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ICD-10–CM Documentation Guidelines

The Comprehensive Review Form (CRF) was designed as stand-alone documentation and to work with ICD-10 Rules.

- All diagnoses must be addressed and documented at least annually.
- All chronic and pertinent historical diagnoses should be brought forward on the CRF, including those from specialists.
- If a diagnosis affects the physicians' care, treatment or medical decision making, it is appropriate to report, even if you are not the treating physician. Include a diagnosis for all medications.
- Documentation such as: probable, possible, rule out, working diagnosis, or suspected **cannot be coded or billed** in the office setting, and are instead coded back to the presenting symptom.
- Cancer: if not being treated, is documented as a "history of…"
- COPD on continuous O2, review for Chronic Respiratory Failure diagnosis to further support the O2.
- Alcoholism/drug addiction/drug dependence, **document it**. If in remission, also document the remission.
    - Don't use the term "abuse" when tolerance and withdrawal are observable, or would require clinical management.
- Strokes: Once the acute phase is over and there are **NO** residuals, document as "HISTORY of CVA".
    - Do not bill acute stroke codes in the office setting.
- For residuals from a stroke, document as residuals/Late Effects/Sequelae due to the CVA (H/o CVA w/Hemiplegia).
- Morbid Obesity must be documented (BMI 40+).
- Diabetes: 3 in 5 diabetics have complications/manifestations/sequelae.
    - Diabetes with manifestations is often not documented or linked appropriately.
- "Linking" is established in the documentation for correct coding to occur. Use terms like: 2nd to, due to, caused by, or manifestation of. The use of "and" or "probably", etc. does not create an etiology/manifestation link.

Linking, Poor Examples: Linking cannot be assumed by the coder for the assessment below, and when coded, it demonstrates a lower acuity level for your patient:

1. Diabetes
2. HTN
3. Retinopathy
4. PVD
5. CKD 4/Nephropathy
6. CHF

Linking, Good Examples: When linked as in the documentation below, conditions can be coded to a higher acuity:

Diabetic neuropathy

Diabetic Background Retinopathy and hypertensive retinopathy

Diabetes with Vascular complications (PVD due to Diabetes)

CKD 4/nephropathy secondary to DM and HTN

Hypertensive Heart Disease with Heart Failure and CKD 4/nephropathy

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ICD-10 DOCUMENTATION HINTS

Code all documented conditions which coexist at the time of the visit that require or affect patient care, management, or treatment, whether or not you are the treating physician.

- **DOCUMENT AT LEAST ONCE A YEAR:**
  - Active status conditions such as **amputations & ostomies**
  - All conditions requiring medication
  - Chronic conditions such as **CHF, DM, & COPD**
  - Conditions that affect the patient's day to day life
  - Pertinent past conditions such as **old MI & major organ transplant**

- **DOCUMENTATION AND CODES MOST OFTEN MISSED ARE:**
  - Abdominal aortic aneurysm – code I71.4
  - Cachexia – code R64
  - Chronic hepatitis C - code B18.2
  - Drug or alcohol dependency in remission – codes F19.21/F10.21
  - Pulmonary hypertension – category I27
  - Respirator dependence – code Z99.11
  - Skin ulcers - categories L97-L98
  - Tracheostomy Status –code Z93.0

- **DOCUMENT CAUSAL RELATIONSHIPS.** For an example, an office note that documents DM and nephropathy separately doesn't code as "diabetic nephropathy" or nephropathy secondary to or due to DM, it is not assumed they are related conditions. They must be documented as diabetic nephropathy or nephropathy secondary to DM, etc.

- **DOCUMENT RESIDUALS/SEQULAE OF PAST CVA'S.** Following an inpatient discharge, documentation should reflect a past history of CVA and all residuals/sequelae should be documented as such, including hemiparesis, aphasia, dysphagia, etc. Documentation should state the specific residual is secondary to or due to a prior CVA, and include information indicating laterality as needed e.g. hemiplegia, right side.

- **DOCUMENTATION SHOULD BE SPECIFIC (WHEN APPLICABLE):**
  - Atrial Fibrillation, not cardiac dysrhythmia
  - Chronic bronchitis, not bronchitis
  - COPD and asthma, not asthma
  - Major depression or recurrent depression, not depression
  - Malnutrition, not loss of weight

- **DON'T DOCUMENT A "PAST HISTORY OF" ANY DISEASE THAT CURRENTLY EXISTS.** The statement "History of" in ICD-10 terms means that the patient no longer has the condition. Diagnoses documented as history of for diabetes, CHF, or COPD are not correct in most cases.

