Top Clinical Documentation Issues for ICD-10-CM/PCS

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AHIMA ICD-10-CM/PCS Ambassador
February 28, 2013
Top Clinical Documentation Issues for ICD-10-CM/PCS That Will Affect CDI Programs in Terms of Productivity or Process

- Expanded anatomy specificity requirements in high volume diseases
- Extensive code categories that combine the underlying cause with manifestations or complications for many common acute and chronic diseases
- Increased numbers of codes that identify both the infective cause or agent and the specific state of the infectious disease diagnosis
- Differentiated terminology for stage, status, exacerbation, relapse and other qualifiers for conditions that can vary widely in their acuity and severity
- Need to link timing and circumstance for injury and treatment in order to identify the episode of care as initial, subsequent or for sequel of failed treatment

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Objectives

• Identify the anatomical specificity required for certain in high volume, high cost diagnoses, and procedures, and the impact getting the detail documented will have on productivity and query writing.

• Inventory the top 3 chronic diagnosis by volume, and develop education opportunities for providers to teach them to be more detailed in documenting chronic disease illness, manifestation, complications, cause, and effect

• Show providers examples of the type of terminology needed to show stage, status, exacerbation, relapse and other qualifiers for conditions that can vary widely in their acuity and severity

• Explain to providers the need to link timing and circumstance of injury and treatment in order to identify the episode of care as initial, subsequent or for sequela or failed treatment

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Increased Specificity of Anatomy and Required Laterality
I-10 Anatomy is Specific

- Cardiac/Vascular: bypass, excision, resection, ligation, repairs, insertion and placement of devices and stents
  - I-10 specificity for heart valves, chambers, blood vessels
  - Arteries, laterality and number of vessels treated
- Musculoskeletal/Orthopedic
  - Laterality, specific bone and specific bone portion
- Central and Peripheral Nervous System
  - Specific to portion of the brain affected
  - Specific artery or vessel in the brain,
  - Specific nerves and nerve plexus
- Pulmonary
  - Lobe specific, laterality
- Digestive/Hepatobiliary Tract
  - Solid organs and digestive tract specific to the body part, segment and specific anatomical portions, laterality

RRA, Inc. 2012
Emphysema Anatomical Specificity Does Matter

- **J43.0** – Unilateral pulmonary emphysema [MacLeod's syndrome]
- **J43.1** – Panlobular emphysema
- **J43.2** – Centrilobular emphysema
- **J43.9** – Bullous emphysema, emphysematous bleb (Assign J43.9 Emphysema, unspecified, for the diagnosis "emphysematous bleb" or "bullous emphysema."

RRA, Inc. 2012
Hepatobiliary/Gastrointestinal Anatomical Specificity Does Matter

- **0FF54ZZ** Fragmentation in right hepatic duct, percutaneous endoscopic approach
- **0FB20ZX** Excision of left lobe liver, open approach, diagnostic
- **0F9F0ZZ** Drainage of accessory pancreatic duct, open approach
- **0DVG4ZZ** Restriction of left large intestine, percutaneous endoscopic approach
- **0DV10CZ** Restriction of upper esophagus with extraluminal device, open approach

RRA, Inc. 2012
Chronic Disease Manifestations and Underlying Cause Expanded
Diabetes Manifestations and Cause Manifestations

ICD-10-CM differentiates diabetic disease and disorders on the following characteristics:

**Type:**
- **Diabetes mellitus due to other underlying condition**
  Examples:
  - Cushing’s syndrome
  - Cystic fibrosis
  - Pancreatitis and other pancreatic disease
- **Drug or chemical induced diabetes mellitus**
- **Diabetes mellitus Type 1 or Type 2**
  - Type 1 (Juvenile)
  - Type 2 (Adult onset)
- **Other specified diabetes mellitus**
  - Post procedural diabetes mellitus due to genetic defects of beta cell function
  - Secondary diabetes mellitus

**Acuity Redefined:**
- **Hyperosmolarity** (with and without coma)
- **Ketoacidosis** (with and without coma)
- **Hypoglycemic** (with and without coma)
- **Hyperglycemia**
Diabetes Complications and Manifestations

- Complicating Conditions and Manifestations:
  - Nephropathy
  - Chronic kidney disease
  - Other kidney conditions
  - Retinopathy (proliferate and non proliferate)
    - With and without macular edema
    - Mild, moderate and severe
  - Neuropathy
    - Unspecified neuropathy
    - Mononeuropathy
    - Polyneuropathy
    - Autonomic polyneuropathy
    - Amyotrophy
    - Other neurologic conditions
Manifestations of Chronic Disease for Diabetes Mellitus

• Complicating Conditions and Manifestations (continued):
  • Circulatory
  • Peripheral angiopathy (with and without gangrene)
  • Arthropathy
  • With diabetic neuropathic arthropathy
  • With other diabetic arthropathy
  • Skin complications
    • With foot ulcer
    • With other skin ulcer
    • With other skin complications
  • Oral complications
    • With periodontal disease
    • With other oral complications
    • Other unspecified diabetic conditions

As is the case with I-9 diabetic codes, diabetes with manifestations in other body systems or causing other diseases will require additional code(s). The term used additional code refers to the codes for the other disease or the manifestation to achieve coding completeness and capture of all impacting codes.

