Florida Blue
Medicare and Commercial
Risk Adjustment
Best Practices and Coding
Educational Guide

March 2022

Table of Contents

Florida Blue MRA and CRA Best Documentation Practices for Diagnosis Coding

Medical coding of patient encounters is only as good as the underlying medical record documentation. Documentation must indicate how physicians are monitoring, evaluating, assessing and treating chronic conditions.

The Evaluation and Management Services Guide issued by the Department of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) advises:

> *Clear and concise medical record documentation is critical to providing patients with quality care and is required for providers to receive accurate and timely payment for furnished services. Medical records chronologically report the care a patient received and are used to record pertinent facts, findings, and observations about the patient's health history. Medical record documentation assists physicians and other health care professionals in evaluating and planning the patient's immediate treatment and monitoring the patient's health care over time.*

Medical record documentation of patient diagnoses that is clear, concise and described to the highest level of specificity leads to:
- Quality patient care with better outcomes
- Accurate diagnosis code assignment
- Appropriate and timely health care provider payment for furnished services

This manual provides you with pertinent guidelines for thorough and accurate documentation.

Key Points

Follow ICD-10-CM guidance

Remember this basic rule:

The importance of consistent, complete documentation in the medical record cannot be overemphasized.

Legibility

The entire medical record must be legible. If it cannot be read, it cannot be proven that the diagnoses are supported and appropriate medical services were performed. An illegible record is of no use in assigning diagnosis codes or determining the medical services that were performed.

Patient Demographics

Every page of the medical record should include, at a minimum, the date of service, the patient's name and the patient's date of birth. Also include the patient identification number, if applicable.

Some common demographic-related errors to avoid are:

- Missing records
- Cloning electronic medical records
- Incorrect beneficiary
- Date of service does not match the date on the claim

Page Numbering

- Every page for each date of service should be numbered
- If numbered the way shown in the best practice, it will be apparent to an objective reviewer whether the record for a particular date is complete

Best Practice
Page 1 of 3
Page 2 of 3
Page 3 of 3
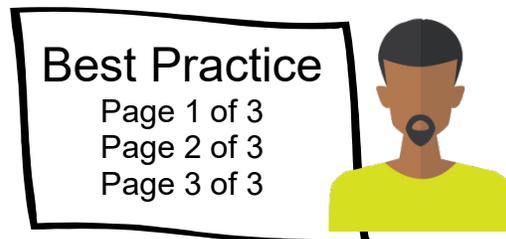
Abbreviations and Acronyms

- Limit the use of abbreviations and acronyms or avoid them altogether.
- Use only industry-standard abbreviations and acronyms. Keep a current list on file from a respected source.
- Realize some standard abbreviations and acronyms have multiple meanings. The meaning of the abbreviation or acronym often can be determined based on context, but this is not always true.

Best Practice

- Spell out in full the initial notation of an abbreviation or acronym with the acronym in parentheses, such as "BKA- Below the knee amputation" which, if not spelled out could also mean bilateral knee aspiration.
- Subsequent mentioning of the condition can use the acronym.
- The diagnosis should again be spelled out in full in the final impression or plan.

Consistency

Use caution when using record templates or electronic medical records that are conflicting or contradictory. Examples of conflicting or contradictory documentation include:

- The final assessment states right hemiparesis due to prior cerebrovascular accident, but the neurologic review of systems (ROS) and neurologic examination are noted as completely normal.
- The chief complaint states the patient presents for evaluation of chest pain, and the final assessment states acute angina. However, the ROS states, "Patient denies any episodes of chest pain."
- The final assessment states atrial fibrillation, but the cardiac ROS shows heart rate rhythm regular.
- The office notes refer to the patient as both "he" and "she," creating a consistency issue.
- The name on record and other documents do not match.

Timelines and Dates

Specific dates and timelines provide essential information and can affect diagnosis code assignment. See the second example below regarding myocardial infarction.

Examples:

- Post-hospitalization or post-operative follow-up office visits
  - Vague: "Patient was recently discharged from the hospital."
  - Vague: "Patient is here for hospital follow-up."
  - Specific: "Patient was discharged from the hospital on 1/15/2020 after admission for _____."
  - Specific: "Patient was discharged from the hospital two weeks ago after admission for _____."
  - Vague: Post-op visit for recent splenectomy.
  - Specific: "Patient is here for first post-op visit for splenectomy performed on 3/25/2020."

- "Recent" myocardial infarction (MI) is a vague description that does not specify whether the myocardial infarction occurred within the last four weeks (coded as acute MI) or is older than four weeks with no current symptoms related to the recent MI (coded as historical MI).
  - Vague: "Follow-up office visit for recent myocardial infarction."
  - Specific: "Patient was discharged from ABC Medical Center on 2/12/2020 after inpatient admission for acute myocardial infarction."
  - Specific: "Patient was discharged from ABC Medical Center one week ago after inpatient admission for acute myocardial infarction."

Historical Versus Current

➢ The statement "history of" in diagnosis coding terms means that the patient no longer has that condition

➢ Do not use the descriptor "history of" to describe:
  - A current or chronic condition that is still present, active or ongoing.
  - A current condition that is in remission. Describe the condition as *in remission*.

➢ Do not document a condition as current if it is historical only.
  - For example, a patient with a history of prostate cancer that has been eradicated in the past presents to the office for an evaluation, examination and PSA lab test to monitor for recurrence. The assessment section should not state "prostate cancer," but rather "history of prostate cancer." The related plan should state, "Will continue to monitor PSA every six months to check for prostate cancer recurrence."

➢ "History of" is acceptable when documenting status conditions such as an amputation.

Specificity

Describe each condition to the highest level of specificity by including any pertinent descriptors such as:

- With or without exacerbation
- Due to, secondary to, associated with or related to
- Acute versus chronic, stages or types
- Controlled or uncontrolled
- Stable, improved or deteriorating
- Right, left or bilateral

Examples:

➢ Diabetes mellitus (DM) – Specify:
  - Type (type 1, type 2, secondary to – specify causal condition)
  - Status of diabetes: If it is uncontrolled then specify hyper- or hypoglycemia
  - With or without complications or manifestations (fully describe each complication or manifestation).
  - If someone with DM has complications or manifestations, you must clearly and directly link diabetes to them using terms such as "with," "due to," "secondary to," "associated with," and "related to"

➢ Chronic kidney disease (CKD) – Specify:
  - Stage I-V or end stage renal disease (ESRD)
  - Even if lab values and/or the glomerular filtration rate (GFR) are documented, the record must clearly specify the stage of CKD
  - Medical coders are not allowed to assign a stage of CKD based on the documented GFR

Confirmed Versus Uncertain

Avoid use of terms that imply uncertainty (such as "probably," "apparently," "likely," or "consistent with") to describe diagnoses or conditions that are confirmed. Always document the signs and symptoms in the absence of a confirmed diagnosis.

Status Conditions

- Document status conditions when applicable (e.g., ostomy status, dialysis status, amputation status, major organ transplant, etc.)
- Chronic conditions need to be reported every calendar year including key condition statuses (e.g., right leg amputation and/or transplant status must be reported each year.)

Chronic Conditions

Members need to have all HCC chronic conditions addressed two times a year. Preferably, once in the first half of the year and once in the second half.

Best Practice
First: 1/1-6/30
Second: 7/1-12/30

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Supporting Documentation

Keep in mind that the previous sections of the medical record should provide supporting documentation for each condition or diagnosis listed. For example:

- Related signs and symptoms and physical exam findings
- Current medication list documenting the conditions for which the drug has been prescribed, the date it was prescribed, the drug name, and dosage with times and/or frequency
- Results of diagnostic testing

Causal Relationships

- The ICD-10-CM classification tells us that the words "with" or "in" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index (either under a main term or subterm) or an instructional note in the Tabular List.

- The classification presumes a causal relationship between any two conditions linked by these terms in the Alphabetic Index or Tabular List unless the documentation clearly states the conditions are unrelated or when another guideline exists that specifically requires a documented linkage between two conditions. (e.g., sepsis uses marks such as slashes and commas to separate a diagnosis and its manifestations as the guideline for "acute organ dysfunction that is not clearly associated with the sepsis").

- For conditions not specifically linked by the relational terms, "with" or "in" in the classification or when a guideline requires that a linkage between two conditions be explicitly documented, the provider must

- State any cause-and-effect relationships between chronic conditions and associated manifestation using the words "due to."

- Indicate a causal relationship in the progress notes. Otherwise, the conditions will be coded separately and the highest specificity code will be missed.

Remember
Avoid the use of punctuation that may not clearly indicate a causal relationship. (ICD-10-CM 2019 guidelines)

Example:
A patient is seen for diabetes mellitus type 2 with kidney/renal disease.

- To show a causal relationship, note labs and urine test results and document one of these:
  - Diabetic nephropathy
  - Nephropathy due to diabetes mellitus
- If the provider documents the following, then the highest specificity code will be captured:
  - Diabetic nephropathy (E11.21)
  - CKD stage 5 due to diabetes (E11.22 and N18.5)
  - Diabetes with end-stage renal disease (E11.22, N18.6 and Z99.2 – renal dialysis status)
- If there is long-term, current use of insulin, add Z79.4.

> ## Best Practice
> Document each and every complication of diabetes with the descriptor "diabetic," as in "diabetes mellitus type II, controlled, with diabetic neuropathy."
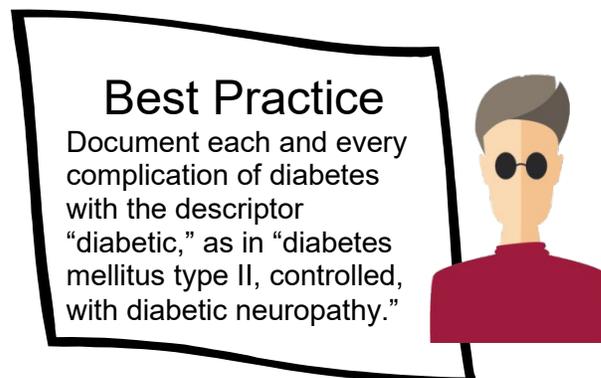
Final Diagnostic Statement

This is the section of the record where you state your final assessment or final impression of the patient's current diagnoses based on all other information you gathered as you evaluated the patient on an individual date of service. In your final diagnostic statement you should include:

- All conditions or diagnoses that impact the patient's care on this date.
- All conditions or diagnoses you evaluated and managed on this date.
- All comorbid or co-existing conditions that impacted patient care, treatment or management on this date.
- The current status (e.g., improved, stable, worsening, etc.) of each diagnosis or condition.
- Each diagnosis needs to conform to ICD-10 coding guidelines
- Each diagnosis must have an *assessment and treatment plan*

Diagnoses must be validated by the provider and documented in the medical record.

Remember ICD-10-CM Guidance:

Code all documented conditions coexisting at the time of the encounter or visit and that require or affect patient care, treatment or management. The requirement does not say that that an individual medical practitioner is treating the condition; it is that conditions that affect the care or treatment of the patient should be reported.

Treatment Plan

- Your current plan of treatment for each diagnosis should be clearly documented and specific. Examples should include dietary recommendations, medication changes, scheduling of diagnostic testing, specific patient education or counseling provided, continued monitoring and other factors that affect diagnosis.

- If referrals are made or consultations requested, the office note should indicate to whom or where the referral or consultation is made or from whom consultation advice is requested.

- Document when you plan to see the patient again, even if on an as-needed basis only.

Health Care Provider Signature and Credentials

- Only authorized personnel may document in the medical record; each person must be clearly identified with full name and credentials.

- All entries must be signed and dated by the health care provider; signatures should be identified by a printed, legible name and credentials

- Signature stamps are not accepted by CMS

- Electronic signatures must be authenticated by the health care provider.

- For a signature to be valid, the following criteria must be met:

    o Services that are provided or ordered must be authenticated by the ordering practitioner

    o Signatures are to be handwritten or electronic; stamped signatures are not acceptable

    o Signatures should be legible

    o Ensure you have a valid provider type (e.g., skilled nursing facility, freestanding ambulatory surgical centers, laboratories, pharmacy, etc.)

Reference: CMS Medicare Program Integrity Manual (Publication [Pub.] 100-08), Chapter 3, Section 3.3.2.4 Documentation by Clinicians Other than the Patient's Provider
- Code assignment is based on the documentation by patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis).

There are a few exceptions, such as codes for the following:
- Body Mass Index (BMI)
- Depth of non-pressure chronic ulcers, pressure ulcer stage
- Coma scale
- National Institutes of Health stroke scale (NIHSS) codes

Code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

A Final Note

A progress note must be based on a face-to-face visit with a patient and should include the following:

- Clear patient identification
- Date of the visit
- Your clinical documentation of the visit (history, physical, etc.)
- A clear statement of the diagnoses including its status and plan of care
- Your signature including credentials and the date signed

Although the main reason for a face-to-face visit may be for something other than the status of an amputation or an artificial opening, all diagnoses that were part of the provider's medical decision-making process should be documented.

Best Practices in Medical Coding

- ➢ Accuracy
- ➢ Specificity
- ➢ Thoroughness
- ➢ Consistency

Medicare Risk Adjustment (MRA) and Commercial Risk Adjustment (CRA) Programs

Risk adjustment is the way that payments to health plans are changed to take into account a person's health status. As a component of the health care reform, this payment methodology was developed in part by CMS and later adopted by HHS. It is designed to improve coverage, preserve consumer choice and improve quality of care for patients.

Comparison of MRA and CRA

CMS-HCC MRA	HHS-HCC CRA
Used by CMS to pay Medicare Advantage plans for enrollees	Used by CMS to pay health insurers in Affordable Care Act marketplace
Is a prospective model that uses diagnoses from a base period to predict costs in a future period Base year (current year) diagnoses determine next year's reimbursement rates and funding	Is a concurrent model that uses diagnoses from a time period to predict cost in that same period Uses current year diagnosis coding to set risk payments in current year
Developed for >65-year-olds and disabled patients of all ages	Developed for all age patients
Pediatrics and obstetrics diagnosis codes are not assigned risk values	Includes categories for infants, children and adults, and includes obstetrical diagnoses
Does not include drug costs	Includes drug costs
Model used by many software programs, integrated into EMR systems.	Model less well known by medical practices
Rulemaking: Proposal at the end of December, final rates in April	Payment to health insurers for caring for sicker patients with chronic and complex conditions

Hierarchical Condition Categories (HCCs) and Risk Adjustment Models

HCCs are a coding system developed by CMS. Both CMS and HHS use HCCs as a key component of the risk adjustment models they use.

In both CMS-HCC and HHS-HCC models, major conditions lead to a higher reimbursement. For patients with multiple conditions, the HCCs are cumulative and based on a hierarchy. In the hierarchy, the lower the HCC number, the greater the risk and therefore, the greater the reimbursement.

MRA (CMS-HCC) and CRA (HHS-HCC) risk adjustment models start with the same list of ICD-10 codes but then vary in the number of diagnosis codes and HCCs used. HHS adopted the CMS-HCC model and uses a wider range of data that includes a patient's age, gender, demographics and diagnoses to estimate the cost of treating that patient.

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Medicare Risk Adjustment
Centers for Medicare and Medicaid Services
Hierarchical Condition Category Model

72,616
ICD-10 Codes

9,856
Diagnosis Codes

86
HCCs

Commercial Risk Adjustment
Department of Health and Human Services
Hierarchical Condition Category Model

72,616
ICD-10 Codes

8245
Diagnosis Codes

128
HCCs
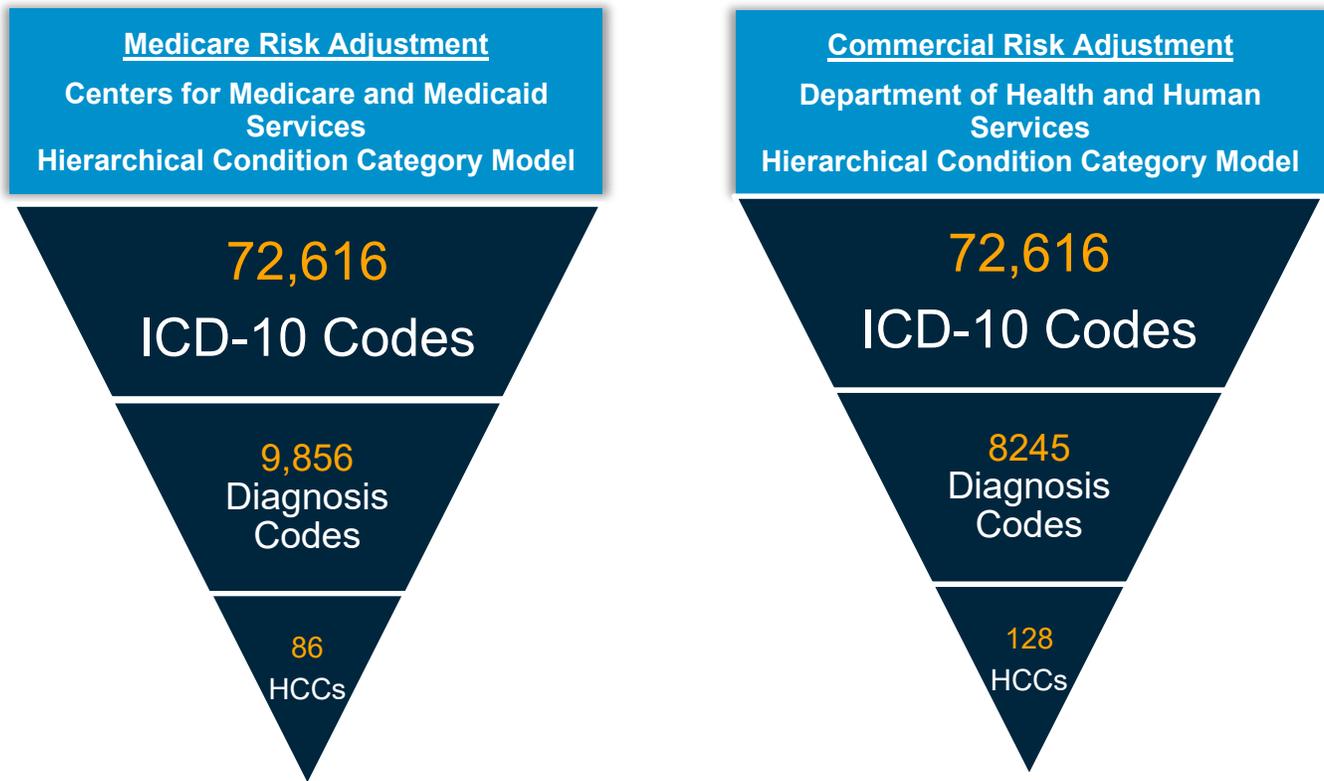
Note: The above MRA chart information is reflective of the 2021 HCC model V24 which is in effect as of October 1, 2020.