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Chronic Kidney Disease (CKD)

The National Kidney Foundation (NKF) recommends the MDRD study equation to estimate the Glomerular Filtration Rate (GFR), as the best overall index of kidney function. The GFR is based on age, gender and race, and can be calculated from lab tests such as the Basic Metabolic Panel, Serum Creatinine and BUN. The NKF provides a GFR calculator on their website: http://www.kidney.org/professionals/kdoqi/gfr_calculator.cfm.

Chronic Kidney Disease is defined as either:

1. Kidney damage - pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests or imaging studies.

OR

2. Glomerular Filtration Rate (GFR) < than 60 mL/min/1.73m for > than 3 months.

The code assignments, describe the different stages in the progression of Chronic Kidney Disease. The new staging system is based on estimates of the glomerular filtration rate at each stage, with each stage defined by level of kidney function. Higher stages represent lower GFR levels.

CHRONIC KIDNEY DISEASE (CKD) STAGES

N18.1 - Chronic Kidney Disease, Stage I
- GFR 90mL/min or more
- Healthy kidneys or some kidney damage with normal or slightly increased GFR
- Plenty of Kidney function but may have protein or albumin in their urine.

N18.2 - Chronic Kidney Disease, Stage II Mild
- GFR 60-89mL/min
- Kidney damage and mild decrease in GFR

N18.3 - Chronic Kidney Disease, Stage III Moderate
- GFR 30-59 mL/min
- Moderate decrease in GFR

N18.4 - Chronic Kidney Disease, Stage IV Severe
- GFR 15-29 mL/min
- Severe decrease in GFR

N18.5 - Chronic Kidney Disease, Stage V
- GFR less than 15 mL/min,
- Excludes those requiring chronic dialysis **(N18.6)**
- Kidney Failure

N18.6 - End Stage Renal Disease
- End-stage renal disease (ESRD) is an administrative term in the U.S. based on conditions for payment by Medicare's ESRD program.
- ESRD includes patients treated by dialysis or transplantation, irrespective of the level of GFR.
- Requires chronic dialysis

N18.9 - Chronic Kidney Disease, Unspecified
- Includes: Chronic Renal Disease, Chronic Renal Failure NOS, Chronic Renal Insufficiency, Chronic Uremia

In addition, for CKD Stage V and ESRD, also code Renal Dialysis Status (Z99.2), if applicable.

ICD-10-CM instructs the coder to use an additional code to identify Kidney Transplant Status if applicable (Z94.0). A kidney transplant may not fully restore kidney function; therefore, patients who have undergone a kidney transplant may still have some form of Chronic Kidney Disease. Code Z94.0, Kidney replaced by transplant, may be assigned **with** the appropriate CKD code, based on the patient's post-transplant stage.

Patients who have had a kidney transplant, where documentation indicates the presence of failure or rejection, assign category, T86.1, Complication of kidney transplant followed by the appropriate CKD code.

http://kidneynotes.blogspot.com/2005/10/chronic-renal-failure-is-no-more-new.html Sources: Renal Physicians Foundation, National Kidney Foundation K/DOQI Clinical Practice Guidelines for Chronic Kidney Disease: Evaluation, Classification, and Stratification 3/06

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Chronic Obstructive Pulmonary Disease (COPD)

Obstructive lung disease is a chronic or recurrent reduction in expiratory airflow within the lung, commonly characterized by irreversible airflow limitations. Since respiratory conditions often overlap or exacerbate one another, physician documentation is critical to proper coding of Obstructive Lung Disease. The complexity of a patient's disease may be missed if the physician only documents "COPD" or "Asthma" in the patient record.

Overlapping nature of the conditions that comprise COPD and Asthma

Due to the overlapping nature of the conditions that make up COPD and asthma, there are many variations in the way these conditions are documented in the patient record. **Code selection must be based on the terms as documented**.

COPD and Asthma – J44.9, J45.909

- COPD, code J44.9, Chronic Airway Obstruction, Not Otherwise Specified, is a non-specific code that should only be used when the documentation does not specify the type of COPD being treated.
- Asthma codes are under category J45. Specific documentation is important since "Asthma" carries no risk adjustment. However, "Chronic Obstructive Asthma" does risk, as this maps to COPD, J44.9 and Asthma, J45.909.

Acute Exacerbation of Chronic Obstructive Bronchitis and Asthma – J44.1, J45.909

It is necessary to distinguish uncomplicated cases and those with an acute exacerbation so-stated in the documentation. Acute exacerbation is a worsening or a decompensation of a chronic condition, and is NOT equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.

