in three new possible situations:

- Further specifying a diagnosis that is already present in the record
- Establishing a cause-and-effect relationship between a documented condition such as a manifestation/etiology, complication and conditions/diagnostic findings
- To resolve conflicting documentation
- (POA was already allowed a yes/no response)

Summary

- **Review**: Chapter specific documentation guidelines
- **Apply**: Chapter specific documentation guidelines to your coding
- **Educate**: Physicians on specific documentation requirements for each specialty
- **Audit**: Specialties to ensure documentation and coding is specific and reflects patient care and severity of
Obstetrics Inpatient Documentation

Summary of Physician Documentation

25 year old pregnant female with term pregnancy was admitted for induction of labor secondary to polyhydramnios at term. She was started on IV Pitocin and developed regular contractions. Artificial rupture of membranes was completed via vaginal approach when the cervix was dilated to 4 cm. She did have an arrest of dilation and failure to progress with her labor. She required a low transverse Cesarean section delivery of a viable male infant. After the infant’s head was delivered, nuchal cord x2 were reduced without difficulty. The patient’s history was significant for smoking cigarettes during this pregnancy.
Obstetrics Inpatient Documentation

- Final diagnoses:
  - Term pregnancy, delivered, viable male
  - Polyhydramnios
  - Primary uterine inertia
  - Nuchal cord x2
  - Current smoker

- Final procedures
  - Low transverse cesarean section
  - Artificial rupture of membranes, vaginal approach
  - Induction of labor with IV Pitocin

Working/Post Discharge ICD-10 Diagnosis and MSDRG Coding

- ICD-10 Diagnosis Code(s) (correct sequencing)

- ICD-10 MSDRG Code (if applicable)
ICD-10 Coding/Query Requirements (if applicable)

- Clinical Indicators:

- Statement:

ICD-10 Working or Post Discharge Diagnosis and MSDRG Answers

- ICD-10 Diagnosis Code(s) (correct sequencing)
  - O40.3XX0 Polyhydramnios, third trimester, not applicable or unspecified
  - Z37.0 Single live birth
  - O99.334 Smoking (tobacco) complicating childbirth
  - F17.210 Nicotine dependence, cigarettes, uncomplicated
  - O62.0 Primary inadequate contractions
  - O69.81X0 Labor and delivery complicated by cord around neck, without compression, not applicable or unspecified
### ICD-10 Working or Post Discharge Diagnosis and MSDRG Answers

- **ICD-10 Procedure Code(s) (correct sequencing)**
  - 10D00Z1  Extraction of products of conception, low cervical, open approach
  - 10907ZC  Drainage of amniotic fluid, therapeutic form products of conception, via natural or artificial opening
  - 3E033VJ  Introduction of other hormone into peripheral vein, percutaneous approach

- **ICD-10 MSDRG Code**
  - MS-DRG 766 – cesarean section W/O CC/MCC
    - RW .7562

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### INPATIENT DIAGNOSIS AND PROCEDURE CODING - HEMATOLOGY

**CASE STUDY**
34 year old African American male with a history of sickle cell disease presented to ER with back pain and whole body pain, remote history of fevers and chills. WBC was slightly elevated and hemoglobin and hematocrit were significantly decreased. Blood cultures grew Staph aureus in 4 of 4 bottles. The patient was admitted with sickle cell pain and Staph aureus bacteremia. The patient was placed on Vancomycin for 6 days and then switched to IV Ancef. The patient was also placed on a PCA pain pump, oxygen and was bolused with IV fluids and continued on maintenance fluids. Transesophageal echocardiogram and bone scan were done with no significant findings. As the patient had Staph bacteremia of unknown origin, Infectious Disease consult was completed and ordered patient to receive 5 weeks of IV Ancef. PICC line was placed to ensure home access for the antibiotics. Patient was discharged with home health.