Sample HCCs

Of the ICD-10 codes that CRA and MRA HCC models use, you will often find that a diagnosis code is assigned to a different category group between the two models. Here are some examples of the differences for a few chronic conditions. See the full list of MRA HCCs on the next pages.

Condition	MRA HCC	CRA HCC
HIV/AIDS	1	1
Cancers	8, 9, 10, 11, 12	8, 9, 10, 11, 12, 13
Diabetes	17, 18, 19	19, 20, 21
Major depression	59, 60	88, 89, 90, 102, 103
Congestive heart failure	85	130
Vascular disease	108	154
Chronic kidney disease	136, 137, 138	187, 188
Amputation status	189	254

CMS HCC Model V24 (86 HCCs)

HCC CAT	Description
1	HIV/AIDS
2	Septicemia, sepsis, systemic inflammatory response syndrome/Shock
6	Opportunistic infections
8	Metastatic cancer and acute leukemia
9	Lung and other severe cancers
10	Lymphoma and other cancers
11	Colorectal, bladder and other cancers
12	Breast, prostate and other cancers and tumors
17	Diabetes with acute complications
18	Diabetes with chronic complications
19	Diabetes without complication
21	Protein-calorie malnutrition
22	Morbid obesity
23	Other significant endocrine and metabolic disorders
27	End-stage liver disease
28	Cirrhosis of liver
29	Chronic hepatitis
33	Intestinal obstruction/perforation
34	Chronic pancreatitis
35	Inflammatory bowel disease
39	Bone/joint/muscle infections/necrosis
40	Rheumatoid arthritis and Inflammatory connective tissue disease
46	Severe hematological disorders
47	Disorders of immunity
48	Coagulation defects and other specified hematological disorders
51	Dementia with complications
54	Substance use with psychotic complications
55	Substance use disorder, moderate/severe or Substance use with complications
56	Substance use disorder, mild, except alcohol and cannabis
57	Schizophrenia
58	Reactive and unspecified psychosis
59	Major depressive, bipolar and paranoid disorders
60	Personality disorders
70	Quadriplegia
71	Paraplegia
72	Spinal cord disorders/injuries
73	Amyotrophic lateral sclerosis and other motor neuron disease
74	Cerebral palsy
75	Myasthenia gravis/myoneural disorders and Guillain-Barre syndrome/inflammatory and toxic neuropathy
76	Muscular dystrophy
77	Multiple sclerosis
78	Parkinson's and Huntington's diseases
79	Seizure disorders and convulsions
80	Coma, brain compression/anoxic damage
82	Respirator dependence/tracheostomy status
83	Respiratory arrest
84	Cardio-respiratory failure and shock
85	Congestive heart failure
86	Acute myocardial infarction
87	Unstable angina and other acute ischemic heart disease
88	Angina pectoris
96	Specified heart arrhythmias
99	Intracranial hemorrhage
100	Ischemic or unspecified stroke

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103	Hemiplegia/hemiparesis
104	Monoplegia, other paralytic syndromes
106	Atherosclerosis of the extremities with ulceration or gangrene
107	Vascular disease with complications
108	Vascular disease
110	Cystic fibrosis
111	Chronic obstructive pulmonary disease
112	Fibrosis of lung and other chronic lung disorders
114	Aspiration and specified bacterial pneumonias
115	Pneumococcal pneumonia, empyema, lung abscess
122	Proliferative diabetic retinopathy and vitreous hemorrhage
124	Exudative macular degeneration
134	Dialysis status
135	Acute renal failure
136	Chronic kidney disease, stage 5
137	Chronic kidney disease, severe (stage 4)
138	Chronic kidney disease, moderate (stage 3)
157	Pressure ulcer of skin with necrosis through to muscle, tendon or bone
158	Pressure ulcer of skin with full thickness skin loss
159	Pressure ulcer of skin with partial thickness skin loss
161	Chronic ulcer of skin, except pressure
162	Severe skin burn or condition
166	Severe head injury
167	Major head injury
169	Vertebral fractures without spinal cord injury
170	Hip fracture/dislocation
173	Traumatic amputations and complications
176	Complications of specified implanted device or graft
186	Major organ transplant or replacement status
188	Artificial openings for feeding or elimination
189	Amputation status, lower limb/amputation complications

HCC Model V05 (128 HCCs)

HCC CAT	Description	HCC CAT	Description
1	HIV/AIDS	19	Diabetes with acute complications
2	Septicemia, sepsis, systemic inflammatory response syndrome/shock	20	Diabetes with chronic complications
		21	Diabetes without complication
3	Central nervous system infections, except viral meningitis	23	Protein-calorie malnutrition
		26	Mucopolysaccharidosis
4	Viral or unspecified meningitis	27	Lipidoses and glycogenosis
6	Opportunistic infections	28	Congenital metabolic disorders, not elsewhere classified
8	Metastatic cancer		
9	Lung, brain and other severe cancers, including pediatric acute lymphoid leukemia	29	Amyloidosis, porphyria and other metabolic disorders
		30	Adrenal, pituitary and other significant endocrine disorders
10	Non-Hodgkin's lymphomas and other cancers and tumors	34	Liver transplant status/complications
11	Colorectal, breast (age < 50), kidney and other cancers	35	End-stage liver disease
		36	Cirrhosis of liver
12	Breast (age 50+) and prostate cancer, benign/uncertain brain tumors and other cancers and tumors	37	Chronic viral hepatitis C
		37_1	Chronic viral hepatitis C
		37_2	Chronic hepatitis, except chronic viral hepatitis C
13	Thyroid cancer, melanoma, neurofibromatosis and other cancers and tumors	38	Acute liver failure/disease, including neonatal hepatitis
18	Pancreas transplant status/ complications	41	Intestine transplant status/complications

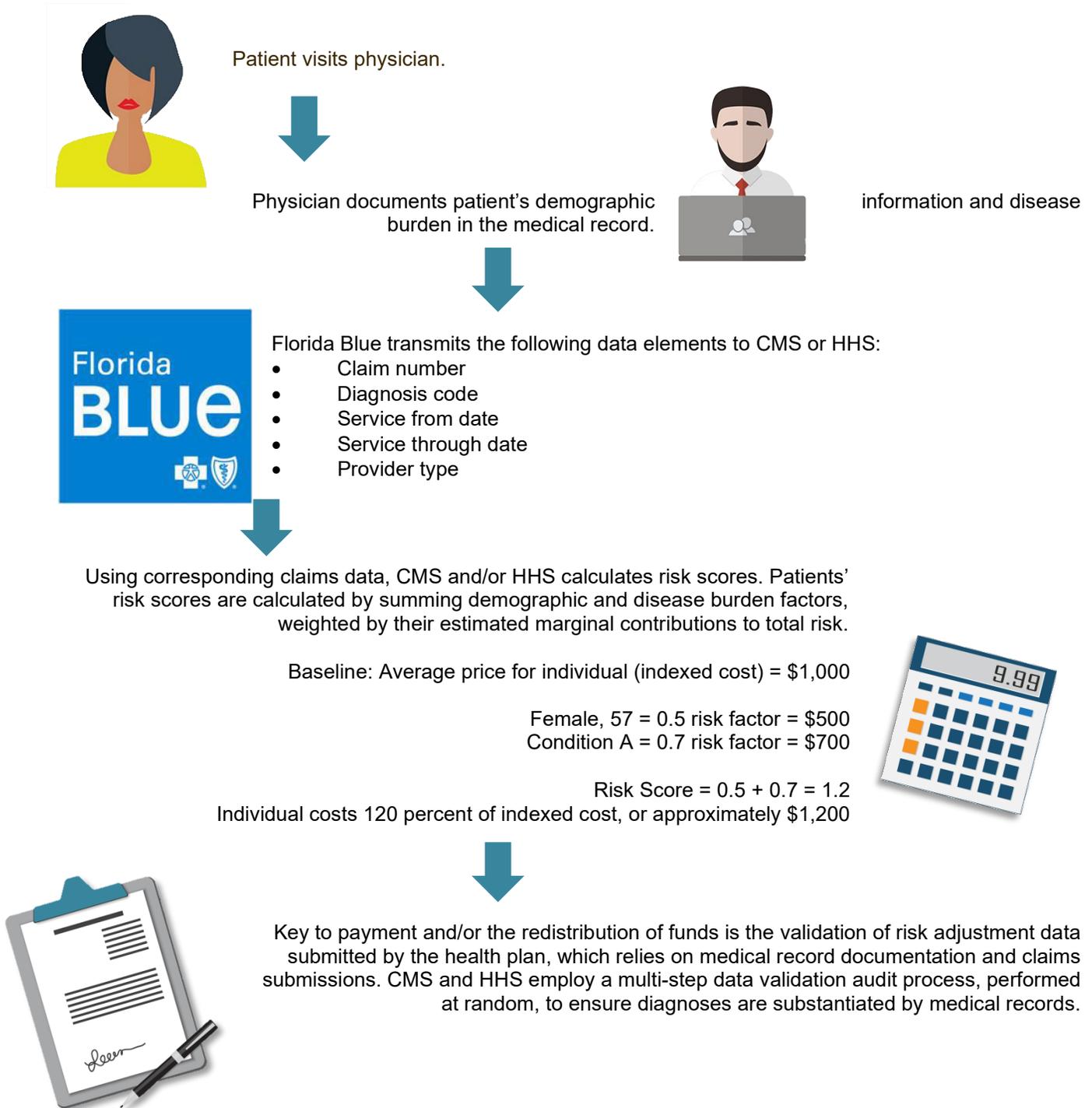| HCC CAT	Description	HCC CAT	Description
42	Peritonitis/gastrointestinal perforation/necrotizing enterocolitis	112	Quadriplegic cerebral palsy
45	Intestinal obstruction	113	Cerebral palsy, except quadriplegic
46	Chronic pancreatitis	114	Spina bifida and other brain/spinal/ nervous system congenital anomalies
47	Acute pancreatitis/other pancreatic disorders and Intestinal malabsorption	115	Myasthenia gravis/myoneural disorders and Guillain-Barre syndrome/ inflammatory and toxic neuropathy
48	Inflammatory bowel disease	117	Muscular dystrophy
54	Necrotizing fasciitis	118	Multiple sclerosis
55	Bone/joint/muscle infections/necrosis	119	Parkinson's, Huntington's and Spinocerebellar disease, and other neurodegenerative disorders
56	Rheumatoid arthritis and specified autoimmune disorders		
57	Systemic lupus erythematosus and other autoimmune disorders	120	Seizure disorders and convulsions
		121	Hydrocephalus
61	Osteogenesis imperfecta and other osteodystrophies	122	Non-traumatic coma, brain compression/ anoxic damage
62	Congenital/developmental skeletal and connective tissue disorders	125	Respirator dependence/tracheostomy status
63	Cleft lip/cleft palate	126	Respiratory arrest
66	Hemophilia	127	Cardio-respiratory failure and shock, including respiratory distress syndromes
67	Myelodysplastic syndromes and Myelofibrosis	128	Heart assistive device/artificial heart
68	Aplastic anemia	129	Heart transplant
69	Acquired hemolytic anemia, including hemolytic disease of newborn	130	Congestive heart failure
		131	Acute myocardial infarction
70	Sickle cell anemia (HbSS)	132	Unstable angina and other acute ischemic heart disease
71	Thalassemia major		
73	Combined and other severe immunodeficiencies	135	Heart infection/inflammation, except rheumatic
74	Disorders of the immune mechanism	137	Hypoplastic left heart syndrome and other severe congenital heart disorders
75	Coagulation defects and other specified hematological disorders		
		138	Major congenital heart/circulatory disorders
81	Drug psychosis		
82	Drug dependence	139	Atrial and ventricular septal defects, patent ductus arteriosus and other congenital heart/circulatory disorders
87	Schizophrenia		
88	Major depressive and bipolar disorders		
89	Reactive and unspecified psychosis, delusional disorders	142	Specified heart arrhythmias
		145	Intracranial hemorrhage
90	Personality disorders	146	Ischemic or unspecified stroke
94	Anorexia/bulimia nervosa	149	Cerebral aneurysm and arteriovenous malformation
96	Prader-Willi, Patau, Edwards and autosomal deletion syndromes		
		150	Hemiplegia/hemiparesis
97	Down syndrome, Fragile X, other chromosomal anomalies and congenital malformation syndromes	151	Monoplegia, other paralytic syndromes
		153	Atherosclerosis of the extremities with ulceration or gangrene
102	Autistic disorder	154	Vascular disease with complications
103	Pervasive developmental disorders, except autistic disorder	156	Pulmonary embolism and deep vein thrombosis
106	Traumatic complete lesion cervical spinal cord	158	Lung transplant status/complications
		159	Cystic fibrosis
107	Quadriplegia	160	Chronic obstructive pulmonary disease, including bronchiectasis
108	Traumatic complete lesion dorsal spinal cord		
		161	Asthma
109	Paraplegia	162	Fibrosis of lung and other lung disorders
110	Spinal cord disorders/injuries	163	Aspiration and specified bacterial pneumonias and other severe lung
111	Amyotrophic lateral sclerosis and other anterior horn cell disease infections		

HCC CAT	Description
183	Kidney transplant status
184	End stage renal disease
187	Chronic kidney disease, stage 5
188	Chronic kidney disease, severe (stage 4)
203	Ectopic and molar pregnancy, except with renal failure, shock or embolism
204	Miscarriage with complications
205	Miscarriage with no or minor complications
207	Completed pregnancy with major complications
208	Completed pregnancy with complications
209	Completed pregnancy with no or minor complications
217	Chronic ulcer of skin, except pressure
226	Hip fractures and pathological vertebral or humerus fractures
227	Pathological fractures, except of vertebrae, hip or humerus
242	Extremely immature newborns, birthweight < 500 grams
243	Extremely immature newborns, including birthweight 500-749 grams
244	Extremely immature newborns, including birthweight 750-999 grams

HCC CAT	Description
245	Premature newborns, including birthweight 1000-1499 grams
246	Premature newborns, including birthweight 1500-1999 grams
247	Premature newborns, including birthweight 2000-2499 grams
248	Other premature, low birthweight, malnourished or multiple birth newborns
249	Term or post-term singleton newborn, normal or high birthweight
251	Stem cell, including bone marrow, transplant status/complications
253	Artificial openings for feeding or elimination
254	Amputation status, lower limb/amputation complications

Risk Score Calculation

Patients' risk scores are calculated by summing demographic and disease burden factors, weighted by their estimated marginal contributions to total risk.

Example:

Patient visits physician.

Physician documents patient's demographic information and disease burden in the medical record.

Florida Blue transmits the following data elements to CMS or HHS:

- Claim number
- Diagnosis code
- Service from date
- Service through date
- Provider type

Using corresponding claims data, CMS and/or HHS calculates risk scores. Patients' risk scores are calculated by summing demographic and disease burden factors, weighted by their estimated marginal contributions to total risk.

Baseline: Average price for individual (indexed cost) = $1,000

Female, 57 = 0.5 risk factor = $500
Condition A = 0.7 risk factor = $700

Risk Score = 0.5 + 0.7 = 1.2
Individual costs 120 percent of indexed cost, or approximately $1,200

Key to payment and/or the redistribution of funds is the validation of risk adjustment data submitted by the health plan, which relies on medical record documentation and claims submissions. CMS and HHS employ a multi-step data validation audit process, performed at random, to ensure diagnoses are substantiated by medical records.

Documentation and Coding Reference Guides

The remainder of this guide provides documentation and coding reference guides for common chronic conditions.

Note: It is neither the intention nor the purpose of these reference guides to replace ICD-10-CM Official Guidelines for coding and reporting. Adherence to the official guidelines when assigning ICD-10-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

Each guideline is divided into three sections:

Overview

- General information about the condition including information such as definitions, causes, signs and symptoms and related tests
- The overview section has a blue header

Provider's Documentation Tips

- Information for providers about what to include in the documentation to ensure the most accurate coding
- The provider section is outlined in green

Coder's Coding Tips

- Information for coders about how to code this condition. The section includes coding examples and more commonly used codes. Note that numerous additional codes associated with the category are not listed in this document. Refer to the manual for more specific coding.
- The coder section is outlined in purple

OVERVIEW

Definition

The National Kidney Foundation defines chronic kidney disease (also known as chronic renal failure) as abnormalities of kidney structure or function, present for three months, with health implications.

