Internal Medicine
ICD-10 Training

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As an approved PMCC instructor of the American Academy of Professional Coders, Nancy provides coding certification courses, outsourced coding, chart auditing, consultative services and seminars in CPT and ICD-9 coding, evaluation and management coding and documentation and compliance planning. Nancy frequently speaks on coding, compliance and reimbursement issues to the provider community.

Nancy is a Fellow of the American College of Medical Practice Executives. She is on the Section Steering Committee of MGMA and is a Past President of MA/RI MGMA. She is the founding President of the Rhode Island Chapter, AAPC.
Mike Enos, CPC, CPMA, CEMC has over 10 years of experience in medical coding, billing compliance and revenue cycle management and has developed a suite of online training courses on Evaluation and Management, ICD-10 and CPC preparation.

After earning a B.A. from Rhode Island College, Mike pursued three professional medical coding certifications, including Certified Professional Coder (CPC), Certified Professional Medical Auditor (CPMA) and Certified Evaluation and Management Coder (CEMC).

Mike has contributed articles to MGMA Connection Magazine, as well as presented at MGMA conferences, AAPC chapter meetings and the New England Quality Care Alliance (NEQCA) Fall Forum. He has served as a billing compliance specialist with Medsafe, and currently works as a compliance consultant with Enos Medical Coding.
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Today’s agenda

• Brief introduction to ICD-10
• Important conventions in the ICD-10 code set
• Chapter-specific guidelines
• Overview of concepts relevant to internal medicine
• Clinical examples
Introduction

• CMS: “On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.”
  – One implementation for all covered by HIPAA (not applicable to automobile insurance, workers’ compensation, some liability insurance)
  – CMS has confirmed – no extensions
  – On April 14, Congress passed The Medicare Access and CHIP Reauthorization Act, which repealed the flawed SGR formula, clearing the final hurdle for ICD-10 implementation
Why change from ICD-9?

• ICD-9 has several problems
  – After more than 35 years, it is no longer useful for tracking diseases
  – It is out of room: Because the classification is organized scientifically, each three-digit category can have only 10 subcategories
    • Medical science keeps making new discoveries, but there are no numbers to assign these diagnoses
• ICD-10 expands to seven digits
  – Computer science, combined with new, more detailed codes of ICD-10, will allow for better analysis of disease patterns and treatment outcomes that can advance medical care
  – These same details will streamline claims submissions by making the initial claim much easier for payers to understand
Why change from ICD-9?

• Under the sponsorship of the World Health Organization, a select group of physicians created the basic ICD-10 structure

• Each physician specialty within the U.S. offered input on each subset of diagnosis codes required
  – In most cases, the specialties advocated capturing additional detail based on information that physicians intuitively use in delivering patient care

• Greater detail will encourage accurate analysis of health data, which will help improve the quality and efficiency of patient care, particularly with increased electronic sharing and exchange of health data
Comparing ICD-9 to ICD-10
# Comparison of code sets

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 characters</td>
<td>3-7 characters</td>
</tr>
<tr>
<td>More than 17,000 codes</td>
<td>More than 155,000 codes (68,000 are for ICD-10-CM)</td>
</tr>
<tr>
<td>First digit may be alpha (E or V only) or numeric; digits 2-5 are always numeric</td>
<td>First character is alpha; digits 2-3 are numeric; 4-7 are alpha or numeric</td>
</tr>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible, new format allows for expansion</td>
</tr>
<tr>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
<tr>
<td>Lacks laterality (right vs. left)</td>
<td>Includes a specific field to identify laterality, which accounts for one-third of the new codes</td>
</tr>
</tbody>
</table>
Example: A patient presents with a right wrist injury
- Physician bills for application of a short arm splint
- A week later, the same patient comes in for a left wrist injury
- ICD-9-CM does not identify left vs. right
- Requires additional documentation

ICD-10-CM describes
- Left vs. right
- Initial encounter, subsequent encounter
- Routine healing, delayed healing, nonunion or malunion
ICD-10 changes everything

