ICD-10 | Clinical Concepts for Family Practice

ICD-10 Clinical Concepts Series

- Common Codes
- Clinical Documentation Tips
- Clinical Scenarios

ICD-10 Clinical Concepts for Family Practice is a feature of Road to 10, a CMS online tool built with physician input.

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ICD-10 Compliance Date: **October 1, 2015**

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Table Of Contents

Common Codes

Clinical Documentation Tips

Clinical Scenarios

Common Codes

ICD-10 Compliance Date: **October 1, 2015**

Abdominal Pain (ICD-9-CM 789.00 to 789.09 range)

R10.0	Acute abdomen
R10.10	Upper abdominal pain, unspecified
R10.11	Right upper quadrant pain
R10.12	Left upper quadrant pain
R10.13	Epigastric pain
R10.2	Pelvic and perineal pain
R10.30	Lower abdominal pain
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

*Codes with a greater degree of specificity should be considered first.

Acute Respiratory Infections (ICD-9-CM 462, 465.9, 466.0)

[Note: Organisms should be specified where possible]

J02.8	Acute pharyngitis due to other specified organisms
J02.9*	Acute pharyngitis, unspecified
J06.9*	Acute upper respiratory infection, unspecified
J20.0	Acute bronchitis due to Mycoplasma pneumoniae
J20.1	Acute bronchitis due to Hemophilus influenzae
J20.2	Acute bronchitis due to streptococcus
J20.3	Acute bronchitis due to coxsackievirus
J20.4	Acute bronchitis due to parainfluenza virus
J20.5	Acute bronchitis due to respiratory syncytial virus
J20.6	Acute bronchitis due to rhinovirus
J20.7	Acute bronchitis due to echovirus
J20.8	Acute bronchitis due to other specified organisms
J20.9*	Acute bronchitis, unspecified

*Codes with a greater degree of specificity should be considered first.

Back and Neck Pain (Selected) (ICD-9-CM 723.1, 724.1, 724.2, 724.5)

M54.2	Cervicalgia
M54.5	Low back pain
M54.6	Pain in thoracic spine
M54.89	Other dorsalgia
M54.9*	Dorsalgia, unspecified

*Codes with a greater degree of specificity should be considered first.

Chest Pain (ICD-9-CM 786.50 to 786.59 range)

R07.1	Chest pain on breathing
R07.2	Precordial pain
R07.81	Pleurodynia
R07.82	Intercostal pain
R07.89	Other chest pain
R07.9*	Chest pain, unspecified

*Codes with a greater degree of specificity should be considered first.

Diabetes Mellitus w/o Complications Type 2 (ICD-9-CM 250.00)

E11.9	Type 2 diabetes mellitus without complications

General Medical Examination (ICD-9-CM V70.0)

Z00.00	Encounter for general adult medical exam without abnormal findings
Z00.01	Encounter for general adult medical exam with abnormal findings

Headache (ICD-9-CM 784.0)

R51	Headache

Hypertension (ICD-9-CM 401.9)

I10	Essential (primary) hypertension

Pain in Joint (ICD-9-CM 719.40 to 719.49 range)

M25.511	Pain in right shoulder
M25.512	Pain in left shoulder
M25.519*	Pain in unspecified shoulder
M25.521	Pain in right elbow
M25.522	Pain in left elbow
M25.529*	Pain in unspecified elbow
M25.531	Pain in right wrist
M25.532	Pain in left wrist
M25.539*	Pain in unspecified wrist
M25.551	Pain in right hip
M25.552	Pain in left hip
M25.559*	Pain in unspecified hip
M25.561	Pain in right knee
M25.562	Pain in left knee
M25.569*	Pain in unspecified knee
M25.571	Pain in right ankle and joints of right foot
M25.572	Pain in left ankle and joints of left foot
M25.579*	Pain in unspecified ankle and joints of unspecified foot
M25.50*	Pain in unspecified joint

*Codes with a greater degree of specificity should be considered first.

Pain in Limb (ICD-9-CM 729.5)

M79.601	Pain in right arm
M79.602	Pain in left arm
M79.603*	Pain in arm, unspecified
M79.604	Pain in right leg
M79.605	Pain in left leg
M79.606*	Pain in leg, unspecified
M79.609	Pain in unspecified limb
M79.621	Pain in right upper arm
M79.622	Pain in left upper arm
M79.629*	Pain in unspecified upper arm
M79.631	Pain in right forearm
M79.632	Pain in left forearm
M79.639*	Pain in unspecified forearm
M79.641	Pain in right hand
M79.642	Pain in left hand
M79.643*	Pain in unspecified hand
M79.644	Pain in right finger(s)
M79.645	Pain in left finger(s)
M79.646*	Pain in unspecified finger(s)
M79.651	Pain in right thigh
M79.652	Pain in left thigh
M79.659*	Pain in unspecified thigh
M79.661	Pain in right lower leg
M79.662	Pain in left lower leg
M79.669*	Pain in unspecified lower leg
M79.671	Pain in right foot
M79.672	Pain in left foot
M79.673*	Pain in unspecified foot
M79.674	Pain in right toe(s)
M79.675	Pain in left toe(s)
M79.676*	Pain in unspecified toe(s)

*Codes with a greater degree of specificity should be considered first.