Chronic kidney disease (CKD) is a condition characterized by a gradual loss of kidney function over time. Early detection and treatment can often keep chronic kidney disease from getting worse. Progression of kidney disease can lead to kidney failure. The final stage of CKD, also known as end-stage renal disease (ESRD), is when the kidneys are no longer able to remove enough wastes and excess fluids from the body and require dialysis or a kidney transplant to maintain life.

Causes (Etiology)

The two most common causes of abnormalities that account for most cases of CKD are:

- Uncontrolled hypertension over many years
- High blood sugar (diabetes) over many years; this happens in uncontrolled type 1 or type 2 diabetes

Symptoms

Signs and symptoms of kidney disease are often nonspecific, meaning they can also be caused by other illnesses. Because kidneys are highly adaptable and able to compensate for lost function, signs and symptoms may not appear until irreversible damage has occurred. Mayo Clinic lists the following symptoms:

- Nausea
- Vomiting
- Loss of appetite
- Fatigue and weakness
- Sleep problems
- Changes in how much is urinated
- Muscle twitches and cramps
- Swelling of feet and ankles
- Persistent itching
- Chest pain, if fluid builds up around the lining of the heart
- Shortness of breath, if fluid builds up in the lungs
- High blood pressure (hypertension) that's difficult to control

Stages of Chronic Kidney Disease

Stage	Description	GFR mL/min/1.73m^2
1	Normal kidney function but urine findings, structural abnormalities, or genetic trait points to kidney disease	More than 90
2	Mildly reduced kidney function, and other findings (as for stage 1) point to kidney disease	60-89
3 (unspec)	Moderately reduced kidney function: there is some damage to kidneys and they're not working as well as they should	30-59
3a	Chronic kidney disease, stage 3a	45-59
3b	Chronic kidney disease, stage 3b	30-44
4	Severely reduced kidney function	15-29
5	Kidney failure not requiring dialysis	Less than 15
6	End stage renal disease (ESRD) requiring dialysis	Less than 15

PROVIDER DOCUMENTATION TIPS

Important Labs and Tests to Capture in Documentation

The National Kidney Foundation recommends tests to measure kidney function and damage and detect abnormalities.

Tests that check how well the kidneys are working include:

- Urine analysis – creatinine clearance, protein (albumin), albumin/creatinine ratio, protein/creatinine ratio, microalbumin

- Blood work (serum) – creatinine levels, albumin, BUN, electrolytes, GFR, calcium, complete blood count, magnesium, phosphorous, potassium, sodium

Patient will need to have most of these tests as often as every 2-3 months when kidney disease gets worse.

Other diagnostic tests that may be done to look for the cause or type of kidney disease include:

- CT scan of the abdomen
- MRI or the abdomen
- Ultrasound of the abdomen
- Kidney biopsy
- Kidney scan
- Kidney ultrasound

The disease may also change the results of the following tests:

- Erythropoietin
- Vitamin D level
- Bone density test
- Parathyroid hormone (PTH)

Glomerular Filtration Rate (GFR) is a measure of the kidney's function. GFR is the best test to measure the level of kidney function and determine the stage of kidney disease.

SOAP

Subjective: In the subjective section of the office note, document the presence or absence of any current symptoms.

- History of the present illness (HPI)
- Review of systems (ROS)
- Past medical history, family history, social history (PFSH)

Objective: In the objective section of the office note, document:

- Exam: Any current associated physical exam findings (e.g., elevated blood pressure, edema, weight loss, etc.)
- Related diagnostic test and/or lab results

Assessment: Documentation should describe the definitive diagnosis

- Document the type of kidney disease (acute or chronic) and the cause of kidney failure
- Document whether the acute renal failure is the first listed or secondary diagnosis.
- A chronic kidney disease diagnosis cannot be captured from labs and diagnostic tests alone. Clinical review of the results should be documented in progress notes by the physician along with a diagnosis of chronic kidney disease and the stage explicitly stated
- Document the specific stage of chronic kidney disease (e.g. Stage 1, Stage 2, Stage 3a, Stage 3b etc.)
- Include the current status of CKD (stable, worsening, improved, etc.)
- Do not use descriptors that imply uncertainty, such as "probable," "apparently," "likely" or "consistent with"
- A relationship is assumed when a patient has both chronic kidney disease and hypertension. However, both conditions should be documented in the medical record on same date of service
- A causal relationship must be explicitly stated in the medical record when the chronic kidney disease is due to diabetes (diabetic nephropathy or chronic kidney disease stage 4 due to diabetes.)

PROVIDER DOCUMENTATION TIPS

Diagnosing CKD

The diagnosis of CKD cannot be coded from diagnostic reports (e.g., lab reports) alone. The review of the diagnostic reports should be documented in the progress note, a clinical rationale regarding pertinent findings noted and the stage of the CKD clearly stated.

Plan/Treatment: Chronic kidney failure has no cure, but treatment can help control signs and symptoms, reduce complications and slow the progress of the disease.

- Proper diet: protein management along with salt, potassium and phosphorus restrictions may help slow disease progression
- Daily exercise
- Avoidance of smoking and other tobacco products
- Avoidance of alcohol and illegal drugs
- Avoidance of substances that are toxic to the kidneys, such as NSAIDs
- Treating complications. While this is not an all-inclusive list, some of the common conditions are:
  - Anemia
  - Hypertension
  - Electrolyte imbalance, hyperparathyroidism
  - Metabolic acidosis and alkalosis
  - Congestive heart failure or pericarditis
  - Infertility, impotence
  - Encephalopathy, neuropathy
- Other treatments may include Medications to control high blood pressure to slow further kidney damage; ACE inhibitors or ARBs are used most often.
- Secondary hyperparathyroidism is extremely common in chronic kidney disease (CKD stage 3 or greater, eGFR<60). CKD stage 3 or greater should raise the question, further supported by any one of the following:
  - Elevated parathyroid hormone (PTH) lab test
  - Dietary phosphate restriction
  - Phosphate binding agents
  - Vitamin D replacement

CODER'S CODING TIPS

ICD-10-CM Official Guideline

Chapter 14: Before assigning a code, be sure you review the **Excludes 2** notes at the beginning of the chapter. **Excludes 2** is a type 2 excludes note that represents "Not included here." An *Excludes 2* note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an *Excludes 2* note appears under a code, it is acceptable to use both the code and the excluded code together (as an additional code), when appropriate.

When coding CKD, the coder should review the health record to identify the:

- Stage of the CKD (e.g. Stage 1, Stage 2, Stage 3a, Stage 3b etc.)
- Dialysis status
- Kidney transplant status
- Whether there are any underlying associated conditions, such as diabetes or hypertension is present
- Review the entire medical record to verify CKD is a current condition

When provider's documentation is between stages such as stage 1-2 or 2-3, the coder should always choose the lower of the two stages if a query from the physician is not available. If the documentation uses descriptors of CKD such as "mild", "moderate" or "severe" in lieu of a stage number, then coders may choose those corresponding stages 2-4 as appropriate.

CODER'S CODING TIPS

CKD classifies to category N18. This category includes instructional notes advising to:

- Code first any associated:
  o Diabetic chronic kidney disease (E08-E13 with .22)
  o Hypertensive chronic kidney disease (I12.-, I13.-)
- Use additional code to identify kidney transplant status, if applicable (Z94.0)

Excludes 1 CKD stage 5 requiring chronic dialysis (N18.6)
       End-stage renal disease N18.6
Includes CKD requiring chronic dialysis
       Use additional code to identify dialysis status (Z99.2)

Chronic Kidney Disease and Kidney Transplant Status

- Kidney transplant may still have some form of CKD; the transplant may not fully restore kidney function
- This doesn't constitute in a complication, merely assign the appropriate code N18 for the patient's stage of CKD and code Z94.0, Kidney transplant status
- If the documentation on the transplant is unclear, a query to the provider will be needed
- Code T86.1- should be assigned for documented complications of a kidney transplant, such as transplant failure or rejection or other transplant complication

Hypertensive Chronic Kidney Disease

- Assign codes from category I12, hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, chronic kidney disease (CKD), are present. CKD should not be coded as hypertensive if the provider indicates the CKD is not related to the hypertension.
- The appropriate code from category N18 should be used as a secondary code with a code from category I12 to identify the stage of chronic kidney disease. See Section I.C.14.--Chronic kidney disease.
- If a patient has hypertensive chronic kidney disease and acute renal failure, an additional code for the acute renal failure is required.

Hypertensive Heart and Chronic Kidney Disease

- Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when both hypertensive kidney disease and hypertensive heart disease are stated in the diagnosis.
- Assume a relationship between the hypertension and the chronic kidney disease, whether or not the condition is so designated.
- The appropriate code from category N18, Chronic kidney disease, should be used as a secondary code with a code from category I13 to identify the stage of chronic kidney disease.
- If heart failure is present, assign an additional code from category I50 to identify the type of heart failure.

Dependence on Renal Dialysis

Codes to Z99.2 which includes:
- Hemodialysis status
- Peritoneal dialysis status
- Presence of arteriovenous shunt (for dialysis)
- Renal dialysis status NOS
- When a patient refuses dialysis treatments code Z91.15 for "noncompliance with renal dialysis"
- If an encounter for fitting and adjustment of peritoneal dialysis is documented, code Z49.02

CODER'S CODING TIPS

Acute Kidney Injury/Acute Kidney (Renal) Failure

- Use N17.9, not to be confused with renal insufficiency (acute)
- If it is documented that patient has temporary dialysis, code Z99.2

Kidney Failure

- It is important to specify the type of kidney failure – acute or chronic – and the cause of the kidney failure, if known.
- If kidney failure is chronic, document the CKD stage and assign codes from category N18.

Coding Example

Documentation

DM 2 w/ diabetic CKD, ESRD on dialysis

Diagnosis Codes

- E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease
- N18.6 End-stage renal disease
- Z99.2 Renal dialysis status

Rationale

ICD-10-CM directs you to N18.5 for CKD stage 5 (also known as end stage kidney disease). There you will find an *Excludes 1* note that directs you to N18.6 when there is documentation of CKD 5 as well as documented dialysis. Under the code N18.6 there is a "Use additional code" note to identify the dialysis status (Z99.2).

Case: CKD with HTN and heart failure

CKD, hypertension and heart failure are documented in the assessment section of the progress note	I13.0 I50.9 N18.9	HCC 85 CC130	Rationale
			The combination code I13.0 includes Hypertensive CKD with heart failure. Requires 3 codes: I13.0, N18.9 (CKD) and I50.9 (heart failure).
			Instructional Note:
			• Use additional code to identify type of heart failure (I50.-)
			• Use additional code to identify stage of chronic kidney disease

CODER'S CODING TIPS

Chronic Kidney Disease

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
I12	Hypertensive chronic kidney disease	I12.0	Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end-stage renal disease
		I12.9	Hypertensive chronic kidney disease w/stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease
I13	Hypertensive heart and chronic kidney disease	I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease
		I13.1	Hypertensive heart and chronic kidney disease without heart failure
		I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease or end-stage renal disease
I50	Heart failure	I50.9	Heart failure, unspecified
N18	Chronic kidney disease (CKD)	N18.1	Chronic kidney disease, stage 1
		N18.2	Chronic kidney disease, stage 2 (mild)
		N18.3	Chronic kidney disease, stage 3 (moderate)
		N18.30	Chronic kidney disease, stage 3 unspecified
		N18.31	Chronic kidney disease, stage 3a
		N18.32	Chronic kidney disease, stage 3b
		N18.4	Chronic kidney disease, stage 4 (severe)
		N18.5	Chronic kidney disease, stage 5
		N18.6	End-stage renal disease

[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

OVERVIEW

Definition

Amputation is the removal of a limb by trauma, medical illness or surgery. As a surgical measure, it is used to control pain or a disease process in the affected limb, such as malignancy or gangrene. In some cases, it is carried out on individuals as a preventative surgery for such problems.

Causes (Etiology)

There are many reasons an amputation may be necessary. The most common is poor circulation because of damage or narrowing of the arteries, called peripheral arterial disease. Without adequate blood flow, the body's cells cannot get oxygen and nutrients they need from the bloodstream and the affected tissue begins to die and infection may set in.

Other causes for amputation may include:

Severe injury (trauma), such as burns, car accident, etc. = "traumatic amputations"

- Cancerous tumor in the bone or muscle of a limb
- Serious infections that do not get better with treatment, such as osteomyelitis, necrotizing fasciitis, gangrene, etc.
- Uncontrolled diabetes mellitus
- Frostbite

Types of Amputations

Lower Limb Amputations

- Toe amputation - removal of one or more toes which will affect walking and balance
- Partial foot amputation – removal of the fore, mid or hind foot
- Ankle disarticulation - removal of the foot through the ankle joint
- Below knee amputation (BKA) - removal of the leg below the knee retaining the knee joint
- Through the knee amputation (disarticulation at knee) - removal of the lower leg and knee joint leaving the entire femur intact
- Above knee amputation (AKA) - removal of the leg above the knee joint
- Hip disarticulation - removal of the entire limb up to and including the femur

Upper Limb Amputations

- Partial hand amputation – removal of fingertips and/or parts of the fingers
- Metacarpal amputation – removal of the entire hand with the wrist still intact
- Wrist disarticulation – removal of the hand and the wrist joint
- Below elbow amputation – partial removal of the forearm below the elbow joint
- Elbow disarticulation – removal of the forearm at the elbow
- Above elbow amputation – removal of the arm above the elbow
- Shoulder disarticulation and forequarter amputation – removal of the entire arm including the shoulder blade and collar bone

PROVIDER'S DOCUMENTATION TIPS

A progress note must be based on a face-to-face visit with a patient and should include the following:

- Clear patient identification
- Date of the visit
- Your clinical documentation of the visit (history, physical, etc.)
- A clear statement of the diagnoses and status
- Your signature

When coding, you can only report the specific code that the medical record documentation supports. Be sure to document specific anatomical location and laterality of the amputation site.

Documentation of the type of amputation (complete/partial, complicated/non-complicated) assists in selection of the most specific code.

The key to documenting an ostomy status is to clearly explain if it's present or reversed.

Areas of the medical record that the status of an amputation may occur

- ROS
- Past surgical procedures
- Past medical history
- Examination

Although the main reason for a face-to-face visit may be for something other than the status of an amputation or an artificial opening, all diagnoses that were part of the provider's medical decision-making process should be documented.

Complications/Sequelae and Treatment

As with any type of surgery, having an amputation carries a risk of complications. The treatment also carries a risk of additional problems directly related to the loss of a limb.

Complications/Sequelae	Treatment
Heart complications (sequelae) - heart attack, heart failure	Early prophylactic measures by discouraging smoking and excessive alcohol consumption, adherence to a low-fat diet as well as having optimal blood pressure, blood glucose and lipid control
Blood clots (sequelae) - DVT	Blood thinners
Wounds/infections (complication) - surgical site infection, tissue necrosis, skin blisters, sinus/osteomyelitis	Treatment is determined based on the type of wound/infection. Most common are VAC therapy, wound debridement and revision surgery
Pain (complication) – post-amputation pain, residual limb pain (RLP), phantom limb sensation/syndrome, phantom limb pain (PLP), stump pain, neuromas	Medications (NSAIDs, opioids, steroid injections, etc.), massage, acupuncture, TENs unit, mental imagery, surgery to remove nerves
Muscle weakness/contracture of compensatory structures (sequelae), contracture of stump (complication)	Rehabilitation, exercise programs, avoid prolonged bed rest/sitting
Psychological effects (sequelae) – depression, anxiety, denial, grief, feeling suicidal, PTSD	Antidepressants, counseling

CODER'S CODING TIPS

Traumatic Amputations

- ICD-10-CM Alpha Index: Amputation>Traumatic>By Site
- Be sure to add the appropriate 7th character extender based on the documentation in the record.
- For any sequelae conditions due to the traumatic amputation, you will first code the sequelae condition followed by the traumatic amputation code with a 7th character extender of 'S'.
- Notes:
  - Do not confuse this with non-traumatic amputations that may have a sequelae, refer to "Amputation Status" below.
  - If no sequelae and no more treatment directed to the traumatic amputation, code as a status with category Z89.

Amputation Complications

- ICD-10-CM Alpha Index: Complication>Amputation>Type of Complication
- Category T87 are for amputation complications and do not require a 7th character extender.
- Phantom limb syndrome is a complication but is coded from Chapter 6, Category G54.
- We would not code a status code with this category, refer to the "Note" under "Important things to remember when coding in ICD-10-CM".

Amputation Status

- ICD-10-CM Alpha Index: Absence>By Site (Acquired)
- Category Z89 are the status codes for acquired absence of limb.
- Disarticulation is the amputation of a limb through a joint, without cutting of bone. The ICD-10-CM coding book does not clearly specify in the index the correct status codes for disarticulation of a joint. Below are the correct subcategory codes for the disarticulations.
  - Disarticulation at ankle: Z89.44-
  - Disarticulation at knee: Z89.61-
  - Disarticulation at hip: Z89.62-
  - Disarticulation at wrist: Z89.12-
  - Disarticulation at elbow: Z89.22-
  - Disarticulation at shoulder: Z89.23-

Coding Examples

Documentation	Diagnosis Codes
Patient is status post left lower BKA resulting from an MVA, site is completely healed. Comes in now due to having PTSD symptoms from losing her leg. Recommend counseling.	F43.10, Post-traumatic stress disorder, unspecified S88.112S, Complete traumatic amputation at level between knee and ankle, left lower leg, sequela Note: We would not code Z89.512, Acquired absence of left leg below knee, in this scenario since S88.112S and the status code both inform us of a left lower leg amputation.
Patient status post right AKA, c/o right lower leg pain 5/10	Z89.611 Acquired absence of right leg above knee

CODER'S CODING TIPS

Artificial Opening Status

The medical term **"ostomy"** refers to any surgical procedure that creates an artificial opening, also known as a **stoma**, into the body.