Detailed clinical information
ICD-10 differences

- Combination codes
- Laterality
- Episode of care
- Exact anatomic location
- Clinical details
- Cause/etiology
Combination codes

• Represents a single code used to classify two diagnoses
  – A diagnosis with an associated sign or symptom
  – Diagnosis with an associated complication

• Simplifies the number of codes needed to clinically spell out a condition
  – *Documentation will need to support all elements*
Combination codes

ICD-10-CM

• **E11.41** Type 2 diabetes with diabetic mononeuropathy

ICD-9-CM

• **250.60** Diabetes with neurological manifestations, type 2 or unspecified, not states and uncontrolled
• **355.9** mononeuritis of unspecified site
Laterality

• Code descriptions include designations for left, right and, in many cases, bilateral
• Documentation should always include laterality

• What additional documentation will be needed?
  - Right
  - Left
  - Bilateral
Laterality

H65.00 Acute serous otitis media, unspecified ear
H65.01 Acute serous otitis media, right ear
H65.02 Acute serous otitis media, left ear
H65.03 Acute serous otitis media, bilateral

T15.00 Foreign body in cornea, unspecified eye
T15.01 Foreign body in cornea, right eye
T15.02 Foreign body in cornea, left eye

• Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral
• If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side
• If the side is not identified in the medical record, assign the code for the unspecified side
Laterality

M79.604 Pain in right leg
M79.605 Pain in left leg
M79.606 Pain in leg, unspecified
M79.609 Pain in unspecified limb

Pretty simple, right? What if I told you this simple distinction between *left* and *right* accounts for about 25,000 of the 69,000 codes in ICD-10?

That's right: 25,000 codes in ICD-10 are different only in that they distinguish between left and right.
• Sometimes the last digit indicates the specific site:
  – **R10.10** Upper abdominal pain, unspecified
  – **R10.11** Right upper quadrant pain
  – **R10.12** Left upper quadrant pain
  – **R10.13** Epigastric pain
  – **R10.30** Lower abdominal pain, unspecified
  – **R10.31** Right lower quadrant pain
  – **R10.32** Left lower quadrant pain
  – **R10.33** Periumbilical pain
  – **R10.84** Generalized abdominal pain
  – **R10.9** Unspecified abdominal pain
ICD-10 structure

• The expanded number of characters of the ICD-10 diagnosis codes provides greater specificity to identify disease etiology, anatomic site and severity
• Characters 1-3: Category ("block")
• Characters 4-6: Etiology, anatomic site, severity or other clinical detail
• Character 7: Extension, for example: episode of care or other clinical detail
Structural change

ALPHA (NOT U)  NUMERIC  CHARACTERS 3-7 CAN BE ANY COMBINATION OF ALPHA OR NUMERIC

1st DIGIT  2nd DIGIT  3rd DIGIT  4th DIGIT  5th DIGIT  6th DIGIT  7th DIGIT
CATEGORY  ETIOLOGY, ANATOMICAL SITE, SEVERITY  EXTENSION
Fifth and sixth characters

Identifies the most precise level of specificity

Example:

S61.257 Open bite of left little finger without damage to nail

3 – S61 is a category for open wound of wrist, hand and fingers

4 – S61.2 specifies the injury is an open wound of the finger

5 – S61.25 specifies it is a bite

6 – S61.257 specifies it is of the left little finger

A seventh character extender is also required for current injuries
Seventh character extenders

• The fact that the codes are up to seven characters in length is a major difference that brings two new considerations: *seventh character extenders* and *dummy placeholders*

• Seventh character extenders are usually a letter and are used to identify specific information about the clinical episode

• Most of the seventh character extenders used in ICD-10-CM pertaining to injuries include:

  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 - Sequela
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S51</td>
<td>Open wound of elbow and forearm</td>
</tr>
<tr>
<td>S51.0</td>
<td>Open wound of <strong>elbow</strong></td>
</tr>
<tr>
<td>S51.01</td>
<td><strong>Laceration</strong> without foreign body of elbow</td>
</tr>
<tr>
<td>S51.012</td>
<td>Laceration without foreign body of <strong>right elbow</strong></td>
</tr>
<tr>
<td>S51.012A</td>
<td>Laceration without foreign body of right elbow, <strong>initial encounter</strong></td>
</tr>
</tbody>
</table>
A unique twist: the placeholder

- Some codes are seven characters, but no fourth, fifth or sixth place is necessary, so “x” is a placeholder:
  
  **T68.XXXA** - Hypothermia, initial encounter
  
  **T67.0XXA** - Heat stroke and sunstroke, initial encounter
  
  **T36.4X6A** - Underdosing of tetracyclines, initial encounter
  
  **S67.21XD** - Crushing injury of right hand, subsequent encounter

  The appropriate seventh character is to be added to code H40.41

  - 0 - stage unspecified
  - 1 - mild stage
  - 2 - moderate stage
  - 3 - severe stage
  - 4 - indeterminate stage
Sequela (late effects)

• A **sequela** is the residual effect (condition produced) after the acute phase of an illness or injury has terminated.

• There is no time limit on when a sequela code can be used; the residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury.

• Examples of sequela include:
  – Scar formation resulting from a burn
  – Deviated septum due to a nasal fracture
  – Infertility due to tubal occlusion from old tuberculosis

• Coding of sequela generally requires two codes sequenced in the following order:
  – The condition or nature of the sequela is sequenced first
  – The sequela code is sequenced second
Signs and symptoms

• Just as in ICD-9-CM, codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been confirmed by the provider.

• Signs and symptoms that are associated routinely with a disease process should **not** be assigned as additional codes, unless otherwise instructed by the classification.

• Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.
Signs and symptoms

• Specific diagnosis codes should be reported when they are supported by the available medical documentation and clinical knowledge of the patient’s health condition; however, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the encounter.

• Each healthcare encounter should be coded to the level of certainty known for that encounter.
“Unspecified” codes

• If a definitive diagnosis has not been established by the end of the encounter, you may report codes for signs and/or symptoms in lieu of a definitive diagnosis.

• When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, you may report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type).

• Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that encounter.

• It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.
“Unspecified” codes

• This differs from “other specified” which means there is no exact code description for the condition described in the documentation

• Be careful when using “unspecified” codes, as some payers may deny claims if an unspecified code is used (e.g., pain in unspecified ear)
It’s all about the documentation

• The level of evaluation and management (E/M) service is based on:
  - Medical necessity
  - Documentation of history, exam and MDM
  - Time

• The detail in ICD-10 depends on the information in the note

• Coders and billers are trained not to use unspecified codes and are always directed to query the provider for more detailed information
Changes by ICD-10-CM chapters

1. Infectious and Parasitic Diseases
2. Neoplasm’s
3. Diseases of the Blood and Blood-Forming Organs
4. Endocrine, Nutritional and Metabolic Diseases
5. Mental and Behavioral Disorders
6. Disease of the Nervous System
7. Diseases of the Eye and Adnexa
8. Diseases of the Ear and Mastoid Process
9. Diseases of the Circulatory System
10. Diseases of the Respiratory System
11. Diseases of the Digestive System
12. Diseases of the Skin and Subcutaneous Tissue
13. Diseases of the Musculoskeletal System and Connective Tissue
14. Diseases of the Genitourinary System
15. Pregnancy, Childbirth and the Puerperium
16. Newborn (Perinatal)
17. Congenital Malformations, Deformations and Chromosomal Abnormalities
18. Symptoms, Signs and Abnormal Clinical and Laboratory Findings
19. Injury, Poisoning and Certain Other Consequences of External Causes
20. External Causes of Morbidity
21. Factors Influencing Health Status and Contact with Health Services
Combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that system

When documenting diabetes, include the following:

- **Type**: e.g. Type 1 or Type 2 disease, drug or chemical induces, due to underlying condition, gestational
- **Complications**: What (if any) other body systems are affected by the diabetes condition? e.g. Foot ulcer related to diabetes mellitus
- **Treatment**: Is the patient on insulin?