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Diabetes Will Require More Documentation

- For example:
  - Diabetes mellitus Type 2, with foot ulcer complicated by episodes of hypoglycemia
  - Chemical induced diabetes mellitus Type 2, with chronic kidney disease, CKD stage 4
  - Status post pancreatectomy with secondary diabetes mellitus, ketoacidosis, and no coma
  - Complete blindness in right eye due to Type 1 diabetes and severe nonproliferate retinopathy with macular edema
  - Hyperglycemic Type 1 diabetes mellitus with peripheral vascular disease and gangrene of the right foot
Expanded Coding Options Will Require Specific Documentation
Codes that Combine Acute Infection and the Cause or Agent

Pneumonia:

Respiratory infections range in complexity and specific infective causes. The coding is categorized into three groups:

1. Bacterial and pneumonia’s due to other causes (fungal, parasitic, mycoses, aspiration, etc.)
2. Viral pneumonias and influenza complicated by pneumonia, Simple pneumonias, and
3. Pneumonias that are as a result of the medical care provided.

The details and timing of the pneumonia should also include complications such as with sepsis, shock, respiratory failure, or as a result of a procedure.

RRA, Inc. 2012
# Bacterial Pneumonia and other Causes of Pneumonia

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B59</td>
<td>Pneumocystosis</td>
</tr>
<tr>
<td>J150</td>
<td>Pneumonia due to Klebsiella pneumoniae</td>
</tr>
<tr>
<td>J151</td>
<td>Pneumonia due to Pseudomonas</td>
</tr>
<tr>
<td>J1520</td>
<td>Pneumonia due to staphylococcus, unspecified</td>
</tr>
<tr>
<td>J15211</td>
<td>Pneumonia due to Methicillin susceptible Staphylococcus aureus</td>
</tr>
<tr>
<td>J15212</td>
<td>Pneumonia due to Methicillin resistant Staphylococcus aureus</td>
</tr>
<tr>
<td>J1529</td>
<td>Pneumonia due to other staphylococcus</td>
</tr>
<tr>
<td>J155</td>
<td>Pneumonia due to Escherichia coli</td>
</tr>
<tr>
<td>J156</td>
<td>Pneumonia due to other aerobic Gram-negative bacteria</td>
</tr>
<tr>
<td>J158</td>
<td>Pneumonia due to other specified bacteria</td>
</tr>
<tr>
<td>J17</td>
<td>Pneumonia in diseases classified elsewhere</td>
</tr>
<tr>
<td>J690</td>
<td>Pneumonitis due to inhalation of food and vomit</td>
</tr>
<tr>
<td>J691</td>
<td>Pneumonitis due to inhalation of oils and essences</td>
</tr>
<tr>
<td>J698</td>
<td>Pneumonitis due to inhalation of other solids and liquids</td>
</tr>
<tr>
<td>J850</td>
<td>Gangrene and necrosis of lung</td>
</tr>
<tr>
<td>J851</td>
<td>Abscess of lung with pneumonia</td>
</tr>
<tr>
<td>J852</td>
<td>Abscess of lung without pneumonia</td>
</tr>
</tbody>
</table>

These diagnoses require the provider to document the infective agent when established and link it to the pneumonia as the cause. These complex pneumonias often have an additional complicating diagnosis of sepsis or respiratory failure that will require specific documentation.

_All of these codes are MCCs when listed as secondary diagnoses_

RRA, Inc. 2012
# Viral Pneumonias and Influenza Complicated by Pneumonia

**Principal Diagnosis:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J09X1</td>
<td>Influenza due to identified novel influenza A virus with pneumonia</td>
</tr>
<tr>
<td>J09X2</td>
<td>Influenza due to identified novel influenza A virus with other respiratory manifestations</td>
</tr>
<tr>
<td>J1000</td>
<td>Influenza due to other identified influenza virus with unspecified type of pneumonia</td>
</tr>
<tr>
<td>J1008</td>
<td>Influenza due to other identified influenza virus with other specified pneumonia</td>
</tr>
<tr>
<td>J1100</td>
<td>Influenza due to unidentified influenza virus with unspecified type of pneumonia</td>
</tr>
<tr>
<td>J1108</td>
<td>Influenza due to unidentified influenza virus with specified pneumonia</td>
</tr>
<tr>
<td>J120</td>
<td>Adenoviral pneumonia</td>
</tr>
<tr>
<td>J121</td>
<td>Respiratory syncytial virus pneumonia</td>
</tr>
<tr>
<td>J122</td>
<td>Parainfluenza virus pneumonia</td>
</tr>
<tr>
<td>J123</td>
<td>Human metapneumovirus pneumonia</td>
</tr>
<tr>
<td>J1281</td>
<td>Pneumonia due to SARS-associated coronavirus</td>
</tr>
<tr>
<td>J1289</td>
<td>Other viral pneumonia</td>
</tr>
<tr>
<td>J129</td>
<td>Viral pneumonia, unspecified</td>
</tr>
</tbody>
</table>

*All of these codes are MCCs when listed as secondary diagnoses*

RRA, Inc. 2012
Simple and Unspecified Pneumonia

Principal Diagnosis:

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>J13</td>
<td>Pneumonia due to Streptococcus pneumoniae</td>
</tr>
<tr>
<td>J14</td>
<td>Pneumonia due to Hemophilus influenzae</td>
</tr>
<tr>
<td>J153</td>
<td>Pneumonia due to streptococcus, group B</td>
</tr>
<tr>
<td>J154</td>
<td>Pneumonia due to other streptococci</td>
</tr>
<tr>
<td>J157</td>
<td>Pneumonia due to Mycoplasma pneumoniae</td>
</tr>
<tr>
<td>J159</td>
<td>Unspecified bacterial pneumonia</td>
</tr>
<tr>
<td>J160</td>
<td>Chlamydial pneumonia</td>
</tr>
<tr>
<td>J168</td>
<td>Pneumonia due to other specified infectious organisms</td>
</tr>
<tr>
<td>J180</td>
<td>Bronchopneumonia, unspecified organism</td>
</tr>
<tr>
<td>J181</td>
<td>Lobar pneumonia, unspecified organism</td>
</tr>
<tr>
<td>J188</td>
<td>Other pneumonia, unspecified organism</td>
</tr>
<tr>
<td>J189</td>
<td>Pneumonia, unspecified organism</td>
</tr>
</tbody>
</table>

The provider documentation should provide the highest level of certainty known and specificity for the pneumonia diagnosis this may sometimes require the provider to use possible or probable for clinical diagnoses.