In anatomy, a stoma is any opening in the body. For example, a mouth, a nose and an anus are natural stomata. Any hollow organ can be manipulated into an artificial stoma as necessary. This includes the esophagus, stomach, duodenum, ileum, colon, pleural cavity, ureters, urinary bladder and renal pelvis. Such a stoma may be permanent or temporary.

Code Categories Related to Artificial Openings

Artificial opening status only, without need of care or attention: Category Z93

Artificial opening requiring attention or management including After care for Attention to artificial openings: Category Z43 and for Fitting and adjustment: Categories Z44-Z46

Complications of external stoma: Codes J95.0-, K94.-, N99.5-.

NOTE: Artificial openings can be coded when documentation in notes clearly shows the artificial opening status, complication, attention and management, and fitting and adjustment being present and current.

Artificial opening status can be captured from Medical History or Problem List alone as long as there is no evidence of closure, removal or reversal and no conflicting information within the notes (e.g., normal abdominal exam, presence of a scar).

NOTE: Artificial openings (ostomies) may be temporary and reversible. For example, a patient with Crohn's disease may have surgery with a temporary colostomy. Provider may not document it as "temporary" and the entire record must be carefully reviewed to ensure that reversal surgery of the colostomy was not performed before capturing an ostomy status code.

NOTE: A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code Z93. 0 Tracheostomy status should not be used with a code from subcategory J95.0, Tracheostomy complications. The status code does not provide additional information. The complication code indicates that the patient has tracheostomy.

Key Words/Language that may be Found in the Documentation

- Mention of "stoma" may be an indicator of presence of an artificial opening of some type.
- When "tube feeding" is mentioned, there may be an artificial opening (e.g., gastrostomy or jejunostomy) but note that a nasogastric (NG) tube feeding is not a surgically created artificial opening.
- Ileal conduit (artificial opening of urinary tract) is not an ileostomy (artificial opening of gastrointestinal tract.
- Wording that could be seen
  - G-tube
  - PEG tube
  - J-tube
  - Pouch
  - Colostomy bag
  - Ostomy
  - Conduit

- These conditions are covered by code Z43. They are intended to further define the code:
  - Closure of artificial openings
  - Passage of sounds or bougies through artificial openings
  - Reforming artificial openings
  - Removal of catheter from artificial openings
  - Toilet or cleansing of artificial openings

Refer to your ICD-10 coding manual for a complete list of codes in this category.

CODER'S CODING TIPS

Artificial Opening Status

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
Z93	Artificial Opening Status	Z93.0	Tracheostomy status
		Z93.1	Gastrostomy status
		Z93.2	Ileostomy status
		Z93.3	Colostomy status
		Z93.4	Other artificial opening of GI tract status
		Z93.50	Unspecified cystostomy status
		Z93.51	Cutaneous-vesicostomy status
		Z93.52	Appendico-vesicostomy status
		Z93.59	Other cystostomy status
		Z93.6	Other artificial opening of urinary tract status (nephrostomy, ureterostomy, urethrostomy)
		Z93.8	Other artificial opening status
		Z93.9	Artificial opening status, unspecified

There may also be other diagnosis codes to report related to complications, malfunctioning or adjustments or change(s) made to the artificial opening.

NOTE: It is neither the intention nor the purpose of this reference guide to replace ICD-10-CM Official Guidelines for coding and reporting. Adherence to these guidelines when assigning ICD-10-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

OVERVIEW

Definition

Angina is a term used for chest pain caused by reduced blood flow to the heart muscle. Angina is a symptom of coronary artery disease. Angina is typically described as squeezing, pressure, heaviness, tightness or pain in your chest.

Angina is also called angina pectoris.

Causes (Etiology)

- **Stable angina / angina pectoris –** usually triggered by physical exertion
- **Unstable angina –** occurs when fat-containing deposits (plaques) in a blood vessel rupture and a blood clot forms
- **Variant (Prinzmetal) angina –** also called Prinzmetal's angina, is caused by a spasm in a coronary artery in which the artery temporarily narrows
- **Microvascular angina –** spasms within the walls of the very small arterial blood vessels causes reduced blood flow to the heart muscle leading to this type of chest pain

Symptoms

Angina may have no obvious signs or symptoms ("silent" myocardial infarction). The symptoms need to be evaluated immediately by a doctor who can determine whether there is stable angina or unstable angina, which can be a precursor to a heart attack. When they do occur, the most common signs and symptoms:

- Chest pain accompanied by pain in arms, jaw, shoulder or back
- Nausea
- Fatigue
- Shortness of breath
- Dizziness
- Sweating

Exams and Testing

- Chest X-ray
- Echocardiogram
- Cardiac catheterization
- Blood tests
- Electrocardiogram (EKG)
- Stress test
- Coronary angiography
- Computed tomography angiogram (CTA)

Treatment

- Lifestyle changes
- Surgical procedures - angioplasty and stenting, coronary artery bypass graft (CABG)
- Cardiac rehabilitation

Medications

- Nitrates - oral or sublingual nitrate can be used, if patients feel chest pain
- Aspirin - ASA
- Beta-blockers
- Statins
- Calcium channel blockers
- Warfarin (Coumadin)
- Heparin

PROVIDER'S DOCUMENTATION TIPS

SOAP

Subjective: Have the patient describe the pain and where it is located

- HPI: Location, duration, context, associated signs & symptoms, severity, modifying factors, quality
- ROS: Pertinent
- Risk Factors: PFSH. Document risk factors that increase risk of coronary artery disease and angina.

Objective: Examination: Pertinent physical exam findings

Important tests to capture in documentation:

- ECG
- Stress testing (exercise testing preferable)
- Coronary angiography

Assessment: For each encounter, document an assessment, clinical impression or diagnosis.

- It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.
- For a presenting problem with an established diagnosis the record should reflect whether the problem is:
  - improved, well controlled, resolving or resolved, OR
  - inadequately controlled, worsening or failing to change as expected.

Plan/Treatment: The initiation of or changes in treatment should be documented.

Supporting Documentation

- Make the distinction between chest pain and angina
- Document social factors that influence cardiac diagnoses such as:
  - Obesity
  - Non-compliance with treatment regimen, including over/under-dosing
  - Tobacco use, abuse, dependence, past history or exposure (second hand, occupational, etc.)
- Document related, secondary or causal illness whenever appropriate (e.g. presence of hypertension)
- Cardiac diagnoses should be documented in a progress note and coded at least once each calendar year

CODER'S CODING TIPS

- Angina that is stable with medication should continue to be documented as such and coded as angina

- Patients who are post CABG or post PTCA/stent who develop active chest pain or angina should be documented as such and coded as angina when there is an Rx for SL nitro also documented.

- For patients with documented CAD and who also have an Rx for angina treatments such as an Rx for nitrates (Isordil, nitroglycerin), calcium channel blockers (nifedipine, nicardipine, verapamil, diltiazem) or beta blockers, query the provider for clarification as many providers will use CAD as a catch all to include patients who are being treated for angina. Code from the I25.1X category to describe a patient with both conditions.

- When the provider has documented "coronary artery disease (CAD)", but no specification of vessel type as being native or graft, the default code for native arteries is applicable. However, if the patient has a history of CABG, the documented CAD with no vessel type specified would be coded to the unspecified native or graft conditions.

- Any other specified form of angina that is not unstable angina or angina pectoris with a documented spasm is reported with code I20.8 - Other forms of angina pectoris. If the angina is unspecified, report I20.9 - Angina pectoris, unspecified

- Certain conditions with the presence of angina result in a combination diagnosis:

CODER'S CODING TIPS

- Angina pectoris with atherosclerotic heart disease
- Post infarct Angina

Unstable angina/AMI

If a patient is admitted with unstable angina and it is determined after study the patient had AMI, only code AMI. Unstable angina is considered integral to AMI.

(See *Coding Clinic*, fourth quarter 1993, pages 39 and 40 and *Coding Clinic*, second quarter 1990, page 15)

Post infarction angina

A code for post infarction angina and a code for AMI may be assigned during the same episode of care. Post infarction angina is coded to the type of angina documented by the physician.

(See *Coding Clinic*, second quarter 1995, page 19 and *Coding Clinic*, fourth quarter 1994, page 55)

Coding Examples

Documentation	Diagnosis Codes
CAD, angina and old myocardial infarct in 2019. Continue current medications: Isordil, Lipitor, Plavix and Aspirin EC Low Dose 81.	I25.119 Coronary atherosclerosis of native coronary artery with unspecified angina pectoris
Chest pain due to angina, nausea, pain radiating to the arm and jaw. Pain described by patient as crushing and unchanged since sudden onset during exercise 5 hours ago. Patient admits tobacco use; relates smoking history of one pack per day for 40 years.	I25.2 Old myocardial infarction F17.210 Tobacco use disorder

Angina Pectoris

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
I25	Atherosclerotic heart disease of native coronary artery	I25.110	Without angina
		I25.111	Angina pectoris with documented spasm
		I25.118	Other forms of angina pectoris, stable Angina, angina equivalent
		I25.119	Angina pectoris, unspecified

NOTE: It is neither the intention nor the purpose of this reference guide to replace ICD-10-CM Official Guidelines for coding and reporting. Adherence to these guidelines when assigning ICD-10-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

OVERVIEW

Definition

A neoplasm is an abnormal growth of tissue which is commonly referred to as a tumor if it forms a mass. This abnormal growth usually but not always forms a neoplasm. Malignant neoplasms are also simply known as cancers and are the focus of oncology.

Types of Cancer

There are more than 100 different types of cancer which are grouped into broad categories. ICD-10 classifies neoplasms into six main groups: malignant primary, malignant secondary, in situ neoplasms, benign neoplasms, neoplasms of uncertain behavior and neoplasms of unknown behavior. See neoplasm chart in the ICD-10-CM.

Type of Cancer	General Information	Codes start with
Benign neoplasms (benign tumors)	Benign tumors grow in only one place. They cannot spread or invade other parts of your body. Even so, they can be dangerous if they press on vital organs, such as your brain or spinal cord.	D
In situ neoplasms	Although it is sometimes called cancer, (confined, non-infiltrating, non-invasive) is not cancer because the abnormal cells do not spread beyond the original tissue. That is, they do not invade nearby tissue the way that cancer cells do.	D
Malignant neoplasms primary	Malignant tumors. Also called cancer.	C
Malignant neoplasms secondary		C
Neoplasms of uncertain behavior	There is not enough information to determine the type of tumor or stage (uncertain histologic behavior). Uncertain behavior is a diagnosis that is rendered by the pathologist when the cellular activity is uncertain to its morphology. The pathologist's determination is uncertain.	D
Neoplasms of unspecified behavior	Unspecified behavior is when the documentation is lacking a conclusive diagnosis. It is incomplete documentation.	D

Metastasis: The spread of cancer from one part of the body to another is called metastasis.

Causes (Etiology)

Cancer is a genetic disease—that is, it is caused by changes to genes that control the way our cells function, especially how they grow and divide. They can also arise during a person's lifetime as a result of errors that occur as cells divide or because of damage to DNA caused by certain environmental exposures.

Risk Factors

- Age: most people diagnosed with cancer are 65 or older
- Habits: certain lifestyle choices such as smoking or drinking
- Obesity: can contribute to cancer
- Family history: only a small portion of cancers are due to an inherited condition
- Cancer-causing substances
- Diet
- Hormones
- Immunosuppression
- Infectious agents
- Radiation
- Sunlight

Symptoms

Cancer symptoms vary depending on many factors, such as the cancer type, stage, size and location. The early stages of cancer may not produce noticeable symptoms. As the disease progresses, symptoms often become more apparent.

Exams and Tests

- Biopsy with pathology reports
- Cancer imaging
- Cancer screening overview (PDQ)
- Cancer staging
- Computed tomography (CT) scans
- Fine-needle aspiration
- Laboratory (blood, urine, etc.)
- Nuclear medicine scans
- Sentinel lymph node biopsy
- Single-photon emission computerized tomography (SPECT) scans

Treatment

Cancer has many types of treatments. The treatment will depend on the type of cancer and how advanced it is and location. The main types of cancer treatment include:

- Surgery (tumor resection)—surgery can be used to:
  - Remove the entire tumor
  - Debulk a tumor
  - Ease cancer symptoms (palliative)

- Radiation therapy (radiotherapy): A cancer treatment that uses high doses of radiation to kill cancer cells and shrink tumors.

- Chemotherapy (also called chemo): A type of cancer treatment that uses drugs to kill cancer cells.

- Immunotherapy: A type of cancer treatment that helps the immune system fight cancer. It is made up of white blood cells and organs and tissues of the lymph system.

- Targeted therapy: A type of cancer treatment that targets the changes in cancer cells that help them grow, divide and spread. Most targeted therapies are either small-molecule drugs or monoclonal antibodies.

- Hormone therapy: A cancer treatment that slows or stops the growth of prostate and breast cancers that use hormones to grow. Hormone therapy is also called hormonal therapy, hormone treatment or endocrine therapy.

- Stem cell transplant: Stem cell transplants are procedures that restore blood-forming stem cells in people who have had theirs destroyed by the very high doses of chemotherapy or radiation therapy that are used to treat certain cancers. ICD-10-CM instructs the coder to use an additional code to identify stem cell transplant status, if applicable (Z94.84).

Some people with cancer will have only one type of treatment. But most people receive a combination of treatments, such as surgery with chemotherapy, radiation therapy and/or adjuvant therapy. A person may decide not to pursue active treatment (e.g., surgery, chemo) and decide instead to do "watchful waiting."

PROVIDER'S DOCUMENTATION TIPS

Supporting Documentation: Active Cancer / Current Malignancy

For proper coding of neoplasms, the documentation in the medical record must indicate:

Primary

- Type - benign, in situ, malignant or uncertain histologic behavior.
- Site of neoplasm
- Any treatment directed to that site including adjuvant therapy, chemotherapy, radiotherapy, immunotherapy and targeted therapy

Secondary (if applicable)

- If a neoplasm is malignant, any secondary (metastatic) sites should be reported. Secondary cancer should indicate the primary site, if known
- Metastasis should indicate the location of metastasis (e.g., bone, liver, lung, etc.)
- Increase specificity in documentation and include whether the patient's condition is diagnosed as not having achieved remission, in remission or in relapse.
- Watchful Waiting - if the patient decides not to pursue treatment, capture the cancer as an active cancer and document the patient's decision and any follow-up diagnostics being used to monitor the cancer
- Malignant neoplasm of the prostate – primary site still on radiation therapy; code to C61.
- Malignant neoplasm lower-outer quadrant of female breast left side primary site – repeat mammogram in 3 months, continuing on Tamoxifen; code to C50.512

Supporting Documentation: History of Cancer / History of Malignancy

When assigning Z85, personal history of malignant neoplasm:

- Document "history of" only when the cancer has been excised or eradicated from its site and no further treatment is directed to that site. Include the date of eradication or excision and the date of end of treatment if applicable.
- Patients who have completed therapy are coded with "personal history of cancer" diagnosis code (Z-code), even if they are undergoing surveillance for re-occurrence of the malignancy.
- Subcategories Z85.0 – Z85.7 should only be assigned for the former site of a primary malignancy, not the site of a secondary malignancy.
- Subcategory's Z85.8-, may be assigned for the former site(s) of either a primary or secondary malignancy included in this subcategory.

CODER'S CODING TIPS

Active/Current

Cancer conditions may be coded as active when adjuvant therapy is directed at the site and documentation supports on going treatment even if provider documents the condition has "NED", "No Reoccurrence" or "In Remission". Adjuvant therapy is often used after primary treatments, such as surgery or radiation. Types of treatment used as adjuvant therapies include chemotherapy, hormone therapy radiation therapy and immunotherapy. (CC 3rd QTR 2009; CC May-June 1985)

If provider documents in the assessment that patient has breast or prostate cancer (even if previously resected) and is on an adjuvant TX medication (e.g., Herceptin, Arimidex, Tamoxifen, Eligard, Lupron), it should be coded as a CURRENT condition. Code C50.919 malignant neoplasm of breast (female), unspecified (risk adjusts), and for long-term (current) use of Arimidex. Z79.811 (No risk adjustment)

Do NOT capture as current a cancer condition if the patient is on an adjuvant TX medication and the documentation indicates *For prevention/prophylactic*, *In remission* or *History of*.

CODER'S CODING TIPS

Cured, Remission and History

Only when the physician documents that the patient has been completely cured, assign a code from Z85.

Don't confuse personal history with "in remission" codes (C90.00 – C95.92) for multiple myeloma and malignant plasma cell neoplasms and leukemia, which have sub-categories for:

- In remission
- In relapse
- Not having achieved remission; failed remission (NOS)

Lymphoma

Patients who present with lymphoma should be documented as active with the ICD-10 codes C81.00 – C88.9. Keep in mind that lymphomas are systemic diseases that do not metastasize in the same way as solid tumors. A lymphoma, regardless of the number of sites involved, is not considered metastatic and therefore never coded as a secondary cancer.