It is now possible to document and code for hypoglycemia and hyperglycemia without using “diabetes mellitus”

- You can also specify if the condition is due to a procedure or other cause

The final important change is that the concept of “secondary diabetes mellitus” is no longer used; instead, there are specific secondary options
There are five Diabetes Mellitus categories in the ICD-10-CM to reflect the current clinical classifications of diabetes:

- **E08** - Diabetes Mellitus due to an underlying condition
- **E09** - Drug- or chemical-induced diabetes mellitus
- **E10** - Type I diabetes mellitus
  - The age of a patient is not the sole determining factor, though most Type 1 diabetics develop the condition before reaching puberty
  - Type 1 diabetes mellitus is also referred to as juvenile diabetes
- **E11** - Type 2 diabetes mellitus
- **E13** - Other specified diabetes mellitus
Diabetes Mellitus combination code examples

- **E08.22** Diabetes mellitus due to an underlying condition with diabetic chronic kidney disease

- **E09.52** Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene

- **E11.41** Type 2 diabetes mellitus with diabetic mononeuropathy
Diabetes Mellitus

• You may use as many codes within a particular category as necessary to describe all of the complications of the disease

• Should be sequenced based on the reason for a particular encounter

• Assign as many codes from categories E08 – E13 as needed to identify all of the patient’s associated conditions
Diabetes Mellitus and use of insulin

• In ICD-10-CM, use code Z79.4, *long-term current use of insulin*, in the same way you currently use V58.67 in ICD-9-CM

• This code is **NOT** to be added to type I diabetic patients (E10 category) or gestational diabetic patients (O24.4 subcategory)
Understanding BMI will help you to determine the parameters of the difference between overweight and obesity.

Use additional code to identify body mass index (BMI) if known: Z68.-

- Underweight: below 18.5
- Normal: 18.5-24.9
- Overweight: 25.0-29.9
- Obese: 30.0 and above

Obesity and BMI codes are required when they are an underlying cause.
Mental and behavioral disorders

- Pain disorders related to psychological factors
- Mental and behavioral disorders due to psychoactive substance abuse
  - Documentation must state the substance and:
    - Use
    - Abuse
    - Dependence
- Be sure to only report drug abuse/dependence “in remission” when the documentation clearly states that the patient is in remission in the provider’s clinical judgement
  - This is note something coders can assume, so working with providers is essential
Smoking and tobacco use

• Tobacco abuse and addiction
  – 20 choices in ICD-10-CM for nicotine dependence
  – Documentation must include:
    • Type (cigarettes, chewing tobacco, etc.)
    • Status (in remission, with withdrawal, etc.)
    • With other nicotine-induced disorders

Examples:
F17.211 Nicotine dependence, cigarettes, in remission
F12.180 Cannabis abuse with cannabis-induced anxiety disorder
Environmental exposure to tobacco smoke

- Exposure to tobacco smoke may be important to document, especially in cases of chronic or recurrent asthma, otitis media or bronchitis
- Documenting this level of detail will require the addition of documentation to capture exposure to tobacco smoke
  - This includes second-hand smoke, newborns affected by maternal use of tobacco, and exposure to tobacco smoke in the perinatal period

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z77.22</td>
<td>Contact with and exposure to environmental tobacco smoke</td>
</tr>
<tr>
<td>P04.2</td>
<td>Newborn (suspected to be) affected by maternal use of tobacco</td>
</tr>
<tr>
<td>Z57.31</td>
<td>Occupational exposure to environmental tobacco smoke</td>
</tr>
</tbody>
</table>
Depression

- Depression affects over 20 million people in the U.S.
- Depression is a disorder of the brain, with a variety of causes, including genetic, environmental, psychological and biochemical factors.
- In ICD-10-CM, depression is classified by episodes in addition to types, such as mild, moderate, severe, and with or without psychotic features.
- ICD-10-CM also includes codes for the episode, such as single episode, recurrent or in remission (full or partial).