Other Forms Of Heart Disease (ICD-9-CM 427.31)

I48.0	Paroxysmal atrial fibrillation
I48.2	Chronic atrial fibrillation
I48.91*	Unspecified atrial fibrillation

*Codes with a greater degree of specificity should be considered first.

URINARY TRACT INFECTION, CYSTITIS (ICD-9-CM 595.0 TO 595.4 RANGE, 595.81, 595.82, 595.89, 595.9, 599.0)

N30.00	Acute cystitis without hematuria
N30.01	Acute cystitis with hematuria
N30.10	Interstitial cystitis (chronic) without hematuria
N30.11	Interstitial cystitis (chronic) with hematuria
N30.20	Other chronic cystitis without hematuria
N30.21	Other chronic cystitis with hematuria
N30.30	Trigonitis without hematuria
N30.31	Trigonitis with hematuria
N30.40	Irradiation cystitis without hematuria
N30.41	Irradiation cystitis with hematuria
N30.80	Other cystitis without hematuria
N30.81	Other cystitis with hematuria
N30.90	Cystitis, unspecified without hematuria
N30.91	Cystitis, unspecified with hematuria
N39.0*	Urinary tract infection, site not specified

*Codes with a greater degree of specificity should be considered first.

Primer for Family Practice Clinical Documentation Changes

ICD-10 Compliance Date: **October 1, 2015**

Specifying anatomical location and laterality required by ICD-10 is easier than you think. This detail reflects how physicians and clinicians communicate and to what they pay attention - it is a matter of ensuring the information is captured in your documentation.

In ICD-10-CM, there are three main categories of changes:

- **Definition Changes**
- **Terminology Differences**
- **Increased Specificity**

Over 1/3 of the expansion of ICD-10 codes is due to the addition of laterality (left, right, bilateral). Physicians and other clinicians likely already note the side when evaluating the clinically pertinent anatomical site(s).

HYPERTENSION

Definition Change

In ICD-10, hypertension is defined as essential (primary). The concept of “benign or malignant” as it relates to hypertension no longer exists.

When documenting hypertension, include the following:

1. Type	e.g. essential, secondary, etc.
2. Causal relationship	e.g. Renal, pulmonary, etc.

ICD-10 Code Examples

I10	Essential (primary) hypertension
I11.9	Hypertensive heart disease without heart failure
I15.0	Renovascular hypertension

ASTHMA

Terminology Difference

ICD-10 terminology used to describe asthma has been updated to reflect the current clinical classification system.

When documenting asthma, include the following:

1. Cause	Exercise induced, cough variant, related to smoking, chemical or particulate cause, occupational
2. Severity	Choose one of the three options below for persistent asthma patients 1. Mild persistent 2. Moderate persistent 3. Severe persistent
3. Temporal Factors	Acute, chronic, intermittent, persistent, status asthmaticus, acute exacerbation

ICD-10 Code Examples

J45.30	Mild persistent asthma, uncomplicated
J45.991	Cough variant asthma

UNDERDOSING

Terminology Difference

Underdosing is an important new concept and term in ICD-10. It allows you to identify when a patient is taking less of a medication than is prescribed.

When documenting underdosing, include the following:

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

ICD-10 Code Examples

Z91.120	Patient's intentional underdosing of medication regimen due to financial hardship
T36.4x6A	Underdosing of tetracyclines, initial encounter
T45.526D	Underdosing of antithrombotic drugs, subsequent encounter

ABDOMINAL PAIN AND TENDERNESS

Increased Specificity

When documenting abdominal pain, include the following:

1. Location	e.g. Generalized, Right upper quadrant, periumbilical, etc.
2. Pain or tenderness type	e.g. Colic, tenderness, rebound

ICD-10 Code Examples

R10.31	Right lower quadrant pain
R10.32	Left lower quadrant pain
R10.33	Periumbilical pain

DIABETES MELLITUS, HYPOGLYCEMIA AND HYPERGLYCEMIA

Increased Specificity

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system.

When documenting diabetes, include the following:

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

A second important change is the concept of “hypoglycemia” and “hyperglycemia.” It is now possible to document and code for these conditions 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.

ICD-10 Code Examples

E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
R73.9	Transient post-procedural hyperglycemia
R79.9	Hyperglycemia, unspecified

INJURIES

Increased Specificity

ICD-9 used separate "E codes" 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:

1. Episode of Care	e.g. Initial, subsequent, sequelae
2. Injury site	Be as specific as possible
3. Etiology	How was the injury sustained (e.g. sports, motor vehicle crash, pedestrian, slip and fall, environmental exposure, etc.)?
4. Place of Occurrence	e.g. School, work, etc.