Important Note: Lymphomas are the "exception to the (history of) rule" when coding. Lymphomas should always be coded as an active condition, even if in remission.

Documentation Example: Lymphoma

Incorrect	**Correct**
Mr. X has a history of lymphoma to his neck lymph nodes	Mr. X's lymphoma is in remission at this time

Coding Example: History of Cancer

Documentation	**Diagnosis Code**
History of colon cancer, no recurrence, no current treatment	Z85.038 Personal history of malignant neoplasm of large intestine

Colorectal and Bladder Cancers

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
C18	Malignant neoplasm of colon	C18.0	Malignant neoplasm of cecum
		C18.1	Malignant neoplasm of appendix
		C18.2	Malignant neoplasm of ascending colon
		C18.3	Malignant neoplasm of hepatic flexure
		C18.4	Malignant neoplasm of transverse colon
		C18.5	Malignant neoplasm of splenic flexure
		C18.6	Malignant neoplasm of descending colon
		C18.7	Malignant neoplasm of sigmoid colon
		C18.8	Malignant neoplasm of overlapping sites of colon
		C18.9	Malignant neoplasm of colon, unspecified
C67	Malignant neoplasm of bladder	C67.8	Malignant neoplasm of overlapping sites of bladder
		C67.9	Malignant neoplasm of bladder, unspecified

CODER'S CODING TIPS

Lung and Other Severe Cancers

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
C15	Malignant neoplasm of esophagus	C15.9	Malignant neoplasm of esophagus, unspecified
C16	Malignant neoplasm of stomach	C16.9	Malignant neoplasm of stomach, unspecified
C17	Malignant neoplasm of small intestine	C17.9	Malignant neoplasm of small intestine, unspecified
C22	Malignant neoplasm of liver and intrahepatic bile ducts	C22.8	Malignant neoplasm of liver, primary, unspecified as to type
C23	Malignant neoplasm of gallbladder	No subcategory code	
C25	Malignant neoplasm of pancreas	C25.9	Malignant neoplasm of pancreas, unspecified
C33	Malignant neoplasm of trachea	No subcategory code	
C34	Malignant neoplasm of bronchus and lung	C34.00	Malignant neoplasm of unspecified main bronchus
C34	Malignant neoplasm of bronchus and lung	C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung
C45	Mesothelioma	C45.9	Mesothelioma, unspecified
C90	Multiple myeloma and malignant plasma cell neoplasms	C90.00	Multiple myeloma not having achieved remission
C92	Myeloid leukemia	C92.10	Chronic myeloid leukemia, BCR/ABLI-positive, not having achieved remission
C92	Myeloid leukemia	C92.90	Myeloid leukemia, unspecified, not having achieved remission

CODER'S CODING TIPS

Breast and Prostate Cancers

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
C43	Malignant melanoma of skin	C43.0	Malignant melanoma of lip
		C43.1	Malignant melanoma of eyelid, including canthus
		C43.2	Malignant melanoma of ear and external auricular canal
		C43.3	Malignant melanoma of other and unspecified parts of face
		C43.4	Malignant melanoma of scalp and neck
		C43.5	Malignant melanoma of trunk
		C43.6	Malignant melanoma of upper limb, including shoulder
		C43.7	Malignant melanoma of lower limb, including hip
		C43.8	Malignant melanoma of overlapping sites of skin
		C43.9	Malignant melanoma of skin, unspecified
C50	Malignant neoplasm of breast (female or male)	C50.0	Malignant neoplasm of nipple and areola
		C50.1	Malignant neoplasm of central portion of breast
		C50.2	Malignant neoplasm of upper-inner quadrant of breast
		C50.3	Malignant neoplasm of lower-inner quadrant of breast
		C50.4	Malignant neoplasm of upper-outer quadrant of breast
		C50.5	Malignant neoplasm of lower-outer quadrant of breast
		C50.6	Malignant neoplasm of axillary tail of breast
		C50.8	Malignant neoplasm of overlapping sites of breast
		C50.9	Malignant neoplasm of breast of unspecified site
C61	Malignant neoplasm of prostate	No subcategory code	

CODER'S CODING TIPS

Lymphoma and Other Cancers

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
C46	Kaposi's sarcoma	C46.9	Kaposi's sarcoma, unspecified
C56	Malignant neoplasm of ovary	C56.9	Malignant neoplasm of unspecified ovary
C71	Malignant neoplasm of brain	C71.8	Malignant neoplasm of overlapping sites of brain
		C71.9	Malignant neoplasm of brain, unspecified
C75	Malignant neoplasm of other endocrine glands and related structures	C75.1	Malignant neoplasm of pituitary gland
		C75.2	Malignant neoplasm of craniopharyngeal duct
C81	Hodgkin lymphoma	C81.90	Hodgkin lymphoma, unspecified, unspecified site
C85	Other specified and unspecified types of non-Hodgkin lymphoma	C85.90	Non-Hodgkin lymphoma, unspecified, unspecified site
C95	Leukemia of unspecified cell type	C95.90	Leukemia, unspecified not having achieved remission
C96	Other and unspecified molignate neoplasms of lymphoid, hematopoetic and related tissue	C96.20	Malignant mast cell neoplasm, unspecified
		C96.21	Aggressive systemic mastocytosis
		C96.22	Mast cell sarcoma
		C96.29	Other malignant mast cell neoplasm

NOTE: It is neither the intention nor the purpose of this reference guide to replace ICD-10-CM official guidelines for coding and reporting. Adherence to these guidelines when assigning ICD-10-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

OVERVIEW

Definition

Chronic obstructive pulmonary disease (COPD) is a progressive lung disease characterized by a chronic obstruction of air flow that interferes with normal breathing. This condition is not fully reversible. Chronic bronchitis and emphysema are included in the group of diseases known as COPD.

Types

There are two main types:

Emphysema: Slow, progressive lung disease caused by damage to alveoli resulting in air becoming trapped in the alveolar sacs causing them to rupture thus preventing the exchange of oxygen and carbon dioxide.

Chronic bronchitis: Long-term, chronic inflammation of the bronchial mucous membrane characterized by cough, hypersecretion of mucus and expectoration of sputum over a long period of time associated with increased vulnerability to bronchial infection. Most people with COPD have a combination of both conditions.

Causes/Risk Factors

- Smoking – the number one cause
- Gastroesophageal reflux disease (GERD), which can worsen COPD or may even cause it
- Long-term exposure to environmental irritants (toxic fumes, dust, air pollution, secondhand smoke, etc.)

Signs and Symptoms

- Chronic cough or cough with large amounts of mucus
- Shortness of breath, which is worse with exertion
- Wheezing and chest tightness
- Fatigue

Note: Periodic worsening or flare-ups of symptoms are called exacerbations, which can range from mild to life-threatening.

Diagnostic Tools

- Pulmonary function testing including spirometry (PFT)
- Arterial blood gas analysis
- Transfer factor for carbon monoxide
- Chest X-ray*
- Pulse oximetry
- Sputum evaluation

*Radiology services alone are not sufficient to support COPD diagnosis. Coders should not assign a COPD diagnosis unless the condition is captured in the medical record documentation by a physician.

Treatment

COPD has no cure, and once the lungs are damaged it is not reversible. Treatment is usually to reduce the progression and manage the symptoms. Treatments include:

- Smoking cessation
- Medications
- Oxygen therapy
- Regular exercise
- Avoiding environmental irritants
- Immunization for influenza and pneumonia
- Balanced nutrition
- Pulmonary rehabilitation

PROVIDER'S DOCUMENTATION TIPS

Supporting Documentation

The American medical Hospital Association (AHA) Coding Clinic advises COPD is a chronic condition that would almost always affect patient care, treatment and management. It is appropriate to document the COPD diagnosis in the final assessment as a current, coexisting condition, even in the absence of specific treatment of the condition for the visit.

- Avoid vague documentation and coding such as asthma unspecified (J45.909) or bronchitis unspecified (J40)
- Consider asthma mild, moderate and intermittent or persistent (J45.2X – J45.42)
- Documentation must support a worsening or a decompensation of the COPD condition to validate an acute exacerbation; describe each final COPD-related diagnosis to the highest level of specificity
- A diagnosis of COPD should be clearly documented and addressed in the medical record along with a treatment plan. A medication list alone does not support a diagnosis of COPD. For example, Advair may be used to treat asthma or COPD
  Note: Patients using an inhaled steroid or other bronchodilators have some form of COPD or asthma.
- Even when the COPD condition is being followed and managed by a different provider, it is important to include the diagnosis in the final assessment

Treatment Plan

- Document a clear and concise treatment plan for COPD, linking related medications to the diagnosis
- Include referrals for diagnostic testing to whom or where the requests are being made

CODER'S CODING TIPS

Coding Basics

COPD and its associated conditions classify to the following categories:

- J43 Emphysema
- J44 Other chronic obstructive pulmonary disease
- J45 Asthma

To ensure accurate and specific diagnosis code assignment, the coder must note the exact diagnosis description in the medical record; then, in accordance with ICD-10-CM official coding conventions and guidelines.

Coding Tips

- COPD is a non-specific code that should only be used when documentation does not specify the type of COPD present
- Codes for emphysema include the diagnosis of COPD
- Consider a documented "history of COPD." Has the condition been resolved? Is there documentation of active treatment?
- Consider smoker's cough with tobacco use disorder (see nicotine dependence category for appropriate code)
- Radiology services alone are not sufficient to support COPD diagnosis. Coders should not assign a COPD diagnosis unless the condition is captured in the medical record documentation by a physician.

CODER'S CODING TIPS

Coding Examples

Documentation	Diagnosis Codes
COPD	J44.9 Chronic obstructive pulmonary disease, unspecified Note: A vague and nonspecific condition description leads to a vague and nonspecific ICD-10-CM code.
COPD with emphysema and chronic bronchitis	J44.9 Chronic obstructive pulmonary disease, unspecified Note: Code J43.9 Emphysema, unspecified, excludes emphysema with chronic (obstructive) bronchitis and redirects the coder to category J44. Category J44, Other chronic obstructive pulmonary disease, includes chronic bronchitis with emphysema

Chronic Obstructive Pulmonary Disease

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
J41	Simple and mucopurulent chronic bronchitis	J41.0	Simple chronic bronchitis (smoker's cough)
		J41.1	Mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis	No subcategory code	
J43	Emphysema	J43.0	Unilateral pulmonary emphysema (MacLeod's syndrome)
		J43.1	Panlobular emphysema
		J43.2	Centrilobular emphysema
		J43.8	Other emphysema
		J43.9	Emphysema, unspecified
J44	Other chronic obstructive pulmonary disease (includes chronic obstructive asthma and chronic obstructive bronchitis)	J44.0	Chronic obstructive pulmonary disease with acute lower respiratory infection
		J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
		J44.9	Chronic obstructive pulmonary disease, unspecified
J45	Asthma	J45.901	Unspecified asthma with (acute) exacerbation
		J45.902	Unspecified asthma with status asthmaticus
		J45.909	Unspecified asthma, uncomplicated
J98	Other respiratory disorders	J98.2	Interstitial emphysema
		J98.3	Compensatory emphysema

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[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

OVERVIEW

Definition

Diabetes mellitus can be a chronic, lifelong disease that involves impaired metabolism of carbohydrate, protein and fat. It is marked by high levels of sugar in the blood due to insufficient secretion of insulin by the pancreas, tissue resistance to insulin produced by the pancreas or both.

Types

Type 1 diabetes mellitus: The pancreas produces little to no insulin, and daily insulin injections are required. Usually (but not always) diagnosed in childhood.

Type 2 diabetes mellitus: The pancreas does not produce enough insulin to maintain normal glucose levels, often because the body tissues do not respond well to insulin (insulin resistance). In some cases, daily insulin injections are required. Type 2 is far more common than Type 1. Usually occurs in adulthood.

Secondary diabetes mellitus: Elevated blood sugar that is caused by another condition, such as malignant neoplasm of the pancreas, pancreatectomy, adverse drug effects or poisoning.

Gestational diabetes: Diabetes triggered by pregnancy is called gestational diabetes (pregnancy, to some degree, leads to insulin resistance). It is often diagnosed in middle or late pregnancy. See Section I.C.15. Diabetes mellitus in pregnancy and Section I.C.15.g. gestational (pregnancy induced) diabetes.

Miscellaneous types of diabetes:

- Type 1.5 diabetes is a non-official term that is sometimes used to refer to a form of type 1 diabetes known as latent autoimmune diabetes in adults (LADA). Codes to Type 1 DM.
- Brittle diabetes mellitus (or labile diabetes) is a sub-type of type 1 diabetes. It is a term used to describe a particularly hard to control type 1 diabetes.

Risk Factors for Type 2 Diabetes Mellitus

- Age (> 45 years)
- Obesity
- Family history of diabetes
- History of glucose intolerance
- Ethnicity (certain groups are at a higher risk)
- Lack of physical activity
- High levels of cholesterol
- PCOS in women
- History of gestational diabetes
- Heart disease

Signs and symptoms

- Frequent urination (polyuria)
- Excessive thirst (polydipsia)
- Excessive hunger (polyphagia)
- Unusual weight loss
- Fatigue
- Irritability
- Blurry vision

Long-term complications (tend to be chronic, but can be reversible)

- Diabetic retinopathy
- Diabetic neuropathy
- Hypertension
- Atherosclerotic peripheral vascular disease
- Diabetic nephropathy
- Hyperlipidemia
- Coronary artery disease (CAD)

Diagnostic Tools

- Medical history of physical exam
- Urinalysis
- Blood tests (fasting or random blood sugar, glucose tolerance tests, glycohemoglobin (HbA1c), metabolic profiles)

Treatment

The type of diabetes would determine the treatment which may include insulin injections or oral medications. Other treatments: dietary management; regular exercise; control of weight, blood pressure and cholesterol; close monitoring of blood glucose levels; diabetes education; and monitoring for complication.

PROVIDER'S DOCUMENTATION TIPS

Diabetes Mellitus Control Status

For many years physicians were trained to document the type of diabetes and whether or not it was controlled or uncontrolled. Uncontrolled diabetes indicated that the patient's blood sugar was not at an acceptable level, because it was either too high or too low.

Per the AHA Coding Clinic, uncontrolled diabetes has no default code. Uncontrolled diabetes is classified by type and whether it is hyperglycemia or hypoglycemia (effective October 1, 2016).

ICD-10-CM does not classify diabetes as controlled or uncontrolled. Rather, the alphabetic index advises that for diabetes mellitus described as *inadequately controlled, out of control or poorly controlled*, we must code to diabetes, by type, with hyperglycemia.

If the documentation is not clear, query the provider for clarification whether the patient has hyperglycemia or hypoglycemia so that the appropriate code may be reported. (*See Section I.C.4 a.*)

Supporting Documentation

- Documentation of complications or manifestations should be stated (as due to or secondary to) or implied (diabetic) and reported with the associated manifestation or complication.
- Document any manifestations or complications in detail including site, laterality and severity when applicable. Describe each complication as "diabetic," even when there are multiple complications. For example: "Diabetes mellitus Type 2 with diabetic peripheral neuropathy and diabetic foot ulcer."
- ICD-10 diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected and the complications affecting that body system.
- Long-term use of insulin is an inherent component of Type 1 diabetes and does not need to be coded separately. For Type 2 diabetes, however, long-term use of insulin is a secondary code and Type 2 diabetes must be supported in order for long-term use of insulin to be documented coded. Include name of the insulin used, clearly link to diabetes and dosage and regime showing regular routine use with ongoing refills.

Demonstrating a Causal Relationship

- A cause-and-effect relationship between chronic conditions and associated manifestations should be explicitly stated in the medical documentation.
- Specify a causal relationship by the words *due to*, *complicated by*, *associated with* or *secondary to*.

CODER'S CODING TIPS

Coding Diabetes Mellitus

In ICD-10-CM, the codes for diabetes mellitus begin with the letter E and are found in Chapter 4: Endocrine, Nutritional, and Metabolic Diseases. The diabetes codes are combination codes that identify:

- The type of diabetes mellitus
- The body system(s) affected
- The particular complications that affect each body system

Coding Alert

The American Hospital Association (AHA) Coding Clinic advises that, in accordance with *ICD-10-CM Official Guidelines for Coding and Reporting*, Section I.A.15, the word *with* should be interpreted to mean *associated with* or *due to* when it appears in a **code title, the alphabetic index or an instructional note in the tabular list**.

The classification **assumes a causal relationship between the two conditions linked by these terms in the alphabetic index or tabular list**. (*Diabetes Mellitus with Associated Conditions*, First Quarter ICD-10 2016, pages 11-12 and *Clarification – Diabetes and Associated Conditions*, Second Quarter 2016, pages 36-37)

Here's an example from the alphabetic index for the main term "diabetes" and the sub-term "with":

Diabetes, diabetic (mellitus) (sugar) E11.9 with

- Amyotrophy E11.44
- Arthropathy NEC E11.618
- Autonomic (poly)neuropathy E11.43
- Cataract E11.36
- Charcot's joints E11.610
- Chronic kidney disease E11.22
- Dermatitis E11.620
- Myasthenia E11.44

Note: This example list is not all-inclusive. For the complete list from the ICD-10-CM coding manual, see the alphabetic index under the various types of diabetes *with*.