Examples:

F32.0  Major depressive disorder, single episode, mild
F33.42 Major depressive disorder, recurrent, in full remission
Anxiety

- Codes for anxiety are classified by type, either *phobic* (e.g., agoraphobia, social phobia, animal phobias, etc.) or *other anxiety* (e.g., generalized anxiety disorder, mixed anxiety disorders)

As always, in the absence of a definitive diagnosis, code any symptoms that are present:

- **R45.0** Nervousness
- **R45.1** Restlessness and agitation
- **R45.3** Demoralization and apathy
- **R45.4** Irritability and anger
- **R45.83** Excessive crying of child, adolescent or adult
- **R46.3** Overactivity
Migraines

• Symptoms that signal the onset of a migraine are used to describe two types of migraine:
  – Migraine with aura (known as “classic” migraine)
  – Migraine without aura (known as “common” migraine)

• **Status migrainosus** refers to a rare and severe type of migraine that can last 72+ hours
  – The pain and nausea are so intense that people who have this type of headache often need to be hospitalized
  – Certain medications or medication withdrawal can cause this type migraine syndrome
Migraines

• An “aura” is a physiological warning sign that a migraine is about to begin
• Migraines with auras occur in about 20-30% of migraine sufferers
• An aura can occur one hour before the attack of pain and lasts 15-60 minutes (symptoms always last less than one hour)
• Visual auras include:
  – Bright flashing dots or lights
  – Blind spots
  – Distorted vision
  – Temporary vision loss
  – Wavy or jagged lines
Migraines

- Migraines with aura
  - 32 choices available
  - Migraines are classified by type and features, including:
    - Hemiplegic, chronic, persistent, with/without aura, intractable, not intractable, with/without status migrainosus, with vomiting, abdominal, ophthalmoplegic, menstrual, etc.
- Example: **G43.701** - Chronic migraine without aura, not intractable, with status migrainosus
ICD-10 terminology used to describe asthma has been updated to reflect the current clinical classification system.

When documenting asthma, include the following:

- **Cause:** Exercise induced, cough variant, related to smoking, chemical or particulate cause, occupational
- **Severity:** Choose one of the three options below for persistent asthma patients:
  - Mild persistent
  - Moderate persistent
  - Severe persistent
- **Temporal factors:** Acute, chronic, intermittent, persistent, status asthmaticus, acute exacerbation
In order to assist with determining the severity of a patient’s asthmatic condition, the following graph may be used:

<table>
<thead>
<tr>
<th>Components of Severity</th>
<th>Intermittent</th>
<th>Persistent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 0-4 years</td>
<td>Ages 5-11 years</td>
<td>Ages &gt;12 years</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>&gt;2 days/week</td>
<td>&gt;2 days/week but not daily</td>
</tr>
<tr>
<td><strong>Nighttime awakenings</strong></td>
<td>0</td>
<td>&lt;2x/month</td>
</tr>
<tr>
<td><em><em>SABA</em> use for symptom control (not to prevent EIB</em>)**</td>
<td>&gt;2 days/week but not daily</td>
<td>&gt;2 days/week but not daily and not more than once on any day</td>
</tr>
<tr>
<td><strong>Interference with normal activity</strong></td>
<td>None</td>
<td>Minor limitation</td>
</tr>
<tr>
<td><strong>Lung function</strong></td>
<td>Not applicable</td>
<td>Normal FEV₁ between exacerbations</td>
</tr>
<tr>
<td>&gt; FEV₁ (% predicted)</td>
<td>&gt;80%</td>
<td>&gt;80%</td>
</tr>
<tr>
<td>&gt; FEV₁/FVC*</td>
<td>&gt;85%</td>
<td>Normal*</td>
</tr>
<tr>
<td><strong>Asthma exacerbations requiring oral systemic corticosteroids†</strong></td>
<td>0-1/year</td>
<td>&gt;2 exacerbations in 6 months, or wheezing &gt;4x per year lasting &gt;1 day AND risk factors for persistent asthma</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>0-1/year</td>
<td>&gt;2/year</td>
</tr>
</tbody>
</table>