Initial encounters may also require, where appropriate:

1. Intent	e.g. Unintentional or accidental, self-harm, etc.
2. Status	e.g. Civilian, military, etc.

ICD-10 Code Examples

Example 1:

A left knee strain injury that occurred on a private recreational playground when a child landed incorrectly from a trampoline:

- **Injury:** S86.812A, Strain of other muscle(s) and tendon(s) at lower leg level, left leg, initial encounter
- **External cause:** W09.8xxA, Fall on or from other playground equipment, initial encounter
- **Place of occurrence:** Y92.838, Other recreation area as the place of occurrence of the external cause
- **Activity:** Y93.44, Activities involving rhythmic movement, trampoline jumping

Example 2:

On October 31st, Kelly was seen in the ER for shoulder pain and X-rays indicated there was a fracture of the right clavicle, shaft. She returned three months later with complaints of continuing pain. X-rays indicated a nonunion. The second encounter for the right clavicle fracture is coded as *S42.021K, Displaced fracture of the shaft of right clavicle, subsequent for fracture with nonunion.*

Family Practice Clinical Scenarios

ICD-10 Compliance Date: **October 1, 2015**

Quality clinical documentation is essential for communicating the intent of an encounter, confirming medical necessity, and providing detail to support ICD-10 code selection. In support of this objective, we have provided outpatient focused scenarios to illustrate specific ICD-10 documentation and coding nuances related to your specialty.

The following scenarios were natively coded in ICD-10-CM and ICD-9-CM. As patient history and circumstances will vary, these brief scenarios are illustrative in nature and should not be strictly interpreted or used as documentation and coding guidelines. Each scenario is selectively coded to highlight specific topics; therefore, only a subset of the relevant codes are presented.

Scenario 1: Abdominal Pain

Scenario Details

Chief Complaint

- "My stomach hurts and I feel full of gas."

History

- 47 year old male with mid-abdominal epigastric pain[1], associated with severe nausea & vomiting; unable to keep down any food or liquid. Pain has become "severe" and constant.
- Has had an estimated 13 pound weight loss over the past month.
- Patient reports eating 12 sausages at the Sunday church breakfast five days ago which he believes initiated his symptoms.
- Patient admits to a history of alcohol dependence[2]. Consuming 5 – 6 beers per day now, down from 10 – 12 per day 6 months ago. States that he has nausea and sweating with "the shakes" when he does not drink.

Exam

- VS: T 99.8°F, otherwise normal.
- Mild jaundice noted.
- Abdomen distended and tender across upper abdomen[3]. Guarding is present. Bowel sounds diminished in all four quadrants.
- Oral mucosa dry, chapped lips, decreased skin turgor

Scenario 1: Abdominal Pain (continued)

Assessment and Plan

- Dehydration and suspected acute pancreatitis.
- Admit to the hospital. Orders written and sent to on-call hospitalist.
- 1L IV NS started in office. Blood drawn for labs.
- Recommend behavioral health counseling for substance abuse assessment and possible treatment.
- Patient's wife notified of plan; she will transport to hospital by private vehicle.

Summary of ICD-10-CM Impacts

Clinical Documentation

1. Describe the pain as specifically as possible based on location.
2. When addressing alcohol related disorders you should distinguish alcohol use, alcohol abuse, and alcohol dependence. ICD-10-CM has changed the terminology and the parameters for coding substance abuse disorders. In this encounter note, as the acute pancreatitis is suspected, and the patient's alcohol intake status is stated, the associated alcoholism code is listed.
3. Abdominal tenderness may be coded. Ideally the documentation should include right or left upper quadrant and indicate if there is rebound in order to identify a more specific code. Currently the ICD-10 code would be R10.819, Abdominal tenderness, unspecified site as the documentation is insufficient in laterality and specificity.

Coding

ICD-9-CM Diagnosis Codes		ICD-9-CM Diagnosis Codes	
789.06	Abdominal pain, epigastric	R10.13	Epigastric pain
789.60	Abdominal tenderness, unspecified site	R10.819	Abdominal tenderness, unspecified site
782.4	Jaundice NOS	R17	Unspecified jaundice
276.51	Dehydration	E86.0	Dehydration
303.90	Other and unspecified alcohol dependence, unspecified	F10.20	Alcohol dependence, uncomplicated

Other Impacts

No specific impacts noted.

Scenario 2: Annual Physical Exam

Scenario Details

Chief Complaint

- "I'm here for my annual check-up.[1]"

History

- 73 year old male with history of coronary artery disease, stent placement, hyperlipidemia, HTN and GERD.
- Recent admission to hospital following a hypertensive crisis. Discharged home on olmesartan medoxomil 20 mg daily.
- Patient stopped taking olmesartan medoxomil due to side effects[2], including a headache that began after starting the medication and still exists, and tiredness.
- Regular activity includes walking, golfing. Active social life. No complaints of chest pain, or dyspnea on exertion.
- Last colonoscopy was 9 months ago. No significant pathology found; some diverticular disease.
- Medications were reviewed.