Final diagnoses:
- Sickle cell pain
- Staphylococcus aureus bacteremia

Final procedures:
- PICC line placement
- Bone scan
- Transesophageal echocardiogram
ICD-10 Coding/Query Requirements (if applicable)

- Clinical Indicators:

- Statement:

**INPATIENT DIAGNOSIS AND PROCEDURE CODING - INFECTIOUS DISEASE CASE STUDY**
Summary of Physician Documentation

71 year old male admitted through the Emergency Department with probable urosepsis and renal insufficiency. The patient is a nursing home resident with a history of cerebrovascular accident (CVA) 2 years prior to admission. He has residual aphasia and right hemiplegia from the CVA. Initial WBC was 23.7, and urinalysis had too numerous to count white cells and 4+ Bacteria. BUN and Creatinine were elevated. Urine and Blood cultures grew Escherichia coli. He was treated with IV Primaxin and IV fluid rehydration and regular tube feedings were continued. WBC decreased to 9.0 and the BUN and Creatinine came down to patient baseline. He was noted to have a history of chronic obstructive pulmonary disease and required intermittent oxygen. He was discharged to return to nursing home on Cipro via feeding tube.

Final Diagnoses

- Urosepsis due to E. coli
- Renal insufficiency
- Chronic obstructive pulmonary disease
- CVA with right hemiplegia and aphasia
Working/Post Discharge ICD-10 Diagnosis and MSDRG Coding

- ICD-10 Diagnosis Code(s) (correct sequencing)

- ICD-10 MSDRG Code (if applicable)

ICD-10 Coding/Query Requirements (if applicable)

- Clinical Indicators:

- Statement:
ICD-10 Working or Post Discharge Diagnosis and MSDRG Answers

- ICD-10 Diagnosis Code(s) (correct sequencing)
  - ??? – E. coli septicemia (See query section)
  - N39.0 – Urinary tract infection
  - B96.20 – Escherichia coli, as cause of disease classified elsewhere
  - N28.9 – Renal insufficiency
  - J44.9 – Chronic obstructive pulmonary disease
  - I69.359 – Right hemiplegia following cerebral infarction
  - I69.329 – Aphasias following cerebral infarction

- ICD-10 Procedure Code(s) (correct sequencing)
  - None

ICD-10 Diagnosis and Procedure Documentation - Respiratory Failure Case Study
Respiratory Failure Documentation

This patient presented to the ED as a transfer from Community Hospital with respiratory distress and was treated with lasix for her CHF. The patient was placed on BiPAP, but was later intubated when her respiratory status worsened. She is being admitted to Memorial Hospital for management of her respiratory distress.

Working/Post Discharge ICD-10 Diagnosis and MSDRG Coding

- ICD-10 Diagnosis Code(s) (correct sequencing)

- ICD-10 MSDRG Code (if applicable)
ICD-10 Coding/Query Requirements (if applicable)

- Clinical Indicators:
  - Dyspnea
  - Shortness of Breath
  - Mental Confusion
  - Atelectasis
  - ABGs with:
    - PaO2 <60mmHg
    - PCO2 >50mmHg
    - Blood Gas <7.35

- Statement:
  - Corresponding treatment:
    - O2 Therapy
    - Inhalation Treatments
    - Ventilation Support
    - IV Steroids initiated
    - Bronchial Dilators
    - Other Treatment: ____________
    - Other Medication: ____________

New monitoring of conditions via:
- Chest X-Ray
- ABGs
- MRI/CT chest
- Sputum Culture results: __________________
- Other: __________________
Respiratory Failure Diagnosis Query

Query physician/provider for clarification regarding the specific diagnosis/condition

- Acute respiratory failure
  - With hypoxia
  - With hypercapnia
- Chronic respiratory failure
  - With hypoxia
  - With hypercapnia
- Respiratory distress
- Respiratory insufficiency
- Other

ICD-10 Working or Post Discharge Diagnosis and MSDRG Answers

ICD-10 Diagnosis Code(s)