All of these codes are MCCs when listed as secondary diagnoses

RRA, Inc. 2012
Pneumonia as a Result of Medical Care

Principal Diagnosis:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J95851</td>
<td>Ventilator associated pneumonia</td>
</tr>
<tr>
<td>J9589</td>
<td>Other post procedural complications and disorders of respiratory system, not elsewhere classified</td>
</tr>
</tbody>
</table>

• The ventilator associated pneumonia or post operative pneumonia diagnoses should only be coded on the basis of the provider documentation relating the pneumonia as specifically due to the ventilator or post procedure.

• Code J95851 has a Use additional code for the organism responsible if known such as ( B95.-, B96.-, B97.- ). A code for the organism would also be listed as s secondary diagnosis to further describe the specific pneumonia and the infective organism associated with the ventilator use.

❖ Code J9589 is used to report Post operative pneumonia and has a Use additional code to identify the specific type of pneumonia, such as Aspiration (J69-1) Bacterial or Viral (J12-J18)

*These are the only pneumonia codes J95851 and J9589 that are CCs and not MCCs when listed as secondary diagnoses. A challenging Query Territory.*

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Pneumonia, Signs, Symptoms, Specificity and Complications

Admitting Impression:
Atelectasis due to hypoventilation and mucus plug

A 57 yo AAM is admitted to the hospital on 9/1/11 with CC: SOB for 3-4 days. He is confused and c/o cough productive of yellow sputum. He remembers falling 4 times over the last 3 weeks without loosing consciousness. Patient seen in private office 2 weeks ago. In the ER the patient was very tachypneic and hypoxic, and was intubated. CXR showed a right lung opacification.

What is the most likely reason for the lung opacification?
Pneumonia?
Effusion?
Atelectasis?

RRA, Inc. 2012
Pneumonia, Signs, Symptoms, Specificity and Complications

The CXR below:
Right lung atelectasis with mediastinal shift. ETT ends at the level of clavicles. The optimal position is in the middle between the clavicles and the carina. This ETT needs to be advanced 2 cm.

What happened?
The CXR showed a right lung atelectasis with multiple rib fractures bilaterally.

The patient had a lot of secretions in his airway and after suctioning, the oxygenation improved. The follow-up CXR showed a resolution of the right lung atelectasis.
Patient extubated by pulmonologist today day 3 of hospital stay.
Sputum culture positive for Streptococcus pneumoniae

RRA, Inc. 2012
Repeat CXR Re-expansion of the right lung after suctioning and Mucomyst (TM) aerosols. The ETT is at the level of the right main bronchus and needs to be pulled back 2-3 cm.

**Close-up of the right-sided rib fractures.**

**Final diagnosis:**
Right lung atelectasis. Bilateral pneumonia. **Bilateral rib fractures.**

**What did we learn from this case?**
The sequence of events was: falls, multiple rib fractures, hypoventilation, atelectasis, pneumonia and **respiratory failure.**

Atelectasis is a common cause of lung opacification. Atelectasis pulls the trachea and the mediastinum to its side. The pneumonia does not change the position of the mediastinal structures. A large pleural effusion can push the mediastinum to the opposite side.

Published: 02/16/2004 Author: V. Dimov, M.D.
Reviewer: S. Randhawa, M.D.

RRA, Inc. 2012
What Should We Query? What Can we Code?

• **What should we query?**
  - Patient intubated? For what diagnosis?
    • Acute hypoxia?
    • Change of mental status? Due to anoxic encephalopathy? (patient hypoxic enough to require intubation)?
    • Was patient on ventilator? How long?
    • Acute hypoxic resp failure?
    • Was this respiratory failure POA?
    • Was the respiratory failure the reason for admission?
    • Co-equal diagnosis of pneumonia, and respiratory failure?
    • Sputum cultures are positive for?
    • CMS guidelines for sequencing respiratory failure?
    • How many rib fractures? How many on each side? (initial care? Subsequent care? With sequela?)

• **What education needs are required for documentation to meet I-10 Specificity and Acuity?**

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Write Your Query For the Pneumonia Case

- Clinical indicators?
- Positive findings?
- Physical exam?
- Incomplete information?
- Treatment provided?