Acute Exacerbation of Asthma and Status Asthmaticus – Category J45

An acute exacerbation of asthma is an increased severity of asthma symptoms. Status asthmaticus is a patient's failure to respond to therapy administered during an asthmatic episode and is a life threatening complication requiring emergency care. Asthma is classified into category J45 with a fourth character indicating the severity and a final character indicates complications for when status asthmaticus or exacerbation is present. When both are present, only code status asthmaticus.

Acute Bronchitis with COPD – J20.9, J44.0

Acute Bronchitis, code J20.9, is due to an infectious organism; however when Acute Bronchitis is documented as COPD, Obstructive Chronic Bronchitis w/ Acute Bronchitis, codes J20.9 and J44.0 are assigned. If a medical record documents Acute Bronchitis with COPD w/ Acute Exacerbation, codes J20.9, J44.0, and J44.1 are assigned.

Chronic Respiratory Failure – J96.10 - J96.12

Chronic Respiratory Failure is reported as a separate diagnosis. ICD-10-CM also requires coders to capture manifestations of Chronic Respiratory Failure (i.e., with hypoxia or hypercapnia), and these manifestations are included in the code descriptions for Respiratory Failure. Code J96.11 is Chronic Respiratory Failure with Hypoxia and J96.12 denotes Chronic Respiratory Failure with Hypercapnia.

Tracheostomy Status / Respirator Status

Status codes indicate that a patient has residuals of a past disease or condition. To report current Tracheostomy status, use code Z93.0, and the Dependence on Respirator status code is Z99.11.

Signs and Symptoms

Do not code signs and symptoms such as wheezing, cough, or shortness of breath when a confirmed diagnosis of COPD is also reported.

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STROKE AND LATE EFFECTS OF PRIOR STROKE

One of the most **common coding errors** seen in chart audit is the assignment of an acute stroke code when the coder is actually trying to code for the residual conditions left behind by a prior stroke. Acute stroke is only coded during the **initial** episode of care. After the initial episode, Late Effects or Personal History codes should be used, and the physician should document the patient record accordingly.

CEREBROVASCULAR ACCIDENTS (STROKE)

In a CVA, there is a decreased supply of blood to the brain that can result in an area of infarction (necrotic cerebral tissue). CVA occurs because of thrombosis, embolism, occlusion, hemorrhage (code category I63).

- There are codes for each type of CVA.
- Unless otherwise stated, CVA/stroke is considered an assumed ischemic infarction, and is coded **I63.9.**

POST-OPERATIVE CEREBROVASCULAR HEMORRHAGE OR INFARCTION

A post-operative cerebrovascular hemorrhage or infarction that occurs as a result of medical intervention is coded I97.820, Following Cardiac Surgery or I97.821, Following Other Surgery.

AFTER THE INITIAL ACUTE CARE EPISODE OF STROKE

After an initial stroke incident has occurred, generally one of two scenarios will exist. Either the patient will have deficits from the stroke (conditions left behind, such as paralysis) or will make a recovery without any long lasting effects.

If the patient recovers **without any lingering problems related to the stroke**, the code would be **Z86.73,** Personal History of Transient Ischemic Attack (TIA) and Cerebral Infarction without residual deficits.

- **Do not use the history code in conjunction with the late effects (sequelae) codes.**
- If after discharge from the initial acute care episode the patient has deficits present, code all deficits to **Sequelae** (Category I69).
- For sequelae where the ICD10 code choice is affected by laterality, the physician should document in the record:
  - Left/right, upper/lower limb, and dominant/non-dominant side.

SOME EXAMPLES		
Example 1:	Stroke, initial incident; CVA	I63.9
Example 2:	Prior stroke with no deficits (history of CVA)	Z86.73
Example 3:	Stroke, initial incident with deficits from **prior** stroke. Acute embolic CVA with infarction; previous CVA with residual dysphagia	I63.40, I69.391
Example 4:	Office visit follow-up for evaluation of hemiplegia due to a CVA one month earlier	I69.35x
Example 5:	Office visit follow-up for evaluation of cognitive deficits and aphasia from prior CVA	I69.31, I69.320
Example 6:	The patient suffered a post-operative stroke following cardiac surgery; acute embolic CVA with infarction	I97.820, I63.40

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DIABETIC CKD & NEPHROPATHY

Physicians know they should routinely check for microalbuminuria in patients with long-standing diabetes. But when a microalbumin level is persistently abnormal, they do not always document the diagnosis of diabetic nephropathy, and instead simply write "diabetes with microalbuminuria". The resulting diagnosis is coded as uncomplicated diabetes and an abnormal lab test:

Physician documents:	Correct ICD-10 codes:	
"Diabetes with Microalbuminuria"	E11.9 – Uncomplicated Diabetes	R80.9 Proteinuria
"Diabetic Nephropathy"	E11.21 Diabetic Nephropathy	No additional code for nephropathy is coded

In addition, every patient who has or is suspected of having chronic kidney disease (CKD) should have the stage of CKD determined and documented. This can be easily done by estimating the glomerular filtration rate (eGFR) based on the patient's serum creatinine, age, gender, height, weight, and race. Some laboratories automatically do the calculation whenever you order a serum creatinine or a metabolic panel, while most others will do it if requested.