The subterm *with* in the index should be interpreted by the coder as a link between diabetes and any condition indented under the word *with*. These conditions should be coded as related to diabetes, **even in the absence of provider's documentation explicitly linking them**, unless the documentation clearly states the conditions are not caused by diabetes. For example, by stating the actual nondiabetic-related cause, that the cause is not diabetes or that the cause is unknown.

Diabetes Mellitus and the Use of Insulin and Oral Hypoglycemic Drugs

If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin:

- Assign code E11- Type 2 diabetes mellitus.
- Assign code Z79.4 Long-term (current) use of insulin or Z79.84 Long-term (current) use of oral hypoglycemic drugs, to indicate that the patient uses insulin or hypoglycemic drugs.
- Assign an additional code from category Z79 to identify the long- term (current) use of insulin or oral hypoglycemic drugs.

If the patient is treated with both oral medications and insulin, only assign the code for long-term (current) use of insulin.

Do not assign code Z79.4 if insulin is given temporarily to bring a Type 2 patient's blood sugar under control during an encounter. See Section I.C.4 a.

CODER'S CODING TIPS

Diabetes Mellitus (DM), Hypertension (HTN) and Chronic Kidney Disease (CKD)

When a Physician Documents…	The Coder Should…
CKD, HTN and DM, with no linkage between any combination of the three listed above or no statement that CKD is unrelated to HTN or DM	Assume CKD is linked to HTN and DM and code both hypertensive CKD and diabetic CKD
DM co-existing with "hypertensive CKD" with no cause-and-effect linkage between DM and CKD	Code only hypertensive CKD; do not code diabetic CKD. The descriptor "hypertensive" specifically identifies hypertension as the cause of CKD. CKD should not be coded as diabetic since the physician has specifically documented a different cause (HTN).
HTN co-existing with diabetic CKD with no cause-and-effect linkage between HTN and CKD	Code only diabetic CKD; do not code hypertensive CKD. The descriptor "diabetic" specifically identifies diabetes as the cause of CKD. CKD should not be coded as hypertensive since the physician has specifically documented a different cause (DM).

Coding Examples

If the physician documents the following, then the highest specificity code will be captured.

Documentation	Diagnosis Codes
Diabetic Peripheral Neuropathy	E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy
Progressing PAD due to diabetes	E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
Type 1 diabetes mellitus resolved following pancreas transplant	Z86.39 Personal history of other endocrine, nutritional and metabolic disease
Type 2 diabetes mellitus resolved after significant weight loss following gastric bypass surgery	When a medical record documents diabetes mellitus as resolved, the condition cannot be coded as current.

Diabetes

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
E10	Type 1 diabetes mellitus	E10.9	Type 1 diabetes mellitus without complications
E11	Type 2 diabetes mellitus	E11.9	Type 2 diabetes mellitus without complications
Z79	Long-term (current) drug therapy	Z79.4	Long-term (current) use of insulin

CODER'S CODING TIPS

Diabetes with Acute Complications

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
E10	Type 1 diabetes mellitus	E10.1	Type 1 diabetes mellitus with ketoacidosis
		E10.641	Type 1 diabetes mellitus with hypoglycemia with coma
E11	Type 2 diabetes mellitus	E11.0	Type 2 diabetes mellitus with hyperosmolarity
		E11.1	Type 2 diabetes mellitus with ketoacidosis
		E11.10	Type 2 diabetes mellitus with ketoacidosis without coma
		E11.11	Type 2 diabetes mellitus with ketoacidosis with coma
		E11.641	Type 2 diabetes mellitus with hypoglycemia with coma

Diabetes Mellitus with Chronic Complications

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
E10	Type 1 diabetes mellitus	E10.2	Type 1 diabetes mellitus with kidney complications
		E10.3	Type 1 diabetes mellitus with ophthalmic complications
		E10.4	Type 1 diabetes mellitus with neurological complications
		E10.5	Type 1 diabetes mellitus with circulatory complications
		E10.6	Type 1 diabetes mellitus with other specified complications
		E10.8	Type 1 diabetes mellitus with unspecified complications
E11	Type 2 diabetes mellitus	E11.2	Type 2 diabetes mellitus with kidney complications
		E11.3	Type 2 diabetes mellitus with ophthalmic complications
		E11.4	Type 2 diabetes mellitus with neurological complications
		E11.5	Type 2 diabetes mellitus with circulatory complications
		E11.6	Type 2 diabetes mellitus with other specified complications
		E11.8	Type 2 diabetes mellitus with unspecified complications

NOTE: It is neither the intention nor the purpose of this reference guide to replace ICD-10-CM Official Guidelines for coding and reporting. Adherence to these guidelines when assigning ICD-10-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

OVERVIEW

Definition

Heart failure is a condition in which the heart muscle is unable to pump enough blood through the heart to meet the body's needs for blood and oxygen.

Types of Heart Failure

Left-sided: The most common form of heart failure, it involves a decreased ability of the left ventricle to effectively pump blood out to the body. Fluid may back up in the lungs causing shortness of breath.

Right-sided: The right side no longer pumps effectively and blood backs up in the body's veins, causing swelling in the issues. This form is usually due to left-sided heart failure.

Systolic: The left ventricle loses its ability to contract normally; thus, it cannot effectively pump blood out of the heart to the body.

Diastolic: The left ventricle loses its ability to relax normally; thus, it cannot fill with blood during the resting period between beats.

Congestive: A slowing of blood flow out of the heart that occurs with heart failure can cause the blood returning to the heart to also slow and back up, resulting in congestion in body tissues. This leads to edema, or swelling, in the lower extremities and congestion in the lungs that interferes with breathing. In addition, this process can interfere with disposal of sodium and water by the kidneys, which also can result in swelling in body tissues.

Causes/Risk Factors

- Smoking
- Hypertension
- Lung disease
- Past heart attack
- Coronary heart valves
- Obesity
- Diabetes
- Congenital heart disease
- Diseases of the heart muscle
- Other medical conditions

Signs and symptoms

- Edema/swelling of feet, ankles, abdomen
- Increased heart rate or palpitations
- Shortness of breath
- Fatigue
- Confusion
- Decreased urine
- Difficulty sleeping
- Decreased exercise tolerance
- Persistent cough or wheezing
- Weight gain
- Loss of appetite
- Indigestion
- Nausea and vomiting

Diagnostic tools

- Medical history and physical exam
- Lab testing, including B-type natriuretic peptide (BNP) lab test: BNP is a substance secreted by the ventricles in response to pressure changes in the heart that occur with heart failure. The blood BNP level increases when heart failure gets worse and decreases when heart failure is stable.
- Chest X-ray
- Electrocardiogram (ECG or EKG)
- Echocardiogram
- Cardiac stress testing and catheterization
- CT or MRI scans
- Nuclear heart scans

Treatment

- Regular monitoring
- Limited salt intake
- Smoking cessation
- Exercise
- Weight control and balanced nutrition
- Treatment of underlying conditions
- Medications (e.g., diuretics, beta blockers, angiotensin- converting enzyme inhibitors, digitalis glycosides, angiotensin receptor blockers)
- Pacemaker or implantable cardioverter defibrillator
- Heart pumps (left ventricular assist devices)
- Heart transplant

PROVIDER'S DOCUMENTATION TIPS

Subjective

Document the presence of absence of any current patient reported symptoms of heart failure.

Objective

Include any current associated physical exam findings (such as edema, weight gain, Shortness of breath, etc.) and diagnostic test results.

Assessment

- If known, the etiology of the CHF such as coronary artery disease, valvular heart disease, cardiomyopathy or hypertensive heart disease
- Type of heart failure (systolic, diastolic or combined)
- Left ventricular ejection fraction (LVEF)
- Assessment for use of ACE inhibitors or beta blockers
- Contraindications for non-use of ACE inhibitors
- Cardiology consultation
- Presence of CHF, a chronic condition that tends to impact care/treatment even without active intervention

- Presence of dyspnea with mild exercise
- Presence of rales
- Paroxysmal nocturnal dyspnea
- Orthopnea
- Fatigue with exertion
- Jugular vein distention
- Ankle swelling
- Pitting edema of the lower extremities

Treatment Plan

Document a specific and concise treatment plan for heart failure, including date of next appointment.

If referrals are made or consultations requested, the office note should indicate to whom or where the referral or consultation is made or from whom consultation advice is requested.

Hypertension with Heart Disease

ICD-10-CM presumes a cause-and-effect relationship between hypertension (HTN) and heart disease, as the two conditions are linked by the term "with" in the alphabetic index. These two conditions should be coded as related even in the absence of physician documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.

Hypertensive Heart and Chronic Kidney Disease

Assign codes from combination category I13, Hypertensive heart and chronic kidney disease, when there is hypertension with both heart and kidney involvement.

CODER'S CODING TIPS

Coding Tips

- Always refer to the ICD-10-CM coding manual in the Tabular List under your specific diagnosis for any *Use Additional Code* instructions, as most of the codes in this reference guide require an additional code to document a complete history or diagnosis.
- Hypertension with heart conditions classified to I50.x or I51.4-I51.7, I51.89 or I51.9 is assigned to a code from category I11, Hypertensive heart disease.
- Use additional code(s) from category I50, Heart failure, to identify the type(s) of heart failure in those patients with heart failure
- If the provider has documented that the conditions are unrelated to the hypertension, code them separately.
- Aortic atherosclerosis / Ectasia (I70.xx, I77.xx) and abdominal aorta aneurysm (I71.xx) are permanent conditions that may be indicated in diagnostic testing study and can be considered present for up to five years. Usually found in the body of the report, these conditions are often overlooked.
- CHF is a common condition in patients post AICD implants and post-op CABGs.

Coding Examples

Documentation	Diagnosis Codes
Hypertensive heart failure	I50.9 Congestive heart failure, unspecified
	I11.0 Hypertensive heart disease w/ heart failure
Hypertensive heart disease with chronic diastolic CHF and chronic kidney disease stage 4	I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1 through 4 chronic kidney disease, or unspecified chronic kidney disease
	I50.32 Chronic diastolic (congestive) heart failure
	N18.4 Chronic kidney disease, stage 4 (severe)

CODER'S CODING TIPS

Congestive Heart Failure

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
I09	Other rheumatic heart diseases	I09.81	Rheumatic heart failure
I11	Hypertensive heart disease	I11.0	Hypertensive heart disease with heart failure
I13	Hypertensive heart and chronic kidney disease	I13.0	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease
		I13.2	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease
I50	Heart failure	I50.20	Systolic (congestive) heart failure
		I50.30	Diastolic (congestive) heart failure
		I50.40	Combined systolic (congestive) and diastolic (congestive) heart failure
		I50.9	Heart failure, unspecified
Z94	Transplanted organ and tissue status	Z94.1	Heart transplant status
Z95	Presence of cardiac and vascular implants and grafts	Z95.2	Presence of prosthetic heart valve
		Z95.3	Presence of xenogeneic heart valve
		Z95.4	Presence of other heart-valve replacement

NOTE: It is neither the intention nor the purpose of this reference guide to replace ICD-10-CM Official Guidelines for coding and reporting. Adherence to these guidelines when assigning ICD-10-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

Hemiplegia/Hemiparesis and Monoplegia (Late Effects/Sequelae of CVA)
Documentation and Coding Reference

OVERVIEW

Definitions

Hemiplegia/Hemiparesis is paralysis or weakness of one side of the body or weakness related to a CVA. According to ICD-10-CM Guideline Section I(C.9.d), category I69, sequelae of cerebrovascular disease, is used to indicate conditions that are a direct consequence of cerebrovascular diseases.

Monoplegia (or diplegia) is paralysis of one limb.

PROVIDER'S DOCUMENTATION TIPS

Clearly identify the cause and effect relationship of any cerebrovascular disease (CVA) and deficits. Document specific symptoms of cognitive deficit following a stroke (e.g. attention, memory, executive function, psychomotor, visuospatial, social emotional) and specifically link them to the CVA.

Follow-Up Care

- Once discharged, a patient's status is post CVA.
- Document and Code history of stroke with no lasting effects noted as personal history code Z86.73

Late Effects/Sequelae

- Late effects/sequelae of cerebrovascular disease (ICD-10-CM category I69) should be used any time after the initial episode of care and only when there is clear documentation of a cause-and-effect relationship.
- Late effects include cognitive deficits, speech and language deficits, hemiplegia/hemiparesis, disturbance of vision and facial weakness.
- The sequelae or "late effects" of a CVA should be documented and coded every time they are assessed.
- If you document "R or L sided weakness" do you mean "R or L hemiplegia or hemiparesis"?
- Monoparesis, or paralysis affecting a single extremity or part of the extremity, does not code to this category.

CODER'S CODING TIPS

Acute Episode: Use codes from ICD-10-CM categories I60-I68, including the code for CVA I63.9 for the initial event or an acute condition that is rarely seen outside of a hospital setting. These codes should not be coded from problem lists or past medical history because the event is no longer considered acute.

Coding Example

Documentation	Diagnosis Code
Residual right hemiparesis due to history of CVA with loss of sensation and fall risk. Consider orthotic for night wear to counteract the progressive contracture. Continue gabapentin for the dysesthesia.	I69.959 Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side

CODER'S CODING TIPS

Hemiplegia/Hemiparesis and Monoplegia

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
I69	Sequelae of cerebrovascular disease	I69.0	Sequelae of nontraumatic subarachnoid hemorrhage
		I69.1	Sequelae of nontraumatic intracerebral hemorrhage
		I69.2	Sequelae of other nontraumatic intracranial hemorrhage
		I69.3	Sequelae of cerebral infarction
		I69.8	Sequelae of other cerebrovascular diseases
		I69.9	Sequelae of unspecified cerebrovascular diseases

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[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

OVERVIEW

Major Depression

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) of the American Psychiatric Association (APA) advises that major depression is a mental disorder, marked by a depressed mood and loss of interest or pleasure in all activities that lasts for at least two weeks and represents a change from previous functioning.

Causes

- The exact cause is not known. Factors that may play a role include:
- Biological differences/physical changes in the brain
- Brain chemicals (called neurotransmitters) that are linked to mood
- Changes in hormone balance
- Genetics/inherited traits
- Life events
- Trauma during early childhood

Signs and Symptoms

Criteria for Major Depressive Episode: DSM-V (Source: DSM-V, American Psychiatric Association)

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition or mood-incongruent delusions or hallucinations.

- Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).
- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5 percent of body weight in a month) or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
- Diminished ability to think or concentrate or indecisiveness, nearly every day (either by subjective account or as observed by others).
- Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

Complications

Major depression that is left untreated can cause complications, such as:

- Alcohol or substance abuse
- Anxiety
- Heart disease or other medical conditions
- Work or school issues
- Family conflicts
- Relationship difficulties
- Social isolation
- Suicide

Diagnostic Tools

- Medical history and physical exam
- Standardized depression screening tools, such as the PHQ-9, a nine-item patient health questionnaire used to screen for and diagnose depression and to monitor response to treatment
- Laboratory tests to check for and monitor underlying medical conditions
- Psychological evaluation

Treatment

- Medications
- Psychotherapy/mental health counseling
- Electroconvulsive therapy
- Vagus nerve stimulation
- Transcranial magnetic stimulation

Bipolar Disorder

At least one of the following:

- Depressed mood most of the day, nearly every day
- Diminished interest in activities

At least four of the following:

- Weight/appetite loss or gain (>5% in a month)
- Agitation or retardation observed by others
- Recurrent thoughts of death, suicidal ideation or attempt
- Insomnia or hypersomnia
- Diminished ability to think or concentrate

PROVIDER'S DOCUMENTATION TIPS

Supporting Documentation

- Document the diagnosis by spelling it out in full.

- Do not use the descriptor "history of" to describe current major depression that is still present, active and ongoing. In diagnosis coding, the phrase "history of" means the condition is historical and no longer exists as a current problem.

- Do not document major depression as if it is current when the condition is truly historical and no longer exists as a current problem.

- Major depression that is in remission but still has impact on patient care, treatment and management should be included in the final assessment or impression with the current status noted as "in remission."

- For a confirmed diagnosis of major depressive disorder or major depression, do not use descriptors that imply uncertainty (such as "probable," "apparently," "likely" or "consistent with").

Major Depression, Bipolar and Paranoid Disorders
Documentation and Coding Reference

PROVIDER'S DOCUMENTATION TIPS

- Do not document suspected major depressive disorder or major depression as if the diagnosis were confirmed. Document the signs and symptoms in the absence of a confirmed diagnosis.

- Describe depression with the highest level of specificity, using all applicable descriptors. Include all of the following:
  - Episode: single or recurrent
  - Severity: mild, moderate, severe
  - Presence or absence of psychosis/psychotic features
  - Remission status: partial or full

Important Notes

- Not directly due to a substance
- Symptoms present for two weeks or more and cause clinically significant distress or impairment

Bipolar Disorder

Document:

- Current episode: hypomanic, manic, depressed, mixed
- Severity: mild, moderate, severe
- Remission status: partial or full
- Type: I or II
- With or without psychotic features
- Psychiatry consultation

CODER'S CODING TIPS

General Tips

- Major depression classifies to categories F32 and F33 with fourth and fifth characters to provide further specificity (mild, moderate, severe; with or without psychotic features; partial or full remission).

- The coder must note the exact diagnosis description documented in the medical record; then, in accordance with ICD-10- M official coding conventions and guidelines:
  - Search the alphabetic index for that specific description; and then
  - Verify the code in the tabular list, carefully following all instructional notes.