RRA, Inc. 2012
CHF Will Continue to be a Query Challenge for I-10
Combination Codes that Include Acuity, Severity and Underlying Cause

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I0981</td>
<td>Rheumatic heart failure</td>
</tr>
<tr>
<td>I110</td>
<td>Hypertensive heart disease with heart failure</td>
</tr>
<tr>
<td>I130</td>
<td>Hypertensive heart and chronic kidney disease with heart failure and stage I through stage IV</td>
</tr>
<tr>
<td></td>
<td>chronic kidney disease, or unspecified chronic kidney disease</td>
</tr>
<tr>
<td>I132</td>
<td>Hypertensive heart and chronic kidney disease with heart failure and stage V chronic kidney</td>
</tr>
<tr>
<td></td>
<td>disease, or end stage renal disease</td>
</tr>
<tr>
<td>I501</td>
<td>Left ventricular failure</td>
</tr>
<tr>
<td>I5020</td>
<td>Unspecified systolic (congestive) heart failure</td>
</tr>
<tr>
<td>I5021</td>
<td>Acute systolic (congestive) heart failure</td>
</tr>
<tr>
<td>I5022</td>
<td>Chronic systolic (congestive) heart failure</td>
</tr>
<tr>
<td>I5023</td>
<td>Acute on chronic systolic (congestive) heart failure</td>
</tr>
</tbody>
</table>

I130 and 1 132 codes there will be a need to follow the code book instructions “Use additional code” for Stage of CKD and the type of Heart Failure.

RRA, Inc. 2012
## CHF and Other and Unspecified CHF

### Principal diagnosis:

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I5030</td>
<td>Unspecified diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I5031</td>
<td>Acute diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I5032</td>
<td>Chronic diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I5033</td>
<td>Acute on chronic diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I5040</td>
<td>Unspecified combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I5041</td>
<td>Acute combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I5042</td>
<td>Chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I5043</td>
<td>Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I509</td>
<td>Heart failure, unspecified</td>
</tr>
<tr>
<td>R570</td>
<td>Cardiogenic shock</td>
</tr>
<tr>
<td>R579</td>
<td>Shock, unspecified</td>
</tr>
</tbody>
</table>

RRA, Inc. 2012
Specificity and Acuity Continue to be a Challenge for I-10

Heart Failure MCCs

- I5021 Acute systolic (congestive) heart failure
- I5023 Acute on chronic systolic (congestive) heart failure
- I5031 Acute diastolic (congestive) heart failure
- I5033 Acute on chronic diastolic (congestive) heart failure
- I5041 Acute combined systolic (congestive) and diastolic (congestive) heart failure
- I5043 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure

Heart Failure CCs

- I501 Left ventricular failure
- I5020 Unspecified systolic (congestive) heart failure
- I5022 Chronic systolic (congestive) heart failure
- I5030 Unspecified diastolic (congestive) heart failure
- I5032 Chronic diastolic (congestive) heart failure
- I5040 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
- I5042 Chronic combined systolic (congestive) and diastolic (congestive) heart failure

I509 Unspecified CHF not a CC and Not a MCC

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CHF Specificity and Severity Case Example

Shortness of breath and diffuse ground glass pattern on CT of the chest. What is the cause?

A 57-year-old AAM is admitted to the hospital with shortness of breath (SOB) for 7 days. He has leg edema, which is getting progressively worse, to the point where his scrotum, penis and even lower abdomen are edematous. He does not have chest pain (CP) or abdominal pain. He is morbidly obese and has difficulty ambulating, using a wheelchair at home. Echo on last admission shows further deteriation of the EF now down to 33%.

Past Medical History (PMH)

CHF, HTN, DM2, CAD, CRI, BPH, AFib, gout, OA, OSA, COPD on home O2 3 L/min and CPAP.

Medications

KCI, Coreg (Carvedilol), Zocor (Simvastatin), Flomax (Tamsulosin), Lasix (Furosemide), Clonidine, Percocet (Oxycodone and Acetaminophen), Nifedipine XL, Humulin N (human NPH insulin injection [rDNA origin]), aerosols, Amiodarone.
CHF Specificity and Severity Case Example

Social history (SH)

Smoker for 20 years, Still smoking daily

Physical examination

VS 36.4-80-22-160/77.  
SpO2 94% on 3 L/min.  
Morbidly obese, appears mildly tachypneic.  
Chest: mild respiratory distress with RR 22, bibasilar rales.  
CVS: irregularly irregular rhythm.  
Abdomen: obese, soft, generalized anasarca with edema extending up to the level of his umbilicus. His penis and testicles are edematous. He has 2 to 3+ peripheral edema with bilateral Dome wraps on for management of stasis edema.

The CXR shows pulmonary congestion, and emphysema

Diagnosis: Right-sided and left-sided CHF.

Author: V. Dimov, M.D.  
Reviewer: S. Randhawa, M.D.

RRA, Inc. 2012
What Should We Query? What Can We Code?

- **What should we query?**
  - Type of CHF?
    - Systolic/diastolic?
    - Acute on chronic exacerbation?
    - Emphysema? Which lobe? With COPD?
    - Morbid obesity? What is the BMI?
    - OSA and on Home $O_2$ 3 liters, CPAP (chronic respiratory failure? Possible COPD/Emphysema per x-ray findings)
    - CRI meaning more specifically? CKD? Stage of CKD? Was there any Acute Kidney Failure?
    - Hypertensive renal failure/with CHF/with CKD stage? - (Triggering a code combination impacts the MDC assignment and DRG)
    - Hypertensive renal failure/with CHF with acute exacerbation?
Write Your Query for the CHF Case

- Clinical indicators?
- Positive findings?
- Physical exam?
- Incomplete information?
- Treatment provided?