Exam

- Chest clear. Heart sounds normal. Mental status exam intact.
- EKG shows no changes from prior EKG.
- Vitals: BP is 159/95, otherwise normal. Per patient, he had good control of BP on meds, but it has risen without medication.
- BUN/creatinine normal limits.

Assessment and Plan

- HTN noted on exam today. Change from olmesartan medoxomil to metoprolol tartrate 50 mg once daily, will titrate dosage every two weeks until BP normalizes.
- Discussed the importance of daily home BP monitoring, low sodium diet, and taking BP medication as prescribed; he verbalizes understanding.
- Schedule follow-up visit in two weeks to evaluate effectiveness of new BP medication therapy, and repeat BUN/creatinine.

Summary of ICD-10-CM Impacts

Clinical Documentation

1. Documenting why the encounter is taking place is important, as the coder may assign a different code based on the type of visit (e.g., screening, with no complaint or suspected diagnosis, for administrative purposes). In this situation, the patient is requesting an encounter without a complaint, suspected or reported diagnosis.

2. Document that the patient is noncompliant with his medication. This "underdosing" concept can often be coded, along with the patient's reason for not taking the prescribed medications. Document if there is a medical condition linked to the underdosing that is relevant to the encounter, and ensure the connection is clearly made. The ICD-10-CM terms provide new detail as compared to the ICD-9-CM code V15.81, history of past noncompliance. In this case there was no noted history of noncompliance. In this note the side effects of stopping the medication include headache, which remains as a patient complaint for this encounter. When documenting headache do differentiate if intractable versus non-intractable.

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
V70.0	Routine medical exam	Z00.01	Encounter for general adult medical examination with abnormal findings
401.9	Unspecified essential hypertension	I10	Essential (primary) hypertension
339.3	Drug-induced headache, not elsewhere classified	G44.40	Drug-induced headache, not els where classified, not intractable
N/A		T46.5X6A	Underdosing of other antihypertensive drugs, initial encounter
N/A		Z91.128	Patient's intentional underdosing of medication regimen for other reason

Other Impacts

- Assess if the new patient-centric preventative health incentives for annual exams are relevant to your practice.
- For hierarchical condition categories (HCC) used in Medicare Advantage Risk Adjustment plans, certain diagnosis codes are used as to determine severity of illness, risk, and resource utilization. HCC impacts are often overlooked in the ICD-9-CM to ICD-10-CM conversion. The physician should examine the patient each year and compliantly document the status of all chronic and acute conditions. HCC codes are payment multipliers.

Scenario 3: Earache

Scenario Details

Chief Complaint

- Right earache and ear pain.

History

- This 20 year old male is an established patient and well known to me. He is a full-time college student, and presents with a right sided ear pain, noted 8/10. The symptoms started yesterday and continue to worsen with no pain relief using acetaminophen. Denies discharge, hearing loss, or ringing/roaring. He denies trauma or recent barotrauma to ear. He denies fever, sore throat, and cough today. He reports recently having an URI that resolved with OTC medications.
- He is up to date on his influenza, HPV, Tdap, and meningococcal immunizations.
- Patient does not use tobacco, alcohol, or illicit drugs. He denies exposure to second hand smoke.
- Medical history includes major depressive disorder with recurrent episodes of mild severity, and bipolar II disorder. His current medications include aripiprazole, and duloxetine.
- No known allergies.
- 16 point review of systems negative except for notations above.

Exam

- Healthy appearing male. A&Ox3. He appears calm and is cooperative.
- Vital signs: BP: 130/78 HR: 70 bpm T: 99.8 °F Wt: 235 lbs Ht: 5’ 10”.
- ENT: auricle and external canals normal bilaterally. Right ear: erythematous membrane, bulging, with loss of landmarks. Pharynx, teeth, and nose exam normal. No cervical adenopathy bilaterally.
- Integumentary: Skin is flushed, warm, and dry with no edema. Mucous membranes are moist.
- Respiratory: Lungs clear CTA with normal respiratory effort.
- Abdomen: non-tender, no organomegely.

Assessment and Plan

- New onset AOM AD, suppurative, with pain unrelieved by acetaminophen.
- Prescriptions: amoxicillin for AOM; ibuprofen for pain.
- Return in one week if symptoms persist.

Scenario 3: Earache (continued)

Summary of ICD-10-CM Impacts

Clinical Documentation

1. In diagnosing otitis media using ICD-9-CM you should document items such as acute, chronic, not specified as acute or chronic, nonsuppurative or suppurative, and with or without spontaneous rupture of the eardrum. In ICD-10-CM, you will need to document these characteristics plus left, right or bilateral that are affected and is the problem initial or recurrent to assign a correct code.
2. In this fictional test case we gave this young male a diagnosis of bipolar II disorder. You would not report the bipolar disorder unless it affects treatment at today's encounter. Conditions that are not treated or that do not affect patient treatment nor are treated should not be reported.