*EIB: Exertional dyspnea or inspiratory or expiratory stridor.
†Corticosteroids include systemic and inhaled corticosteroids.

Approved Instructor
Asthma

• **Uncomplicated** asthma is stable and well-controlled

• An **acute exacerbation** is a worsening or a decompensation of a chronic condition

• **Status asthmaticus** is an acute exacerbation of asthma that remains unresponsive to initial treatment from bronchodilators
  
  – Status asthmaticus can vary from a mild form to a severe form with bronchospasm, airway inflammation and mucus plugging that can cause difficulty breathing and respiratory failure
Bronchitis and bronchiolitis

When documenting bronchitis and bronchiolitis, include the following:

- **Acuity**: Acute, chronic, subacute (delineate when both acute and chronic are present, e.g., acute and chronic bronchitis)
- **Causal organism**: Respiratory syncytial virus, metapneumovirus, unknown, etc.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J20.2</td>
<td>Acute bronchitis due to <em>streptococcus</em></td>
</tr>
<tr>
<td>J20.6</td>
<td>Acute bronchitis due to <em>rhinovirus</em></td>
</tr>
<tr>
<td>J21.0</td>
<td>Acute bronchiolitis due to <em>respiratory syncytial virus</em></td>
</tr>
<tr>
<td>J42</td>
<td><strong>Chronic</strong> bronchitis</td>
</tr>
</tbody>
</table>
• Includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions for which no diagnosis classifiable elsewhere is recorded

• Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider
• For inpatient admissions to short-term, acute and long-term care, as well as psychiatric hospitals, if the diagnosis documented at the time of discharge is qualified as one of the following, code the condition as if it existed or was established:
  – Probable
  – Suspected
  – Likely
  – Questionable
  – Possible
  – Still to be ruled out
  – Other similar terms indicating uncertainty
• In the outpatient setting, code the condition(s) to the highest degree of certainty for that encounter/visit, including symptoms, signs, abnormal test results or other reason for the visit

• If the provider documents a “borderline” diagnosis at the time of discharge, the diagnosis is coded as confirmed unless the classification provides a specific entry (e.g., borderline diabetes)
  – If a borderline condition has a specific index entry in ICD-10-CM, it should be coded as such
  – Since borderline conditions are not uncertain diagnoses, no distinction is made between the care setting (inpatient versus outpatient)
Injuries

- In ICD-9, “E codes” were used to record external causes of injury
- ICD-10 better incorporates these codes and expands sections on poisonings and toxins

When documenting injuries, include the following:
- **Episode of care**: Initial, subsequent, sequelae
- **Injury site**: Be as specific as possible
- **Etiology**: How was the injury sustained (e.g. sports, motor vehicle crash, pedestrian, slip and fall, environmental exposure, etc.)?
- **Place of occurrence**: School, work, etc.

Initial encounters may also require, where appropriate:
- **Intent**: Unintentional or accidental, self-harm, etc.
- **Status**: Civilian, military, etc.
Injuries

Consider a left knee strain injury that occurred on a private playground when a child landed incorrectly from a trampoline.