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Complications and Severity of Chronic Disease
COPD and Bronchitis

Principal Diagnosis:

- J411  Mucopurulent chronic bronchitis
- J418  Mixed simple and mucopurulent chronic bronchitis
- J42   Unspecified chronic bronchitis
- J430  Unilateral pulmonary emphysema [MacLeod's syndrome]
- J431  Panlobular emphysema
- J432  Centrilobular emphysema
- J438  Other emphysema
- J439  Emphysema, unspecified
- J440  Chronic obstructive pulmonary disease with acute lower respiratory infection
- J441  Chronic obstructive pulmonary disease with (acute) exacerbation
- J449  Chronic obstructive pulmonary disease, unspecified
- J470  Bronchiectasis with acute lower respiratory infection
- J471  Bronchiectasis with (acute) exacerbation
- J479  Bronchiectasis, uncomplicated

*Note Chronic Obstructive Asthma requires a code from J440-J449 and a code for the Asthma code set J4520-J45998

*Note Chronic Obstructive Bronchitis has no combination code and requires a code from J200-J410 and J440-J449. Diagnoses descriptions with the term “acute” will have a CC impact.

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Detailed Manifestations for Chronic Bronchitis

Chronic bronchitis is classified as follows:

- **Simple chronic bronchitis** (**J41.0**) — chronic bronchitis with mucoid sputum production, non-obstructive,
- **Mucopurulent chronic bronchitis** (**J41.1**) — "muco" — mucus, and "purulent" — pus. Chronic bronchitis with persistent or recurrent purulent sputum production in the absence of localized suppurative disease, such as bronchiectasis.\(^1\)
- **Mixed simple and mucopurulent chronic bronchitis** (**J41.8**), or
- **Unspecified chronic bronchitis** (**J42**)
- **Chronic bronchitis is often associated with COPD and asthma.** In these instances, a code from category **J44** Other chronic pulmonary disease or category **J45** Asthma may be assigned. Always begin with the index, main term Bronchitis, subterm "chronic" or other subterm and carefully select the correct code using the tabular based on provider documentation. Follow the "Use additional code" instruction notes in the tabular, when applicable.

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**Example 1:**
Provider documents "obstructive chronic bronchitis:" Assign J44.9 Chronic obstructive pulmonary disease, unspecified. See the index main term Bronchitis, subterms chronic, with airway obstruction, or subterm obstructive.

**Example 2:**
Provider documents "smokers' bronchitis, nicotine dependence:" Assign J41.0 Simple chronic bronchitis. See the index main term Bronchitis, subterm smokers'. Assign F17.200 Nicotine dependence, unspecified, uncomplicated as a secondary code.
Bronchitis Due to Specific Organism or Virus

Principal Diagnosis:

- **J200** Acute bronchitis due to Mycoplasma pneumoniae
- **J201** Acute bronchitis due to Hemophilus influenzae
- **J202** Acute bronchitis due to streptococcus
- **J203** Acute bronchitis due to coxsackievirus
- **J204** Acute bronchitis due to parainfluenza virus
- **J205** Acute bronchitis due to respiratory syncytial virus
- **J206** Acute bronchitis due to rhinovirus
- **J207** Acute bronchitis due to echovirus
- **J208** Acute bronchitis due to other specified organisms
- **J209** Acute bronchitis, unspecified
- **J210** Acute bronchiolitis due to respiratory syncytial virus
- **J211** Acute bronchiolitis due to human metapneumovirus
- **J218** Acute bronchiolitis due to other specified organisms
- **J219** Acute bronchiolitis, unspecified
- **J398** Other specified diseases of upper respiratory tract
- **J40** Bronchitis, not specified as acute or chronic
- **J410** Simple chronic bronchitis

*Note Chronic Obstructive Bronchitis has no combination code and requires J200-J410 and J440-J449. The diagnosis descriptions with the term “acute” will have a CC impact*
Asthma Requires Documented Frequency and Severity

Principal diagnosis:

- J4520 Mild intermittent asthma, uncomplicated
- J4521 Mild intermittent asthma with (acute) exacerbation
- J4522 Mild intermittent asthma with status asthmaticus
- J4530 Mild persistent asthma, uncomplicated
- J4531 Mild persistent asthma with (acute) exacerbation
- J4532 Mild persistent asthma with status asthmaticus
- J4540 Moderate persistent asthma, uncomplicated
- J4541 Moderate persistent asthma with (acute) exacerbation
- J4542 Moderate persistent asthma with status asthmaticus
- J4550 Severe persistent asthma, uncomplicated
- J4551 Severe persistent asthma with (acute) exacerbation
- J4552 Severe persistent asthma with status asthmaticus
- J45901 Unspecified asthma with (acute) exacerbation
- J45902 Unspecified asthma with status asthmaticus
- J45909 Unspecified asthma, uncomplicated
- J45990 Exercise induced bronchospasm
- J45991 Cough variant asthma
- J45998 Other asthma

*Note Chronic Obstructive Asthma requires a code from J440-J449 and a code for the Asthma J4520-J45998. Diagnosis codes that include the term “acute”, “exacerbation”, and “status asthmaticus will have a CC impact.