- J96.01 Acute respiratory failure with hypoxia
- J96.02 Acute respiratory failure with hypercapnia
- J96.11 Chronic respiratory failure with hypoxia
- J96.12 Chronic respiratory failure with hypercapnia
- J96.21 Acute and chronic respiratory failure with hypoxia
- J96.22 Acute and chronic respiratory failure with hypercapnia

All respiratory failure codes are MCCs
Kidney Transplant Admission Documentation

Summary of Physician Documentation:

14 year old male is admitted for his second kidney transplant with a history of renal failure and failed left kidney transplant. Prior to surgery, the patient underwent hemodialysis, through the existing AV fistula. The transplant was accomplished within 48 hours of the harvesting of the donor organ. Tissue samples confirmed an adequate donor match. The previously transplanted right kidney was removed and replaced with the donor kidney. The patient required one postoperative hemodialysis session before the newly transplanted kidney was functioning adequately. He was watched closely for signs of rejection and had an uneventful postoperative course.
Kidney Transplant Admission Documentation

- **Final Diagnoses:**
  - Kidney transplant failure
  - Renal failure

- **Final Procedure:**
  - Kidney transplant
  - Hemodialysis

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Working/Post Discharge ICD-10 Diagnosis and MSDRG Coding

- ICD-10 Diagnosis Code(s) (correct sequencing)

- ICD-10 MSDRG Code (if applicable)
ICD-10 Coding/Query Requirements (if applicable)

• Clinical Indicators:

• Statement:

Working/Post Discharge ICD-10 Diagnosis and MSDRG Coding

• ICD-10 Diagnosis Code(s) (correct sequencing)
  ■ T86.12 – Kidney transplant failure
  ■ N19 – Unspecified kidney failure

• ICD-10 Procedure Code(s) (correct sequencing)
  ■ 0TY10Z0 – Left kidney transplantation, allogeneic, Open Approach
  ■ 5A1D60Z – Performance of urinary filtration, multiple

• ICD-10 MSDRG Code (if applicable)
  ■ MS-DRG 652 – KIDNEY TRANSPLANT
19 month old female presented to the ER with cough, congestion, not drinking and decreased urination. On exam, the patient was noted to be significantly dehydrated with moderate respiratory distress due to wheezing. She was diagnosed with acute croup and asthma infiltrate on chest x-ray described as bronchial pneumonia. The physician specified that the patient was admitted due to the respiratory distress caused by the croup. She was treated with IV antibiotics, inhaled steroids, bronchodilators, croup tent (cool mist) and cautious IV fluids. She did not improve and required transfer to Children’s hospital.
Pediatrics Admission Documentation

- Final Diagnoses
  - Acute croup
  - Asthma
  - Bronchial pneumonia
  - Dehydration

- Final Procedure:
  - Cool mist croup tent

Working/Post Discharge ICD-10 Diagnosis and MSDRG Coding

- ICD-10 Diagnosis Code(s) (correct sequencing)

- ICD-10 MSDRG Code (if applicable)
ICD-10 Coding/Query Requirements (if applicable)

- Clinical Indicators:

- Statement:

ICD-10 Working or Post Discharge Diagnosis and MSDRG Answers

- ICD-10 Diagnosis Code(s) (correct sequencing)
  - J05.0 – Acute obstructive laryngitis (croup)
  - J18.0 – Bronchopneumonia, unspecified organism
  - E86.0 – Dehydration
  - J45.909 – Unspecified asthma, uncomplicated

- ICD-10 Procedure Code (s) (correct sequencing)
  - 3EOF22Z – Introduction of Electrolytic and Water Balance Substance into Respiratory Tract, via Natural or Artificial Opening (croup tent)

- ICD-10 MSDRG Code – 152 – Otitis Media & URI
  W MCC RW 1.0162
Questions

Thanks for Attending!

Intended for internal guidance only, and not as recommendations for specific situations. Readers should consult a qualified attorney for specific legal guidance.