Coding Reminders

- ICD-10-CM code assignment is based on the exact diagnosis as described by the physician in the medical record. Coders are not allowed to make any assumptions based on documented signs and symptoms or other patient work-up that may show that the DSM-5 criteria for major depression are met. Only the physician can assign a diagnosis of major depression based on his or her evaluation of the patient and application of specific diagnostic criteria.

- The abbreviation MDD can have more than one meaning (manic depressive disorder versus major depressive disorder, which classify to two different ICD-10-CM codes). No code can be assigned unless the meaning of the abbreviation MDD is clear.

- Situational depression codes to F43.21, Adjustment disorder with depressed mood.

- NEW CODE ALERT- A new code effective October 1, 2021, for "depression NOS" or "unspecified depression" is F32.A Depression unspecified.
  - "Chronic depression" and "Depression" (with no further description) codes to F32.A, Depression, unspecified.

Major Depression, Bipolar and Paranoid Disorders
Documentation and Coding Reference

CODER'S CODING TIPS

- The new code F32.A will enable the distinction between patients diagnosed with "depression" and patients diagnosed with other, more specific types of depression.

- Major depression coexisting with bipolar disorder classifies to the applicable combination code under category F31 for bipolar disorder. Depression is a component of bipolar disorder. The Excludes1 note at category F31 indicates it is not appropriate to assign a separate code for major depression along with codes capturing both conditions under category F31.

Coding Example

Documentation	Diagnosis Code
72-year-old female with a history of mood disorder. No SI/HI. Continue on Celexa. TSH okay.	F39 Mood disorder

Major Depression, Bipolar and Paranoid Disorders

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
F31	Bipolar disorder	F31.9	Bipolar disorder, unspecified
F32	Depression episode	F32.0	Major depressive disorder, single episode, mild
		F32.1	Major depressive disorder, single episode, moderate
		F32.2	Major depressive disorder, single episode, severe without psychotic features
		F32.3	Major depressive disorder, single episode, severe with psychotic features
		F32.4	Major depressive disorder, single episode, in partial remission
		F32.5	Major depressive disorder, single episode, in full remission
		F32.8	Other depressive episodes
		F32.9	Major depressive disorder, single episode, unspecified
		F32.A	Depression unspecified, depression NOS, depressive disorder NOS
F33	Major depressive disorder recurrent	F33.0	Major depressive disorder, recurrent, mild
		F33.1	Major depressive disorder, recurrent, moderate
		F33.2	Major depressive disorder, recurrent, severe without psychotic features
		F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
		F33.4[1]	Major depressive disorder, recurrent, in remission
		F33.8	Other recurrent depressive disorders
		F33.9	Major depressive disorder, recurrent, unspecified
F39	Unspecified mood [affective] disorder	No subcategory code	

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[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

Depression Signs Mnemonic

SIG-E-CAPS is a mnemonic to help remember the signs of depression.

Sleep changes: increase during the day or decreased sleep at night

Interest: loss of interest in activities that used to interest them

Guilt (worthless): depressed elderly tend to devalue themselves

Energy: lack of energy is the common presenting symptom (fatigue)

Cognition/Concentration: reduced cognition and/or difficulty concentrating

Appetite (weight loss): usually declined, occasionally increased

Psychomotor: agitation (anxiety) or retardations (lethargic)

Suicide: preoccupation with death

Morbid Obesity and Protein-Calorie Malnutrition
Documentation and Coding Reference

OVERVIEW

Definition

Obesity: Morbid obesity is defined as a body mass index (BMI) greater than or equal to
- 40 kg/m^2, or
- 35 kg/m^2 with obesity related health conditions or comorbidities including, but not limited to, diabetes, hypertension or obstructive sleep apnea.

Diagnosis code assignment is based on the provider's clinical judgment and corresponding medical record documentation of the specific obesity condition.

Protein-Calorie Malnutrition: A form of malnutrition where there is inadequate calorie or protein intake. BMI less than 19 OR weight loss greater than or equal to 2% in one month, 5% in 3 months or 10% in 6 months.

Cachexia or "wasting syndrome": Loss of weight, muscle atrophy, fatigue, weakness and significant loss of appetite in someone who is not actively trying to lose weight. Normally seen in patients with conditions such as, but not limited to, cancer, AIDS, celiac disease, COPD, multiple sclerosis, RA, CHF and tuberculosis.

Causes/Risk Factors

- Physical inactivity
- Unhealthy diet
- Unhealthy eating habits
- Lack of adequate sleep

- Certain medications
- Certain medical conditions
- Genetics and family history
- Older age

Complications and Health Risks May Include

- Shortness of breath with activity and exertion
- Difficulty sleeping
- Back and joint pain
- High blood pressure and hypertension
- High cholesterol and triglycerides
- Type 2 diabetes mellitus

- Heart disease
- Stroke
- Kidney disease
- Sleep apnea
- Cancer
- Gallbladder disease

Prevention and Self-Management

- Nutritionally balanced diet
- Healthy eating habits

- Regular physical exercise
- Good sleep habits

PROVIDER'S DOCUMENTATION TIPS

Supporting Documentation

- Physical exam
- Calculation of height, weight and BMI documentation in progress notes or medical records

- Measurement of body fat percentage
- Measurement of waist circumference
- Evaluation of comorbid conditions

Specificity

Document condition to the highest level of specificity, as in morbid obesity, severe obesity, extreme obesity, protein-calorie malnutrition, etc.

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PROVIDER'S DOCUMENTATION TIPS

Abbreviations

Limit or avoid altogether the use of abbreviations or acronyms. Spell out each final diagnosis.

Associated Conditions

Document clear linkage between underlying conditions that caused the obesity, morbid obesity, overweight, or protein-calorie malnutrition condition; and between the BMI and other diagnoses for which the BMI has clinical significance.

Current Versus Historical

Do not describe a current obesity, morbid obesity, overweight or protein-calorie malnutrition, etc. diagnosis as "history of." In diagnosis coding, the phrase "history of" means the condition is historical and no longer exists as a current problem.

Summary

Physicians use multiple resources and criteria to define and diagnose obesity and/or protein-calorie malnutrition related conditions. BMI is a screening tool only. It is not the only criterion used to diagnose. Diagnosis code assignment is based on the physician's clinical judgment and corresponding medical record description of the specific condition.

CODER'S CODING TIPS

- If the patient's BMI results fall within the range listed below, be sure to file a claim with the appropriate Z code to capture the result through the claim.

- Z68.1 - Z68.45 are only applicable to adult patients 20 years of age or older.

- Z68.1 - Z68.45 are considered unacceptable as a principal diagnosis as it describes a circumstance that influences an individual's health status but not a current illness or injury, or the diagnosis may not be a specific manifestation but may be due to an underlying cause.

- To code one of the above BMIs, the associated diagnosis of overweight, obesity or morbid obesity must be documented in the progress note.

- If the member is in a wheelchair and unable to be weighed in the provider's office, then document "wheelchair bound" to support not being able to calculate a BMI.

- If the member refuses to be weighed, document as such.

Coding Example

Documentation	Diagnosis Codes
Vitals: Height 5 feet 5 inches, weight 270 lbs., BMI 44.9 Final Diagnosis: Obstructive sleep apnea and Pickwickian syndrome (obesity hypoventilation syndrome)	G47.33 Obstructive sleep apnea E66.2 Pickwickian syndrome Z68.41 Body mass index 40.0-44.9, adult

Morbid Obesity and Protein-Calorie Malnutrition
Documentation and Coding Reference

CODER'S CODING TIPS

Morbid Obesity

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
E66	Overweight and obesity	E66.0	Obesity due to excess calories
		E66.2	Morbid (severe) obesity with alveolar hypoventilation
Z68	Body mass index (BMI)	Z68.41	BMI 40.0-44.9, adult
		Z68.42	BMI 45.0-49.9, adult
		Z68.43	BMI 50.0-59.9, adult
		Z68.44	BMI 60.0-69.9, adult
		Z68.45	BMI 70 or greater, adult

BMI adult codes are for use for persons 20 years old of age or older

Protein-Calorie Malnutrition

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
E40	Kwashiorkor	No subcategory code	
E41	Nutritional marasmus	No subcategory code	
E42	Marasmic Kwashiorkor	No subcategory code	
E43	Unspecified severe protein-calorie malnutrition	No subcategory code	
E44	Protein-calorie malnutrition of moderate and mild degree	E44.0	Moderate protein-calorie malnutrition
		E44.1	Mild protein-calorie malnutrition
E45	Retarded development following protein-calorie malnutrition	No subcategory code	
E46	Unspecified protein-calorie malnutrition	No subcategory code	
E64	Sequelae of malnutrition and other nutritional deficiencies	E64.0	Sequelae of protein-calorie malnutrition
R64	Cachexia	No subcategory code	

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[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

Parkinson's and Huntington's Diseases
Documentation and Coding Reference

OVERVIEW

Definitions

Parkinson's: An incurable, progressive disorder of the nervous system that affects movement

Huntington's disease: A devastating inherited neurodegenerative disease characterized primarily by progressive motor, cognitive and psychiatric symptoms.

PROVIDER'S DOCUMENTATION TIPS

Supporting Documentation for Parkinson's

Document observations made during encounter including but not limited to:

- Resting tremor
- Rigidity
- Decreased facial expressions
- Handwriting changes
- Skin problems, such as dandruff
- Bradykinesia
- Asymmetric onset
- Speech changes
- Urinary problems
- Restless leg syndrome

Specify if primary Parkinson's (paralysis agitans, malignant neuroleptic syndrome) or secondary (identify cause)

- Drug induced (specify drug)
  - Malignant neuroleptic syndrome
  - Neuroleptic induced
- Due to other external agent (specify agent)
- Post encephalitic
- Vascular

No blood or lab test available to diagnose Parkinson's disease

- MRI/CT are used to rule out other disorders that cause similar symptoms
- Diagnosis is based on the doctor's examination that causes similar symptoms

Document and code for complications of Parkinson's disease as such:

- Dementia
- Depression
- Urinary complications
- Falls
- Psychosis
- Sleep disorders
- Constipation
- Neurology consultation

Supporting Documentation for Huntington's Disease

- Objective indicators: motor; cognitive, behavioral and psychiatric
- Labs
- Neurology consultation

Documentation Examples

Insufficient Documentation	Best Practice Documentation
Parkinson's	Primary Parkinson's disease treated with Levodopa.
Parkinson's	Drug–induced Parkinsonism due to metoclopramide used to treat diabetic gastroparesis

CODER'S CODING TIPS

Documentation	Diagnosis Code
Patient caregiver reports increase in falls related to Parkinsonism. Provided referral to occupational therapist for home safety evaluation. Final Diagnosis: Paralysis agitans	G20 Paralysis agitans

Parkinson's and Huntington's Diseases

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
G10	Huntington's disease	No subcategory code	
G20	Parkinson's disease	No subcategory code	
G21	Secondary Parkinsonism	G21.9	Secondary Parkinsonism, unspecified

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[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

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OVERVIEW

Definition

Diseases of the blood vessels outside the heart and brain are generally referred to as "peripheral vascular disease" (PVD). These diseases, over time, cause occlusion of the peripheral blood vessels. The most prevalent peripheral vascular disease is known as peripheral arterial disease. The most prevalent type of peripheral venous disease is deep vein thrombosis (DVT), or deep venous thrombus.

Signs and Symptoms (usually lower extremities)

- Most common symptom of PVD is intermittent claudication (pain or discomfort in the lower extremities and buttocks that occurs with exercise/activity and resolves with rest)
- Diminished pulses in legs or feet
- Decreased blood pressure in the affected limb(s)
- Arterial bruits (a whooshing sound heard with a stethoscope over the artery)
- Ulceration and sores with poor healing
- Discoloration of skin (bluish, dusky)
- Decreased warmth in the lower extremities

Diagnostic Tools

- Medical history and physical exam
- Ankle-brachial index (ABI) test (compares blood pressures of the ankle and arm)
- Laboratory testing (e.g., blood testing for elevated cholesterol or diabetes)
- Ultrasound of the lower extremities (angiography of the arteries of the lower extremities)

Causes and Factors

- Atherosclerosis
- Diabetes mellitus
- Smoking
- Hyperlipidemia
- Heart disease
- High blood pressure
- Obesity

PROVIDER'S DOCUMENTATION TIPS

- If known, document the cause of the peripheral arterial disease, as well as any complication (e.g., PAD due to diabetes with ulcer lower leg)
- Always document the current status of this condition, i.e. stable, improved, worsening.
- Other common symptoms that, if present on examination, you would include in your documentation are:
    - Diminished pulses to the leg or foot
    - Discoloration of skin
    - Decreased warmth
- Pain in affected extremity. Do not document current peripheral vascular disease as "history of". CMS and ICD-10-CM guidelines interpret "history of" to mean the condition is historical and is no longer present.

Diabetes with Peripheral Arterial Disease or Peripheral Vascular Disease

- With a diagnosis of diabetic vascular disease, the record must **clearly link the vascular disease to diabetes** as the cause (language such as "diabetic", "with", "due to", etc.).

- Code assignment depends on the medical record description of the specific type of diabetes mellitus and the specific type of vascular disease.

PROVIDER'S DOCUMENTATION TIPS

- When documenting ulcers (L97.-) and pressure ulcers (L89.-), it is important not to document them as "wounds," "open wounds" or "lesions".

- Always specify the location of each ulcer as well as indicate the stage of the pressure ulcer.

CODER'S CODING TIPS

- "Peripheral arterial disease," "peripheral vascular disease" and "intermittent claudication" are coded to I73.9.
  - Atherosclerosis of the native arteries of the extremities classifies to subcategory I70.2. An additional code is used, if applicable, to identify chronic total occlusion of artery of extremity (I70.92).

Diabetes with Peripheral Arterial Disease or Peripheral Vascular Disease

- Code diabetes mellitus from categories E08 – E13 as follows:
  - E08 Diabetes mellitus due to underlying cause (code first the underlying condition)
  - E09 Drug or chemical induced diabetes mellitus (code first the drug or chemical)
  - E10 Type 1 diabetes mellitus
  - E11 Type 2 diabetes mellitus
  - E13 Other specified diabetes mellitus

- Fourth and fifth characters represent diabetic peripheral angiopathy with and without gangrene are required:
  - .51 diabetic peripheral angiopathy without gangrene
  - .52 diabetic peripheral angiopathy with gangrene
  - .59 other circulatory complications (diabetes mellitus with circulatory (vascular) complication not specified as peripheral)

- Diabetes mellitus can cause circulatory or vascular complications that are not peripheral. For example:
  - Cerebrovascular atherosclerosis, meaning atherosclerosis of the blood vessels within the brain; or
  - Coronary artery atherosclerosis, meaning atherosclerosis of the blood vessels in the heart

Atherosclerosis/Arteriosclerosis/Stenosis

- Atherosclerosis of the aorta without further specification classifies to code I70.0.
- Atherosclerosis of the aortic valve without further specification classifies to code I35.8.
- Sclerosis
  - Sclerosis of the aorta without further specification classifies to code I70.0.
  - Sclerosis of the aortic valve without further specification classifies to code I35.8.
- Stenosis
  - Stenosis of the aorta without further specification classifies to code Q25.1 (coarctation of aorta > coarctation of aorta (preductal) (postductal) > stenosis of aorta
- When a record documents a current condition of "aortic atherosclerosis" with no other description or specification, this condition should be classified to code I70.0 unless there is documentation that leads the coder to suspect it is the aortic valve and not the aorta that is affected.

Notes on Code I70

- I70.22: Includes intermittent claudication site, stable or monitor.
- I70.24: Identify ulcer severity with code L97.
- I70.25: Identify ulcer severity with code L98.49.
- I70.26: Includes any or all preceding conditions. Use additional code for ulcer severity identification.

CODER'S CODING TIPS

Coding Example

Documentation	Diagnosis Codes
PAD due to diabetes with ulcer of lower leg	E11.51 Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene L97.909 Ulcer of lower limbs, except pressure ulcer, unspecified

Vascular Disease

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
I70	Diseases of arteries, arterioles and capillaries	I70.0	Atherosclerosis of aorta
		I70.20	Unspecified atherosclerosis of native arteries of extremities
		I70.21	Atherosclerosis of native arteries of extremities with intermittent claudication
		I70.22[2]	Atherosclerosis of native arteries of extremities with rest pain
		I70.23	Atherosclerosis of native arteries of right leg with ulceration
		I70.24[3]	Atherosclerosis of native arteries of left leg with ulceration
		I70.25[4]	Atherosclerosis of native arteries of other extremities with ulceration
		I70.26[5]	Atherosclerosis of native arteries of extremities with gangrene
I72	Other aneurysm	I72.9	Aneurysm of unspecified site
I73	Other peripheral vascular diseases	I73.9	Peripheral vascular disease, unspecified
I77	Other disorders of arteries and arterioles	I77.1	Stricture of artery
		I77.8	Other specified disorders of arteries and arterioles
I79	Disorders of arteries, arterioles and capillaries in diseases classified elsewhere	I79.8	Other disorders of arteries, arterioles and capillaries in diseases classified elsewhere
I80	Phlebitis and thrombophlebitis	I80.209	Phlebitis and thrombophlebitis of unspecified deep vessels of unspecified lower extremity
I82	Other venous embolism and thrombosis	I82.409	Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity
		I82.509	Chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity

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[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

OVERVIEW

Definition

Rheumatoid arthritis (RA) is a chronic, systemic inflammatory disorder that primarily affects the joints, causing pain, swelling and stiffness. It is an autoimmune disease in which the body's immune system attacks the body's own tissues. RA usually begins after age 40, but it can occur at any age.