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
382.00	Acute suppurative otitis media without spontaneous rupture of eardrum	H66.001	Acute suppurative otitis media without spontaneous rupture of ear drum, right ear

Other Impacts

No specific impact noted.

Scenario 4: Anemia

Scenario Details

Chief Complaint

- Discuss laboratory results.

History

- 38 year old established female seen by me over one week ago for decreased exercise tolerance and general malaise over the past four weeks when doing her daily aerobics class. Labs were ordered on that visit. She presents today with pale skin, weakness, and epigastric pain; symptoms are unchanged since previous visit. Laboratory studies reviewed today are as follows: HGB 8.5 gm/dL, HCT 27%, platelets 300,000/mm3, reticulocytes 0.24%, MCV 75, serum iron 41 mcg/dL, serum ferritin 9 ng/ml, TIBC 457 mcg/dL; Fecal occult blood test is positive.
- She takes Esomeprazole daily for GERD with esophagitis and reports taking OTC antacids at bedtime for epigastric pain for the past three months. She also uses ibuprofen as needed for headaches.
- Current pain is 0/10.
- Medical history significant for GERD, peptic ulcer, pre-eclampsia with last pregnancy.
- LMP: two weeks ago, normal flow, unchanged in last three months.
- Married; three children ages 15, 12, and 1 year old.
- Patient does not use tobacco, alcohol, or illicit drugs.
- No known allergies.
- No changes in interval history and review of systems noted from encounter 8 days ago.

Exam

- Well-nourished, well groomed, pleasant female who shows good judgment and insight. Oriented X 3. Good recent and remote memory. Appropriate mood and affect.
- Vital signs: T 98.7, RR 18, BP: 118/75, standing 120/60, HR: 90.
- HEENT: PERRLA.
- Neck: Supple. No thyromegaly.
- Lungs: clear to auscultation with normal respiratory effort.
- Cardiovascular: Regular rate and rhythm. No pedal edema.
- Integumentary: Pale, clear of rashes and lesions, no ulcers. Early cheilosis noted.
- Rectal: No gross blood on exam one week ago; stool sample results noted above.
- Lymphatics: No lymphadenopathy.
- Musculoskeletal: The patient had good, stable gait.

Scenario 4: Anemia (continued)

Assessment and Plan

- Iron-deficiency anemia secondary to blood loss.
- Continue esomeprazole as prescribed.
- Replace ibuprofen use with acetaminophen extra strength for headaches, dosage as per label.
- Prescribed iron sulfate supplements for three month trial. Counseled patient on appropriate use of iron supplementation and side effects.
- Patient to return in one week for repeat laboratory studies.

Summary of ICD-10-CM Impacts

Clinical Documentation

1. In ICD-10-CM, gastro-esophageal reflux disease is differentiated by noting "with esophagitis" versus "without esophagitis." "With esophagitis" must be documented in the record.

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
280.0	Iron deficiency anemia secondary to blood loss (chronic)	D50.0	Iron deficiency anemia secondary to blood loss (chronic)
530.81	Disease, Gastroesophageal reflux (GERD)	K21.0	Gastro-esophageal reflux disease with esophagitis

Other Impacts

- 530.11 Reflux esophagitis is not coded when GERD is coded in ICD-9-CM because 530.11 is an "excluded code" from 530.81 in ICD-9-CM but it is a combination code in ICD-10-CM.

Scenario: COPD with Acute Pneumonia Example

Scenario Details

Chief Complaint

- "I just got out of the hospital 2 days ago. I'm a little better, but still can barely breathe."

History

- 67-year-old male with 40 pack/year history of cigarette use (still smoking) and severe oxygen dependent COPD developed cough with increased production of green/gray sputum 2 weeks prior to office visit. Admitted to hospital through Emergency Department with diagnosis of presumed pneumonia superimposed on severe COPD. Hospital exam confirmed acute RLL pneumococcal pneumonia. Patient treated with an IV cephalosporin as he has known penicillin allergy, and was discharge from hospital to home 2 days prior to office visit.
- PMH shows severe O2 dependent COPD, with type II diabetes mellitus secondary to chronic prednisone therapy, which is treated with oral hypoglycemics. Patient also has known hypertension, on ACE inhibitor therapy.

Review of Systems, Physical Exam, Laboratory Tests

- T 99, BP 145/105, P 92 and irregular, RR 28
- Chest exam shows decreased lung sounds throughout all lung fields except in RLL where there were mild rhonchi and wheezes noted
- ABG's on 2L O2 by nasal cannula show PO2 62, PCO2 47, pH 7.40
- CXR shows hyperinflation of lungs with small RLL alveolar infiltration. Comparison to CXR from hospitalization shows approximately 75% resolution of pneumonia.
- ECG reveals persistent atrial fibrillation which was not present on previous ECG of 6 months earlier, but had been found at time of recent hospitalization. Labs show finger stick glucose of 195mg%.