RRA, Inc. 2012
### Asthma the I-10 Qualifiers for Severity

<table>
<thead>
<tr>
<th>Intermittent asthma (J45.2-)</th>
<th>Moderate persistent asthma (J45.4-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma is considered intermittent if without treatment any of the following are true:</td>
<td>Asthma is considered moderate persistent if without treatment any of the following are true:</td>
</tr>
<tr>
<td>• Symptoms (difficulty breathing, wheezing, chest tightness, and coughing):</td>
<td>• Symptoms occur daily.</td>
</tr>
<tr>
<td>• Occur on fewer than 2 days a week.</td>
<td>• Inhaled short-acting asthma medication is used every day.</td>
</tr>
<tr>
<td>• Do not interfere with normal activities.</td>
<td>• Symptoms interfere with daily activities.</td>
</tr>
<tr>
<td>• Nighttime symptoms occur on fewer than 2 days a month.</td>
<td>• Nighttime symptoms occur more than 1 time a week, but do not happen every day.</td>
</tr>
<tr>
<td>• Lung function tests (spirometry and peak expiratory flow [PEF]) are normal when the person is not having an asthma attack. The results of these tests are 80% or more of the expected value and vary little (PEF varies less than 20%) from morning to afternoon.</td>
<td>• Lung function tests are abnormal (more than 60% to less than 80% of the expected value), and PEF varies more than 30% from morning to afternoon.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mild persistent asthma (J45.3-)</th>
<th>Severe persistent asthma (J45.5-)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma is considered mild persistent if without treatment any of the following are true:</td>
<td>Asthma is considered severe persistent if without treatment any of the following are true:</td>
</tr>
<tr>
<td>• Symptoms occur on more than 2 days a week but do not occur every day.</td>
<td>• Symptoms occur throughout each day.</td>
</tr>
<tr>
<td>• Attacks interfere with daily activities.</td>
<td>• Severely limit daily physical activities.</td>
</tr>
<tr>
<td>• Nighttime symptoms occur 3 to 4 times a month.</td>
<td>• Nighttime symptoms occur often, sometimes every night.</td>
</tr>
<tr>
<td>• Lung function tests are normal when the person is not having an asthma attack. The results of these tests are 80% or more of the expected value and may vary a small amount (PEF varies 20% to 30%) from morning to afternoon.</td>
<td>• Lung function tests are abnormal (60% or less of the expected value), and PEF varies more than 30% from morning to afternoon.</td>
</tr>
</tbody>
</table>

These are necessary details to describe the chronic status, the documentation still requires details to be included to describe the “severity” of the acute aspect of the chronic condition such as “acute”, “Exacerbation” and “Status Asthmaticus” to be documented for the correct I-10 code assignment.

RRA, Inc. 2012
Asthma exacerbation with carbon dioxide retention

A 46-year-old African American female (AAF) with h/o asthma presented to the ER with shortness of breath. This was her 3rd ER visit in the last ten days. She stated that her typical triggers are pet hair and dust. She was sitting in the park this afternoon and developed shortness of breath. Her boyfriend immediately brought her to the ER for evaluation. Five days ago, she was sent home with Prednisone, Advair and albuterol and stated that had been compliant with the medications. She admitted to cocaine use after discharge, but denied any chest pain. She also denied any fever, chills, hemoptysis, leg pain/swelling, productive cough but reported rhinorrhea for 3 days.

**Past medical history (PMH)**
Asthma

**Medications**
Prednisone 20 mg po qd, fluticasone-salmeterol (Advair) 250-50 mcg BID, albuterol PRN

**Social history (SH)**
Smoking in the past, current cocaine use

**Family medical history (FMH)**
Asthma in her mother
Asthma Specificity of Frequency and Severity

Physical examination

Vital signs 110/67- HR 110- temp 98.2 °F (36.8 °C)- resp 28- pulse ox 89% on RA
General appearance: moderate distress, cachectic, frail, acutely ill, disheveled.
ENT: Oropharynx clear, no plaques or exudates
Respiratory: Diminished breath sounds. Extensive wheezing throughout.
Cardiovascular: no murmurs, no rubs, no gallops
Gastrointestinal: soft, NT, ND, no organomegaly, + BS
Genitourinary: No CVAT
Musculoskeletal: No c/c/e, no calf tenderness, normal ROM, equal palpable peripheral pulses and normal strength
Skin: no rashes noted.

• What is the most likely diagnosis?
  Asthma exacerbation due to URTI and cocaine abuse
• What else?

RRA, Inc. 2012
Asthma Specificity of Frequency and Severity

What tests would you review?
- CXR, ABG, CBCD, BMP, Urine toxic screen

What happened? **ABG showed pH of 7.36, PaCO2 50, PaO2 107, HCO3 28.**
She was given continuous nebulized albuterol with symptomatic improvement. Her respiratory rate decreased to 22, HR 76, O2 sat was 99% on room air. She still continued to have pursed lip exhalations.
CXR: Lungs were mildly hyperinflated, but clear of infiltrate, effusion or pneumothorax.
CBCD and BMP were unremarkable.
She was admitted to internal medicine and treatment with Methylprednisolone 40 mg iv q 6 hr and albuterol UD q 4 hr was started.

What happened next?
The patient improved rapidly and was discharged 2 days later. **She admitted to not using her Advair.** SW was involved and a follow-up with PCP was arranged. **She was advised to stop using cocaine.** Discharge medications included prednisone taper, Advair, Albuterol PRN.

Final diagnosis: **Asthma exacerbation with carbon dioxide retention**

Asthma is the most common chronic respiratory disease, affecting up to 10% of adults and 30% of children (**JACI, 2011**).

RRA, Inc. 2012
What Should We Query? What Can We Code?

- **What should we query?**
  
  Underlying cause of asthma exacerbation?
  - Infection? Was it ruled out
  - Cocaine? Is this dependence? Was this the trigger?
  - Cachectic, frail and acutely ill?
  - Noncompliant with medication (under dosing by patient decision?)
    - Timing and chronicity of the asthma?