What is the correct way to diagnose, document, and then code diabetic nephropathy?

1) Start with a patient who has diabetes
2) Order lab tests at least annually for microalbuminuria, serum creatinine, and estimated GFR
3) Based on the results; determine if the patient has chronic kidney disease (CKD) and the stage of CKD: e.g. GFR = 30-59 mL/min/1.73m2 is consistent with Stage 3 CKD
4) Rule out causes of renal disease other than diabetes: e.g. medication induced
5) Document accurately and completely and submit the correct codes with your claim

The correct documentation and coding for a patient with diabetic nephropathy seen at least once each year might be:

Progress Note:	Diagnosis Codes:
Diabetes complicated by stage 3 CKD	E11.22, N18.3
End stage renal disease due to uncontrolled diabetes	E11.22, E11.65, N18.6

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Determining Major Depression

Do all of the following apply?

- The symptoms do not meet criteria for Mixed Episode (i.e., Major Depression and Mania).
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of concern.
- The symptoms are not due to the direct physiological effects of a substance.
- The symptoms are not better accounted for by bereavement.
- The patient has had symptoms present for the same two week period.

YES

Does at least one (1) of the following apply?

- Depressed mood most of the day, nearly everyday, as indicated by either subjective report (e.g., feels sad or empty) or observation made by other (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).

NO

Does not meet diagnosis criteria for Major Depression

YES

NO

Do at least four (4) of the following apply?

- Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
- 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).
- 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.

YES

Diagnosis of Major Depression may be assigned.

ICD-10 Diagnosis

Major Depression, Single	***or***	**Major Depression, Recurrent**
-Mild, F32.0		-Mild, F33.0
-Moderate, F32.1		-Moderate, F33.1
-Severe w/o psychotic features, F32.2		-Severe w/o psychotic features, F33.2
-Severe w/psychotic features, F32.3		-Severe w/psychotic features, F33.3
-In Remission:		-In Remission:
-In partial remission, F34.5		-In partial remission, F33.41
-In full remission, F32.4		-In full remission, F33.42
		-In remission unspecified, F33.40
		-Other recurrent depression, F33.8
		-Major Depressive d/o Unspec., F33.9

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PROTEIN-CALORIE MALNUTRITION

In order to improve the reporting of malnutrition, it is important for physicians to **document** the condition in the medical record and for coders to be aware of malnutrition as a potential diagnosis. The ICD-10 code categories are E43-E46.

The most severe malnutrition problems are associated with **Protein Calorie Malnutrition (PCM),** also known as **Protein Energy Malnutrition (PEM),** which occurs in both chronic and acute forms. Other standards are used and accepted as indicators of Protein Calorie Malnutrition:

- Body Weight as a value relative to the established norms in the general population;
- Body Mass Index (BMI) which can define Protein Calorie Malnutrition as well as Obesity;
- General Weight Loss Standard.

The overall opinion is that no "gold standard" for the assessment of nutritional status exists.

Subjective Global Assessment (SGA) for PEM includes 6 clinical parameters, followed by a personal judgment as to whether the patient has:

(A) No malnutrition, **(B)** Possible, or mild malnutrition, or **(C)** Significant malnutrition.

1. Unremitting, involuntary weight loss that is greater than 10% in the previous months, especially in the last few weeks;
2. Food intake is severely curtailed;
3. Muscle wasting and fat loss, with attention to the presence of edema, or ascites present on physical examination;
4. Persistent, essentially daily gastrointestinal symptoms such as anorexia, nausea, vomiting, or diarrhea in the previous 2 weeks;
5. Marked reduction in physical capacity;
6. Presence of metabolic stress due to trauma, inflammation or infection.

Protein-calorie malnutrition may accompany illnesses such as:

Alcohol Abuse and/or Dependence
Alcoholic Hepatitis
Anemia
Cancer
Celiac Disease
Chronic Kidney Disease or ESRD
Cirrhosis or Liver Disease
COPD
Cystic Fibrosis
Drug Abuse and/or Dependence
Obesity
Pancreatitis

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