Assessment and Plan

- Acute Community Acquired Pneumococcal Pneumonia: continue oral cephalosporin. Schedule office follow up visit in 1 week with repeat CXR.
- Severe COPD: continue O2, low dose Prednisone, and inhaled bronchodilator.
- Chronic Hypoxemic, Hypercarbic Respiratory Failure
- Persistent Atrial Fibrillation: continue digoxin initiated during recent hospitalization
- Hypertension: continue ACE inhibitor therapy
- Diabetes Mellitus, Type II, secondary to prednisone therapy; continue oral hypoglycemic therapy
- Penicillin Allergy
- Tobacco Dependence

Scenario: COPD with Acute Pneumonia Example (continued)

Summary of ICD-10-CM Impacts

Clinical Documentation

- ICD-10-CM separates pneumonia by infectious agent. Document the infectious agent of pneumonia, as there are discrete ICD-10-CM codes for each type.
- ICD-10-CM separates by acuity of respiratory failure, and hypoxia or hypercapnia, if present.
- Document drug allergies with ICD-10-CM status" Z" codes from Chapter 21 to identify these.
- Document the type of cardiac arrhythmia. Atrial fibrillation in ICD-10-CM separates into paroxysmal, persistent, chronic, typical, atypical, unspecified. Acute atrial fibrillation defaults to unspecified in ICD-10-CM.
- The Table of Drugs & Chemicals has a code assignment for Adverse effect of the drug that would be followed by the secondary diabetes code. Go to the Volume 3 Index to Table of Drugs and Chemicals. Along the left hand side proceed alphabetically to "Glucocorticoids" and then move horizontally across to the column for Adverse Effect". In Volume 1 (Tabular List) the instruction at the beginning of the code category T38 are the instructions for the 7th character.
- Note: Drug-induced Diabetes Mellitus is a secondary type of diabetes due to the use of glucocorticoids. This code can only be coded as an "additional code" and would never be first-listed

The code categories for secondary diabetes are :

- Due to underlying disease (E08)
- Due to drug (E09)
- Due to other specified condition such as post pancreatectomy. (E13)

These three categories can never be first-listed per ICD-10-CM guidelines. The underlying cause would be first-listed diagnosis.

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
481	Pneumonia, Pneumococcal	J13	Pneumonia due to Streptococcus pneumoniae
496	COPD	J44.0	Chronic obstructive pulmonary disease with acute lower respiratory infection
V46.2	Oxygen dependence	Z99.81	Dependence on supplemental oxygen
427.31	Atrial fibrillation	I48.1	Persistent atrial fibrillation
249.00	Diabetes, secondary, drug induced	E09.9	Drug or chemical induced diabetes mellitus without complications
E932.0	Therapeutic use of Prednisone	T38.0x5A	Adverse effect of glucocorticoids and synthetic analogues, initial encounter
401.9	HTN	I10	Essential (primary) hypertension
V14.0	Allergy, Penicillin	Z88.0	Allergy status to penicillin
305.1	Tobacco dependence	F17.210	Nicotine dependence, cigarettes, uncomplicated

Scenario: COPD with Acute Pneumonia Example (continued)

Other Impacts

- Management of chronic conditions such as COPD, Diabetes Mellitus, Hypertension, and Atrial Fibrillation should be described in the record.

Scenario: Cervical Disc Disease

Scenario Details

Chief Complaint

- "My neck hurts and I have a tingling pain sensation going down my right arm."

History

- Patient is a 68 year-old male with history of neck pain that has been worsening over the last two years. Recently, he has experienced some numbness and a painful tingling sensation in his right arm going down to his thumb. No other symptoms or pertinent medical history.

Review of Systems, Physical Exam, Laboratory Tests

- Review of systems is negative except for the neck pain and sensations in his right arm described above. No history of acute injury to neck or arm.
- Physical exam is normal except for neurological exam of the right upper extremity, which reveals slight decrease to sensation in the thumb and forefinger region of the hand in the C6 nerve root distribution. No evidence of weakness in the muscles of the arm or hand.
- MRI scan of the neck shows degenerative changes of the C5-6 disc with lateral protrusion of disc material. No other abnormalities noted.

Assessment and Plan

- Cervical transforaminal injection at C5-6

Scenario: Cervical Disc Disease (continued)

Summary of ICD-10-CM Impacts

Clinical Documentation

- Subcategory M50.1 describes cervical disc disorders. M50.12 Cervical disc disease that includes degeneration of the disc as a combination code. The 5th character differentiates various regions of the cervical spine (high cervical C2-3 and C3-4; mid-cervical C4-5, C5-6, and C6-7; cervicothoracic C7-T1 and the associated radiculopathies at each level). This is a combination code that includes the disc degeneration and radiculopathy

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
722.0	Cervical disc displacement without myelopathy	M50.12	Cervical disc disorder with radiculopathy, mid-cervical region
722.4	Degeneration of cervical intervertebral disc		

Scenario: Abdominal Pain

Scenario Details

Chief Complaint

- "My stomach hurts."