Polymyalgia rheumatica (PMR) is a syndrome with pain or stiffness, usually in the neck, shoulders, upper arms and hips, but which may occur all over the body. The pain can be very sudden or can occur gradually over a period of time coded as polymyalgia rheumatica M35.3.

Signs and Symptoms

Some people who have this disease experience periods in which symptoms get worse (flares) and other times when they get better (remissions). Others have a severe form of the disease that is active most of the time, lasts for many years or a lifetime and leads to serious joint damage and disability. Symptoms may include:

- Joint pain, warmth, redness and swelling
- Joint stiffness in the morning or after inactivity that can last for hours
- Fatigue
- Occasional fever
- Firm lumps (called rheumatoid nodules) that grow under the skin close to affected joints
- Loss of appetite and weight loss

PROVIDER'S DOCUMENTATION TIPS

Supporting Documentation

Best DMARD therapy documentation practices include:

- Specific details regarding current DMARD therapy in the treatment plan section of the record (not simply the medication list) and clear linkage of the medication to the diagnosis of rheumatoid arthritis; or
- Specific information describing any contraindication to DMARD therapy; or
- A notation that rheumatoid arthritis is inactive; or
- A statement of patient refusal of DMARD therapy and the reason for refusal.

Documentation Tips

- Document onset, frequency and severity of symptoms

- For rheumatoid arthritis, document the joint(s) affected, progression and any deformities, if applicable

- Capture test results used to confirm diagnosis

- Remember to document and code for associated complications

- Treatment used to control symptoms and/or prevent joint damage should be documented such as: DMARD (disease-modifying antirheumatic drug) therapy for rheumatoid arthritis.

- Osteoarthritis is the most common form of arthritis. Rheumatoid arthritis affects only about one-tenth as many people as osteoarthritis. The main difference between osteoarthritis and rheumatoid arthritis is the cause behind the joint symptoms.
  - Osteoarthritis is caused by mechanical wear and tear on joints.
  - Rheumatoid arthritis is a systemic autoimmune disease. "Systemic" means the condition affects the entire body. "Autoimmune" means the body's own immune system mistakenly attacks the body's joints, causing inflammation and joint damage.

PROVIDER'S DOCUMENTATION TIPS

Comparison of Rheumatoid Arthritis and Osteoarthritis

	Rheumatoid Arthritis	Osteoarthritis
Age of onset	May begin at any time in life	Usually begins later in life
Speed of onset	Relatively rapid, over weeks to months	Slow, over years
Joint symptoms swelling	Pain, swelling, stiffness	Achiness and tenderness, but little or no
Pattern of joints affected	Often affects small and large joints on both sides of the body (symmetrical), such as both hands, both wrists or elbows, or balls of both feet	Often begins on one side of the body and may spread to the other side. Symptoms begin gradually and are often limited to one set of joints, usually the finger joints closest to the fingernails or thumbs, large weight-bearing joints (hips, knees) or the spine.
Duration of morning Stiffness	Longer than one hour	Less than one hour – returns at the end of the day or after periods of activity
Presence of symptoms affecting the whole body (systemic)	Frequent fatigue and a general feeling of being ill	Whole body symptoms are not present

CODER'S CODING TIPS

Differential Diagnosis Guide

- Inflammatory arthritis involving 3 or more joints
- Positive RF testing
- Elevated levels of CRP or ESR
- Diseases with similar features have been excluded (psoriatic arthritis, acute viral polyarthritis, polyarticular gout, systemic lupus erythematosus, etc.)
- Symptoms greater than six weeks
- Rheumatology consultation
- As per the Rheumatology Association criteria for rheumatoid arthritis diagnosis

Coding Example

Documentation	Diagnosis Codes
Rheumatoid arthritis with polyneuropathy	M05.50 Rheumatoid arthritis with polyneuropathy
Inflammatory myopathy related to rheumatoid arthritis	M05.40 Inflammatory myopathy related to rheumatoid arthritis

Rheumatoid Arthritis and Inflammatory Connective Tissue Disease

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
M05	Rheumatoid arthritis with rheumatoid factor	M05.9	Rheumatoid arthritis with rheumatoid factor, unspecified
M06	Other rheumatoid arthritis	M06.9	Rheumatoid arthritis, unspecified

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[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

Specified Heart Arrhythmias
Documentation and Coding Reference

OVERVIEW

Definitions

Paroxysmal atrial fibrillation: Begins suddenly and stops on its own. Symptoms range from mild to severe; can last seconds, minutes, hours or days; and can occur intermittently.

Persistent atrial fibrillation: Persists and does not terminate on its own within seven days. Often requires pharmacologic or electrical cardioversion to restore normal rhythm.

Longstanding persistent: Persistent and continuous atrial fibrillation lasting more than twelve months.

Permanent atrial fibrillation: Persistent or longstanding persistent atrial fibrillation where cardioversion cannot or will not be performed or is not indicated. This term is used to identify patients with persistent atrial fibrillation where a join decision has been made by the patient and clinician to no longer pursue a rhythm control strategy.

Chronic atrial fibrillation: May refer to any persistent, longstanding persistent or permanent atrial fibrillation. However, in clinical practice, use of one of the more specific descriptive terms is preferred over the use of the nonspecific term chronic atrial fibrillation.

Chronic persistent atrial fibrillation: Has no widely accepted clinical definition or meaning. AHA Coding Clinic advises to code this description to "Other persistent atrial fibrillation" (code I48.19).

Signs and symptoms

- Palpitations (sensations of a racing, irregular heartbeat or a pounding or flopping in the chest)
- Decreased blood pressure
- Weakness or fatigue
- Lightheadedness
- Chest pain

Possible Causes

- High blood pressure
- Heart attacks
- Abnormal heart valves
- Congenital heart defects
- Stimulants, such as medications, caffeine, tobacco or alcohol
- Emphysema or other lung diseases
- Stress related or other illnesses
- Sleep apnea

PROVIDER'S DOCUMENTATION TIPS

Documentation Tips

- Document if the patient is on medication for a specified heart arrhythmia or has a pacemaker
- Even though the arrhythmia may be controlled by a pacemaker or by meds it should still be documented and coded

Important Tests to Capture in Documentation

- Electrocardiogram
- Event monitor
- Cardia CT
- Stress test
- Electrophysiologic study
- Holter monitor
- Echocardiogram
- MRI
- Tilt table test
- Cardiology consultation

CODER'S CODING TIPS

Coding Tips

- Even though the arrhythmia may be controlled by a pacemaker or by meds it should still be documented and coded
- Patients who were converted to normal sinus rhythm (NSR) from atrial fibrillation and remain on medication to maintain NSR should still be coded as atrial fibrillation (I48.91), provided the condition has been evaluated and is listed in the final diagnostic statement
  - Rationale: Patient requires ongoing medication for control of this condition. Treatment with ongoing medication should be clearly documented (e.g. atrial fibrillation stable on…).
- If treatment of A-fib includes chronic use of anticoagulants such as warfarin (except aspirin), code also Z79.01 (Long-term current use of anticoagulants)

Coding Examples

Documentation	Diagnosis Codes
Patient with chronic atrial fibrillation, rate controlled with beta blocker, with stable congestive heart failure. Remains on chronic warfarin, INR therapeutic.	I48.20 Chronic atrial fibrillation I50.9 Congestive heart failure Z79.01 Long-term (current) use of anticoagulants
Successful cardioversion of atrial fibrillation one month ago, stable on amiodarone and remains in normal sinus rhythm	I48.91 Atrial fibrillation

Specified Heart Arrhythmias

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
I44	Atrioventricular and left bundle-branch block	I44.2	Atrioventricular block, complete
I47	Paroxysmal tachycardia	I47.1	Supraventricular tachycardia
		I47.2	Ventricular tachycardia
		I47.9	Paroxysmal tachycardia, unspecified
I48	Atrial fibrillation and flutter	I48.2	Chronic atrial fibrillation
		I48.91	Unspecified atrial fibrillation
		I48.92	Unspecified atrial flutter
I49	Other cardiac arrhythmias	I49.5	Sick sinus syndrome (sinoatrial node dysfunction)

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[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

OVERVIEW

Definitions

According to American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5):

> Substance use disorder occurs when a person's use of alcohol or another substance (drug) leads to health issues or problems at work, school or home. The term "substance use" refers to the use of drugs or alcohol and includes substances such as cigarettes, illegal drugs, prescription drugs, inhalants and solvents. A substance use problem occurs when using alcohol or other drugs causes harm to you or to others. Substance use problems can lead to addiction.

World Health Organization:

- Substance abuse: The harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.
- Substance dependence: A cluster of behavioral, cognitive and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance and sometimes a physical withdrawal state.

Diagnostic Criteria

The DSM-5 manual advises the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance (such as using the substance for longer than intended; or a persistent desire to cut down or regulate the substance use or multiple unsuccessful attempts to decrease or discontinue use).

In total, the DSM-5 outlines 11 specific criteria for diagnosing a substance use disorder and allows clinicians to specify the severity of the disorder as follows:

- Mild: 2-3 criteria met
- Moderate: 4-5 criteria met
- Severe: 6 or more criteria met

NOTE: The purpose of this guideline is to address medical record documentation and diagnosis coding. In-depth diagnostic criteria are outside the scope of this document. Healthcare providers must consult the DSM-5 manual – which is the gold standard - for detailed information related to diagnostic criteria for substance use disorders.

Substance Use Disorders and Mental Health Problems

Mental health problems and substance use disorders sometimes co-exist for the following reasons:

- Mental health problems and substance use disorders share some underlying causes.
- Some people with mental health problems may turn to substance use to self-medicate.
- Use of certain substances can cause people with addiction to experience mental health issues.

Signs and Symptoms

Signs and symptoms are variable, depending on the particular substance being used. Examples include:

- Slurred speech
- Alcohol odor on breath
- Enlarged liver
- Nasal irritation

- Mild tremor
- Marijuana odor on clothing
- Dilated or small "pinpoint" pupils
- Needle marks

Treatment

- Individual, family and group counseling
- Support groups and 12-step programs (Alcoholics Anonymous, Narcotics Anonymous, etc.)
- Inpatient and outpatient rehabilitation programs
- Treatment of underlying medical conditions
- Medications

PROVIDER'S DOCUMENTATION TIPS

Supporting Documentation

- Document: substance, start date, quantity, frequency of use and specify if abuse or dependence

- A person may abuse drugs or alcohol but not be dependent on them; the provider must clearly document the condition.

- Signs of physical damage caused by abuse/dependence (liver damage, weight loss, etc.)

- Substance use disorders (e.g., anxiety, depression, sleep disorder, etc.) span a wide variety of problems arising from substance use and cover 11 different criteria:
  - Taking the substance in larger amounts or for longer than you meant
  - Wanting to cut down or stop using the substance but not managing to
  - Spending a lot of time getting, using or recovering from use of the substance
  - Cravings and urges to use the substance
  - Not managing to do what you should at work, home or school, because of substance use
  - Continuing to use, even when it causes problems in relationships
  - Giving up important social, occupational or recreational activities because of substance use
  - Using substances again and again, even when it puts you in danger
  - Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance
  - Needing more of the substance to get the effect you want (tolerance)
  - Development of withdrawal symptoms, which can be relieved by taking more of the substance

- Use additional code(s) to identify presence of:
  - Alcohol use, abuse or dependence, including in remission
  - Tobacco use or dependence, including history of use
  - Hypertension

- The DSM 5 (Diagnostic and Statistical Manual of Mental Disorders) allows clinicians to specify how severe the substance use disorder is depending on how many symptoms are identified.

This Number of Symptoms…	Indicate This Severity of Substance Use Disorder
2-3	Mild
4-5	Moderate
6 or more	Severe

- Clinicians can also add "in early remission", "in sustained remission", "on maintenance therapy" and "in a controlled environment".

PROVIDER'S DOCUMENTATION TIPS

Specificity

Avoid vague diagnosis descriptions, e.g., "other" or "unspecified." Document each condition to the highest level of specificity, including the following as appropriate:

- Remission – partial or full, early or sustained
- Specific substance involved and whether there is use versus abuse versus dependence
- All related symptoms/conditions, such as with intoxication, psychotic behavior, sleep disturbance, withdrawal, etc.

Followed by a Different Provider

When a substance use disorder is being followed and managed by a different provider, it is still appropriate to include the diagnosis in the final assessment when the condition has impact on patient care, treatment and management.

Example: "Opioid dependence in sustained remission per records from his treating psychiatrist, Dr. James Milner."

CODER'S CODING TIPS

- Substance use disorders are classified in Chapter 5: Mental, Behavioral and Neurodevelopmental disorders.

- Always report the most specific code the medical record supports

- Remember to code the alcohol or drug use with any alcoholic or drug induced disorders (e.g., Anxiety, depression, sleep disorder, etc. or Opioid use with sleep disorder) if applicable

Remission

- Selection of codes for "in remission" requires the provider's clinical judgment. Coders are not allowed to clinically interpret documented time frames to decide on their own that the condition is in remission. The appropriate codes for "in remission" are assigned only on the basis of specific provider's documentation (as defined in the official guidelines for coding and reporting), unless otherwise instructed by the classification or the coding path leads to remission.

- Mild substance use disorders in early or sustained remission are classified to the appropriate codes for substance abuse in remission.

- Moderate or severe substance use disorders in early or sustained remission are classified to the appropriate codes for substance dependence in remission.

Use, Abuse and Dependence Hierarchy:

Documented Pattern of Use	Assign only the code for
Use and abuse	Abuse
Abuse and dependence	Dependence
Use, abuse and dependence	Dependence
Use and dependence	Dependence

CODER'S CODING TIPS

Coding Examples

Documentation	Diagnosis Codes
32-year-old white male presents with complaints of irritability, nervousness and insomnia. States he has lost his appetite and has lost 5 pounds in the last two weeks. Admits he has been a regular marijuana smoker since age 16. His wife has been upset about his marijuana use; so he stopped cold turkey about 2 ½ weeks ago. Final Diagnosis: Marijuana use withdrawal	F12.93 Cannabis use, unspecified with withdrawal Note: Code F12.93 is used to report cases of physiological withdrawal from cannabis occurring in a person who is using cannabis regularly but not described as cannabis dependence.
25-year-old female was admitted to inpatient facility for acute respiratory failure due to Percocet abuse with intoxication. The acute respiratory failure and Percocet intoxication resolved after treatment; and she is now being transferred to an inpatient drug rehabilitation facility for treatment of Percocet abuse. Final Diagnosis: Acute respiratory failure due to Percocet abuse with intoxication	96.00 Acute respiratory failure, unspecified whether with hypoxia or hypercapnia F11.129 Opioid abuse with intoxication, unspecified

Drug/Alcohol Dependence, Abuse and Psychosis

ICD-10-CM Category Code	Category Code Description	Subcategory Code[1]	Description
F10	Alcohol related disorders (abuse, dependence, use)	F10.1	Alcohol abuse
		F10.11	Alcohol use disorder, mild
		F10.2	Alcohol dependence
		F10.9	Alcohol use, unspecified
F11	Opioid related disorders (abuse, dependence, use)	F11.1	Opioid abuse
		F11.11	Opioid abuse, in remission
		F11.2	Opioid dependence
		F11.9	Opioid use, unspecified
F13	Sedative, hypnotic or anxiolytic related disorders (abuse, dependence, use)	F13.1	Sedative, hypnotic or anxiolytic- related abuse
		F13.11	Sedative, hypnotic or anxiolytic abuse, in remission
		F13.2	Sedative, hypnotic or anxiolytic- related dependence
		F13.9	Sedative, hypnotic or anxiolytic- related use, unspecified
Z51	Encounter for other aftercare	Z51.81	Encounter for therapeutic drug level monitoring
Z79	Long-term (current) drug therapy	Z79.891	Long-term (current) use of opiate analgesic

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[1]Numerous additional codes associated with this category are not listed here. The primary code has been listed; please refer to the ICD-10 Official Guidelines for more specific coding.

References

2020 ICD-10-CM Guidelines - CDC

https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases.

American Academy of Professional Coders

https://www.aapc.com/

Medical coding guidelines

American College of Cardiology

https://www.acc.org/

The American College of Cardiology, a 49,000-member nonprofit medical society, is dedicated to enhancing the lives of cardiovascular patients.

American Hospital Association

www.aha.org/

The Association represents hospitals, healthcare networks and their patients and communities.

Center for Medicare & Medicaid Services

https://www.cms.gov/

US federal agency that administers Medicare, Medicaid, age 65 and older
FY 2020 V24 HCC Model

Department of Health and Human Services

https://www.hhs.gov/

The U.S. Department of Health and Human Services (HHS) age 0 to 64
FY 2020 127 HCC Model

National Cancer Institute

https://www.cancer.gov/

Current cancer information from the U.S. National Cancer Institute

National Heart, Lung, and Blood Institute (NHLBI)

https://www.nhlbi.nih.gov/

The National Heart, Lung, and Blood Institute (NHLBI) provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals.

National Institute of Arthritis and Musculoskeletal and Skin Diseases

https://www.niams.nih.gov/

The mission of the National Institute of Arthritis and Musculoskeletal and Skin Diseases is to support research into the causes, treatment and prevention of arthritis and musculoskeletal and skin diseases.

The National Kidney Foundation

https://www.kidney.org/

Dedicated to the awareness, prevention and treatment of kidney disease, the NKF helps those who care for, suffer from and are at risk of kidney disease.

WebMD

www.webmd.com/

A source for health and medical news and information.