  Asthma frequency and severity status?
  - **Mild intermittent?**
  - **Mild persistent?**
  - Moderate intermittent
  - Moderate Persistent
  - Severe persistent

  All with or without acute exacerbation or status asthmaticus
Write Your Query for the Asthma Case

- Clinical indicators?
- Positive findings?
- Physical exam?
- Incomplete Information?
- Treatment provided?
- Frequency and acuity?
- With or without infection?

RRA, Inc. 2012
ICD-10-PCS Impact on Specificity and Productivity
Injury and Fracture Treatment

Required for Diagnosis: Open or closed (assignment of the code for open fractures will require the use and knowledge of the Gustilo open fracture classification system), initial treatment, subsequent treatment for routine healing, delayed healing, nonunion, malunion, or sequela. Must be determined to assign the diagnosis.

Required for Procedures:

• Upper or lower bones/body part specific bone and portion of the bone including left or right body part must always be documented.

• Root or objective of operation(s)

• The approach used

• Other important terms for the insertion and removal of specific device(s) used for repositioning and reduction of fractures and dislocations.

• Other qualifiers for device placement and types of fixation devices

RRA, Inc. 2012
Devices Must Specific to be Coded

- **Fracture care devices and additional details needed for PCS coding:**
  - Internal fixation device
  - Intramedullary fixation device
  - No device
  - Autologous tissue substitute
  - Non autologous tissue substitute
  - Synthetic substitute
  - Bone growth stimulator
  - Drainage device

RRA, Inc. 2012
Unique Aspects of Devices Must Be Captured

- Other important qualifying aspects of specific types of devices used for the fracture reduction/repair/reposition procedures:
  - Rigid Plate (internal fixation device –insert-reposition – upper bones)
  - Monoplanar (external fixation device – insert-reposition –upper –lower bones)
  - Ring (external fixation device – insert- reposiition –upper-lower-bones)
  - Hybrid (external fixation device- insert- reposiition –upper-lower bones)
  - Limb Lengthening device ( external –insertion -upper-lower bones)

RRA, Inc. 2012
Fracture Repair and Episode of Care

• Because every procedure is unique to the fracture being treated, specific details are required to assign the ICD-10-PCS procedure codes.

• Assumptions can not be made on the objective, approach or the type of devices being used to treat the fracture/dislocation.

• Generalized surgical terms and the reference to manufacturer as device description without the device details will result in a query to the surgeon.

• The details for removal of complicated (infected, painful) or failed devices (broken, dislocated) must be carefully documented and include the timing and episode of care as initial, subsequent, routine/delayed healing, malunion/nonunion or sequela of fracture.

RRA, Inc. 2012
Procedure Specificity for ICD-10-PCS
Anatomy Challenges for ICD-10-PCS

0RW40AZ  Revision of Interbody Fusion Device in **Cervicothoracic Vertebral Joint**, Open Approach

0RWH3KZ  Revision of Nonautologous Tissue Substitute in **Left Acromioclavicular Joint**, Percutaneous Approach

0R904ZZ  Drainage of **Occipital-cervical Joint**, Percutaneous Endoscopic Approach

0R9100Z  Drainage of **Cervical Vertebral Joint** with Drainage Device, Open Approach

0RG74ZJ  Fusion of 2 to 7 **Thoracic Vertebral Joints**, Posterior Approach, Anterior Column, Percutaneous Endoscopic Approach

RRA, Inc. 2012
# Documentation Challenges for ICD-10-PCS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0FQ00ZZ</td>
<td>Repair Liver, Open Approach</td>
</tr>
<tr>
<td>0FQ03ZZ</td>
<td>Repair Liver, Percutaneous Approach</td>
</tr>
<tr>
<td>0FQ04ZZ</td>
<td>Repair Liver, Percutaneous Endoscopic Approach</td>
</tr>
<tr>
<td>0FQ10ZZ</td>
<td>Repair <strong>Right Lobe Liver</strong>, Open Approach</td>
</tr>
<tr>
<td>0FQ13ZZ</td>
<td>Repair <strong>Right Lobe Liver</strong>, Percutaneous Approach</td>
</tr>
<tr>
<td>0FQ14ZZ</td>
<td>Repair <strong>Right Lobe Liver</strong>, Percutaneous Endoscopic Approach</td>
</tr>
<tr>
<td>0FQ20ZZ</td>
<td>Repair <strong>Left Lobe Liver</strong>, Open Approach</td>
</tr>
<tr>
<td>0FQ23ZZ</td>
<td>Repair <strong>Left Lobe Liver</strong>, Percutaneous Approach</td>
</tr>
<tr>
<td>0FQ24ZZ</td>
<td>Repair <strong>Left Lobe Liver</strong>, Percutaneous Endoscopic Approach</td>
</tr>
</tbody>
</table>

RRA, Inc. 2012
Impact of ICD-10-PCS on Concurrent and Post Discharge Query Process

• Brief operative report vs. dictated operative report
• Example of query issues:
  – Complex abdominal and vascular repair
  – Intra-operative complications
  – Post operative complications
  – Type of device and approach used
  – Clarification of aborted, reduced or expanded procedures
  – Diagnostic vs. Therapeutic intent
  – Diagnosis impact on (HACs)

RRA, Inc. 2012
Surgical Case Example for ICD-10-PCS

- C/O Gunshot wound to groin and thigh
- Trauma call directly to O.R.
- Procedures brief operative report
  - Hepatoraphy
  - Ligation left external iliac vein
  - Shunt left external iliac artery
  - Primary repair of inferior vena cava
  - Small bowel resection with primary re-anastomosis