History

- Patient is a 65-year-old male admitted to the hospital with abdominal pain. He has a history of Crohn's disease of the large intestine. He also has a history of coronary artery disease, had a heart attack 5 years ago, but has had no problems since then. He smoked cigarettes for 45 years, but quit after his myocardial infarction. He also has a history of allergic reactions to Penicillins and Cephalosporins.

Review of Systems, Physical Exam, Laboratory Tests

- 99.8
- Abdomen: diffuse tenderness over entire abdomen
- CT scan of abdomen: abscess secondary to Crohn's disease of descending colon

Assessment and Plan

- Crohn's disease, large intestine with abscess.
- Awaiting GI consultation

Scenario: Abdominal Pain (continued)

Summary of ICD-10-CM Impacts

Clinical Documentation

- Crohn's disease in ICD-10-CM is separated by small, large intestine or both (small and large intestine), with or without complications of rectal bleeding, obstruction, fistula, or abscess (combination codes).

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
555.1	Regional enteritis, large intestine	K50.114	Crohn's disease of the large intestine with abscess
567.22	Abscess, abdominal		
412	Old myocardial infarction	I25.2	Old myocardial infarction
V15.82	History of tobacco use	Z87.891	Personal history of nicotine dependence or personal history of tobacco use.
V14.0	History of allergy to Penicillin	Z88.0	Allergy status to Penicillin
V14.1	History of allergy to other antibiotic (cephalosporins)	Z88.1	Allergy status to other antibiotic agent

Other Impacts

- Coding allergies to specific medications allows the providers who share a common EHR to be notified of these allergies. They can be placed into the ongoing problem list therefore becoming available whenever relevant for coding on the claim.
- At the beginning of Chapter 10 Respiratory conditions this instruction is found:
  Use additional code, where applicable, to identify:
  - 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)
- These tobacco-related codes should also be coded into the ongoing problem list for future coding situations as indicated in ICD-10-CM.

Scenario: Diabetes

Scenario Details

Chief Complaint

- "I am here for my quarterly evaluation of my diabetes."

History

- Patient is a 50-year-old woman with Type 1 diabetes since childhood. She has been on insulin since age 13. As a result of her diabetes she has chronic kidney disease and is currently on dialysis for ESRD. She also has diabetic neuropathy affecting both lower extremities.

Review of Systems, Physical Exam, Laboratory Tests

- No changes in underlying condition during the last 3 months. She continues to perform self-testing of her blood sugar levels on a daily basis, is on dialysis every other day, most recently 24 hours ago, and has not noticed any changes in the numbness in her legs.
- BP 140/75, P 80, R 16 and T 98.8
- Dialysis fistula without any signs of infection
- Decreased sensation over lower extremities below the knees
- Lab: BUN/Cr nl, K+ 3.5, glu 105, Hgb A1c 7.9

Assessment and Plan

- Continue BS checks daily with sliding scale as previously prescribed
- Start Capsaicin topically and defer to nephrologist for any Rx at this time. She has an appointment 10 am tomorrow.

Scenario: Diabetes (continued)

Summary of ICD-10-CM Impacts

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
250.41	Diabetes with renal manifestations, type 1, not stated as uncontrolled	E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
585.6	End stage renal disease	N18.6	End-stage renal disease
250.61	Diabetes with neurological manifestations, type 1, not stated as uncontrolled	Z99.2	Dependence on renal dialysis Presence of AV shunt for dialysis
357.2	Polyneuropathy in diabetes	E10.42	Type 1 diabetes mellitus with polyneuropathy
V45.11	Renal dialysis status		

Other Impacts

E10.22 is a combination code in ICD-10-CM incorporating both the type of diabetes (type 1 is E10) and the manifestation chronic kidney disease (after decimal point.22). Instructions from Volume 1 under the code E10.22 is to “use additional code to identify stage of chronic kidney disease N18.1 –N18.6”. In this documentation the ESRD is documented.

Code the type of diabetes and each associated complication (diabetes with renal disease and diabetic neuropathy) in ICD-10-CM.

Code the stage of the patient’s chronic kidney disease per instruction under the diabetic code E10.22 Code the dialysis and AV graft by the use of “status codes” (Z codes). The key word to find this status code in the Index to Diseases from Volume 3 is “Dependence” and then sub indent to the word “on” and then to the words renal dialysis Z99.2

Scenario: ER Follow Up

Scenario Details

Chief Complaint

- "Seen in the ER over the weekend."