When documenting injuries, include the following:

<table>
<thead>
<tr>
<th>Injury</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strain of other muscle(s) and tendon(s) at lower leg level, left leg, initial encounter</td>
<td>S86.812A</td>
<td></td>
</tr>
<tr>
<td>Fall on or from other playground equipment, initial encounter</td>
<td>W09.8xxA</td>
<td></td>
</tr>
<tr>
<td>Other recreation area as the place of occurrence of the external cause</td>
<td>Y92.838</td>
<td></td>
</tr>
<tr>
<td>Activities involving rhythmic movement, trampoline jumping</td>
<td>Y93.44</td>
<td></td>
</tr>
</tbody>
</table>
Adverse effects

When coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the **nature of the adverse effect** followed by the appropriate code for the **adverse effect** of the drug (T36-T50).

- The code for the drug should have a fifth or sixth character “5” (for example T36.0X5-)
- Examples of the nature of an adverse effect are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure or respiratory failure

**Examples**

- R11.2 Nausea with vomiting, unspecified
- T36.0x5A Adverse effect of penicillins, initial encounter
Poisoning

- When coding a poisoning or reaction to the improper use of a medication (e.g., overdose, wrong substance given or taken in error, wrong route of administration), first assign the appropriate poisoning code from categories T36-T50.
- The poisoning codes have an associated intent as their fifth or sixth character (accidental, intentional self-harm, assault and undetermined).
- Use additional codes for all manifestations of poisonings.

T38.4X1A  Poisoning by oral contraceptives, accidental (unintentional)
R11.0     Nausea
Underdosing

- Underdosing refers to taking less of a medication than is prescribed by a provider or a manufacturer’s instruction
- For underdosing, assign the code from categories T36-T50 (fifth or sixth character “6”)
- Codes for underdosing should never be assigned as principal or first-listed codes
  - If a patient has a relapse or exacerbation of the medical condition for which the drug is prescribed because of the reduction in dose, then the medical condition itself should be coded
- Noncompliance (Z91.12-, Z91.13-) or complication of care (Y63.6-Y63.9) codes are to be used with an underdosing code to indicate intent, if known
Adverse effects, poisonings, underdosing

When documenting underdosing, include the following:

- **Intentional, Unintentional, Non-compliance**: Is the underdosing deliberate (e.g., patient refusal)?
- **Reason**: Why is the patient not taking the medication (e.g., financial hardship, age-related debility, etc.)?

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z91.120</td>
<td>Patient’s intentional underdosing of medication regimen due to financial hardship</td>
</tr>
<tr>
<td>T36.4x6A</td>
<td>Underdosing of tetracyclines, initial encounter</td>
</tr>
<tr>
<td>T45.526D</td>
<td>Underdosing of antithrombotic drugs, subsequent encounter</td>
</tr>
</tbody>
</table>
Vaccinations

• In ICD-9-CM, there were many diagnosis codes to describe the need for various specific types of vaccines
• In ICD-10-CM, the diagnosis code is the same for all encounters for immunization (Z23)
• The detail of what vaccine is being administered should still be described in the note, and it will still be reported in the procedure code
• If a vaccination was not carried out, ICD-10 offers specific codes to detail the reason:
  – Compromised condition of the patient (Z28.0)
  – Patient refusal for reasons of belief or group pressure (Z28.1)
  – Parent/caregiver refusal (Z28.82)
  – Patient has previously had the disease (Z28.81)
Routine exams and screenings

ICD-10 will improve the quality of data collection for routine preventive exams, early screening and the detection of childhood illnesses.

When documenting routine exams and screenings, include the following:

- **Patient’s age**: In days, months or years as appropriate
- **Exam type**: Well child exam, hearing screen, sports physical, school physical, adult well exam, etc.
- **Findings**: Note normal vs. abnormal findings, as codes vary depending on results

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z00.00</td>
<td>Encounter for general adult medical examination <strong>without abnormal findings</strong></td>
</tr>
<tr>
<td>Z00.110</td>
<td>Health examination for newborn <strong>under 8 days old</strong></td>
</tr>
<tr>
<td>Z00.121</td>
<td>Encounter for routine child health examination <strong>with abnormal findings</strong></td>
</tr>
<tr>
<td>Z00.129</td>
<td>Encounter for routine child health examination <strong>without abnormal findings</strong></td>
</tr>
<tr>
<td>Z02.5</td>
<td>Encounter for examination for participation in sport</td>
</tr>
</tbody>
</table>
History