History

- Mrs. Jones is a 64-year-old female, with a history of morbid obesity, type 2 diabetes with nephropathy, and asthma, presents here for follow-up ER visit two days ago for shortness of breath. Patient was discharged with a diagnosis of bronchitis, an Albuterol and Beclomethasone inhaler prescription, along with five day course of Z pack and a six-day steroid dose pack. Patient is improving on the regimen. She is no longer wheezing and her phlegm is now scant. Her sugars however, have been poorly controlled with the Prednisone with fasting sugars greater than 200.
- Patient has long-standing asthma with 2-3 exacerbations per week and daily need for rescue inhalers. Patient is still smoking half a pack a day. She is compliant with her inhalers when she is not feeling well.
- Patient has diabetes with overt proteinuria with her last creatinine of 1.3
- Hypertension
- Morbid Obesity

Review of Systems, Physical Exam, Laboratory Tests

- BMI 44; central adiposity; no respiratory distress; able to speak in full sentences
- BP 142/64 HR94 RR 12 Sats: 98% on RA
- HEENT: TM clear; conjunctiva clear; no sinus tenderness; mallampati 3 airway
- Neck: thick; no adenopathy
- Lungs: scattered wheezing; no consolidation prolonged expiratory phase
- Ext: thin no edema

Assessment and Plan

- Asthma: moderate persistent, with acute exacerbation
- Bronchitis
- Current Smoker
- Diabetes Type 2 with nephropathy and poorly controlled hyperglycemia secondary to prescribed use of steroid medication

Scenario: ER Follow Up (continued)

Summary of ICD-10-CM Impacts

Clinical Documentation

- Choosing the first-listed diagnosis in this scenario is determined by the Section IV Guidelines of ICD-10-CM found in Volume 2 of ICD-10-CM
- Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services
- Selection of first-listed condition
- In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.
- ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit
- List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.
- Asthma was chosen as first-listed in this scenario.
- Asthma is classified as mild, moderate and severe with additional detail as intermittent, persistent and severe; include if there is acute exacerbation or status asthmaticus. Bronchitis was not specified as “acute” so the assignment is made to not specify as acute or chronic. In ICD-10-CM both bronchitis and asthma are reported separately.
- Bronchitis is reported separately from asthma per ICD-10-CM guidelines. Bronchitis was not specified as acute or chronic and the default code would be J40. Conditions involving infectious processes will have “acute” versus “chronic” choice. Providers should document whenever possible “acute” or “chronic”.
- Guidelines require reporting of tobacco use or exposure for respiratory, vascular and some other chronic illnesses such as oral and esophageal cancer codes. The guideline message for using these codes is found at the beginning of the respiratory Chapter 10 in this scenario.
- Diabetic manifestations are incorporated into the primary code for Diabetes Mellitus (combination codes). In this case diabetes with nephropathy is a combination code.
- “Uncontrolled” diabetes is no longer a concept in ICD-10. Diabetes that is poorly controlled should include whether hyperglycemia or hypoglycemia is present; whenever either is present it should be coded accordingly. This patient would also have hyperglycemia reported as the recorded Blood sugars show hyperglycemia.
- Adverse effects of prescribed medications are reported from the Table of Drugs & Chemicals and then a final code assignment from Tabular List for the 7th character. Identify which medications are causing adverse reactions and go to The Table of Drugs and Chemicals found in Volume 3 of ICD-10-CM. Along the left side of that table find the drug or (drug class if individual drug is not found.)

  Then the 7th characters are found at the beginning of the T38 category in Volume 1 (Tabular List) of ICD-10-CM. The choices for 7th character for this Table are:

  A= initial encounter

  D= subsequent encounter

  S= Sequela

Scenario: ER Follow Up (continued)

Clinical Documentation (continued)

- In this scenario it would be an initial encounter as this is the first time this provider is evaluating the patient for this adverse effect.
- Hypertension and Obesity are documented as co-morbid conditions and reported when treatment is given for affected by these conditions. Instructions found at the obesity code instruct to also report the BMI if documented.
- Note: In ICD-10-CM "Nephritis" is not referenced in the diabetes complication codes with nephropathy

Coding

ICD-9-CM Diagnosis Codes		ICD-10-CM Diagnosis Codes	
493.92	Asthma, unspecified with (acute) exacerbation	J45.41	Moderate persistent asthma with (acute) exacerbation
N/A		J40	Bronchitis, not specified as acute or chronic
305.1	Tobacco use disorder	F17.210	Nicotine dependence, cigarettes, uncomplicated
250.42	Diabetes with renal manifestations, Type II or unspecified type, uncontrolled	E11.21	Type 2 Diabetes Mellitus with diabetic nephropathy
583.81	Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere	N/A	
N/A		E11.65	Type 2 diabetes mellitus with hyperglycemia
995.20	Effect, adverse to medication properly administered	T38.0x5A	Adverse effect of glucocorticoids and synthetic analogues, initial encounter
401.9	Hypertension, unspecified	I10	Essential (primary) hypertension.
278.01	Morbid obesity	E66.01	Morbid (severe) obesity due to excess calories
V85.41	BMI 40.0 – 44.9	Z68.41	Body mass index (BMI) 40.0-44.9, adult