- There are two types of history Z codes: personal and family
  - **Personal history** codes explain a patient's past medical condition that no longer exists and that he or she is not receiving treatment for, but has the potential for recurrence and may require continued monitoring
  - **Family history** codes are used when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease
ICD-10 coding for diabetes

• Diabetes Mellitus is coded in ICD-10 from E08-E13

• Combination codes report
  – Type of diabetes
  – Manifestations and complications
  – Use of insulin

• Additional codes are required for CKD and ulcers
Type 2 diabetes mellitus with right foot ulcer and long term use of insulin.

<table>
<thead>
<tr>
<th>Type of Diabetes</th>
<th>E11.621 Type 2 Diabetes with foot ulcer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manifestations and Complications</td>
<td>L97.511 Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin</td>
</tr>
<tr>
<td>Patient status</td>
<td>Z79.4 Long-term (current) use of insulin</td>
</tr>
</tbody>
</table>
Jake presents with his mother for evaluation of his asthma. She says he wakes up a couple nights every month with "coughing fits," and he uses his inhaler to relieve his symptoms about 3 times each week. He is currently taking Singulair. His activities have been somewhat limited due to his symptoms. He is diagnosed with mild persistent asthma.

J45.30 Mild persistent asthma, uncomplicated
J45.31 Mild persistent asthma with (acute) exacerbation
J45.32 Mild persistent asthma with status asthmaticus
Auditing injuries

Injuries require extensive documentation to support at least 3 codes on the initial claim:

1. Diagnosis code for injury
   - The type of injury
   - The specific site
   - The episode of care
2. Activity and/or external cause
3. Place of occurrence
### Wrist sprain playing tennis

<table>
<thead>
<tr>
<th>Injury</th>
<th>S63.511A Right wrist sprain, carpal joint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity/External Cause</td>
<td>Y93.73 Racquet sport</td>
</tr>
<tr>
<td>Place of occurrence</td>
<td>Y92.312 Tennis court</td>
</tr>
</tbody>
</table>
A 28-year-old patient presents for consultation for bariatric surgery. Physician has documented that the patient was counseled on controlling her calories and set up with a dietician so that she can learn to eat right to see if the patient can lose some weight. Patient states she eats in excess of 3000 calories a day and does not exercise. Her weight is 290 pounds and BMI is documented at 37.

**Morbid obesity with a BMI of 37**

<table>
<thead>
<tr>
<th></th>
<th>E88.01 Morbid obesity due to excess calories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>Z68.37 Body Mass Index 37.0-37.9, adult</td>
</tr>
</tbody>
</table>
Kelly was seen in the ER for shoulder pain and X-rays indicated there was a displaced fracture of the shaft of the right clavicle. She returned three months later with complaints of continuing pain. X-rays indicated a nonunion.

| S42.021A | Initial encounter for closed fracture |
| S42.021B | Initial encounter for open fracture |
| S42.021D | Subsequent encounter for fracture with routine healing |
| S42.021G | Subsequent encounter for fracture with delayed healing |
| **S42.021K** | Subsequent encounter for fracture with nonunion |
| S42.021P | Subsequent encounter for fracture with malunion |
| S42.021S | Sequela |

Documentation of an injury with episode of care
Preparing for ICD-10 with Greenway Health

Christina Golden,
Product Marketing
1,689
family / general practices

1,242
internal medicine practices
What is clinically driven RCM?
ICD-10 Product training

• **Independent**: ICD-10 videos, FAQs and overview documents

• **Guided**: Virtual Interactive (VIA) training, ICD-10 videos, FAQs and overview documents

• **Hands On**: One-to-one workflow training (remote and onsite), VIA training, ICD-10 videos, FAQs and overview documents