45 units PRBCs, 34 FFP, 2 platelets, Factor VIIIX3, Cryoprecipitate

Post Op course:
- Creatinine Peaked to 1.4
- CKs to 21,000
- Maintained L Posterior Tibialis (PT) pulse with doppler
- Left leg compartments initially soft but became firm by next morning
- Na+ HCO₃⁻ & Mannitol administered

RRA, Inc. 2012
### Surgical Case Example

**Treatment Options**
- Address the cause
- Administer mannitol

- Fasciotomy and Decompression
  - Double anterolateral & posteromedial or single lateral

**Back to O.R.**

**Brief Operative note:**
- Compartment Pressure
  - 35mmHg
- Fasciotomy
- External Iliac Artery Graft

---

**Compartment Syndrome:**

**Physiology**
- Increased pressure within an anatomical compartment
- Decreased capillary perfusion (approx 25-30 cm H2O)

**Etiology**
- Fractures, trauma, vascular injuries, hematoma, contusion, burns, tight dressings/casts, massive fluid resuscitation

**Symptoms**
- Awake & alert – 6Ps: Pain *, Pressure, Paresthesia, paralysis, Pale (pink), Pulseless

- Altered/decreased LOC – high index of suspicion

**Diagnosis:**
- Clinical Diagnosis
- Measure Intra-compartment pressure
- Wick/Slit Catheter

---

* RRA, Inc. 2012
Post operative course:
- Fevers to 102 degrees Fahrenheit
- Unable to culture source
- OR for wound closure
- Necrotic muscle tissue of left lower leg
- Culture positive Oxacillin resistant staphylococcus
- Extensive debridement of anterior and lateral compartments
- Eventual discharge after prolonged treatment

Final Diagnosis: GSW groin and thigh, Injury liver, iliac artery, inferior vena cava and small bowel, post procedure compartment syndrome, fever cultures positive for staph
  – Procedures: Hepatoraphy
  – Ligation left external iliac vein
  – Shunt left external iliac artery
  – Primary repair of inferior vena cava
  – Small bowel resection with primary re-anastomosis
  – Fasciotomy, debridement necrotic tissue
    • 45 units PRBCs, 34 FFP, 2 platelets, Factor VIIIX3, cryoprecipitate
    • Return to OR x2
    • Fasciotomy, debridement
What Should We Query? What Can We Code?

- What should we query?
  - All of the injuries require some additional details to be coded for I-10 including specific anatomy.
  - All of the procedures require additional details to be coded for I-10 including approach, specific anatomy, type of device(s) used.
  - Post operative complications (compartment syndrome) not clearly specified? As a result of procedure or treatment?
  - Compartment syndrome due to the trauma? Compartment syndrome due to massive transfusion?
  - Fever due to extensive trauma? Post op fever? Post operative wound infection? Organism responsible?
  - Acute blood loss anemia

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Write Your Query For the Surgical Case

- Clinical indicators?
- Positive findings?
- Physical exam?
- Incomplete information?
- Non specific diagnoses?
- Non specific procedures?
- Treatment provided?
- Complications of trauma or treatment?

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Surgical Case Example

• Brief Operative Report
  – Median sternotomy with resection of the anterior mediastinal mass
  – Portion of the anterior pericardium was removed with the specimen
  – Intra-operative tumor/endocrine consult
  – 2 chest tubes placed
    • Mediastinal
      Right chest

  Post operative blood sugars out of control, insulin coverage provided

No complications
Surgical Case Example

• Anterior Mediastinal Mass
  – Hospital course
    • CT Scan
    • Thyroid scan
      – Positive for right thyroid, negative for sternal
      – Biopsy of mass
        » Thyroid in origin
        » Diagnosed as mediastinal goiter

» PMH of diabetes mellitus Type 2
» Chronic foot ulcers ? (bilateral)
What Should We Query? What can we Code?

- Objective of the procedure? Diagnostic? Other?
- Excision vs. resection (all or part)
- Approach?
- Removal of other tissue? Diagnostic or incidental to procedure?
- Poor glycemic control? Post procedure uncontrolled DM? (HAC?)
- Diabetic manifestations? Foot ulcer?

RRA, Inc. 2012
Write Your Query for the Surgical Case

- Clinical indicators?
- Positive findings?
- Physical exam?
- Incomplete information?
- Non specific diagnoses?
- Non specific procedures?
- Treatment provided?
**Moving Forward: The Regulatory Timeline**

Timeline for implementation of various ACA programs

- **Health Care and Education Reconciliation Act of 2010 amends PPACA**
  - Mar 30, 2010
- **EHR Registration begins**
  - Jan 3, 2011
- **Physician resource use reporting to begin**
  - 2012
- **CMS adds Outpatient Data to Hospital compare Website**
  - Jul 8, 2010
- **Physician resource use reporting to begin**
  - 2012
- **Medicare VBP to Begin**
  - October 2012
- **Public Reporting to begin of HACs where payment was denied**
  - 2014
- **You are Here**
  - 2/28/13
- **Payment Reductions for Re-admissions begins**
  - October 2012
- **ICD-10-CM/PCS Compliance**
  - Oct 1, 2014
- **CMS goal to have EHR interoperable**
  - 2014
- **Value Based Payment Modifier to Physician fee Schedule**
  - Jan 2015
- **HAC expanded to Medicaid**
  - Jul 1, 2011
- **Patient protection and affordable care act (PPACA) establishes and maintains quality-related initiatives**
  - Mar 23, 2010
- **CMS to Launch Physician compare website**
  - Jan 3, 2011
- **Payment Reductions for Re-admissions begins**
  - October 2012
- **Value Based Payment modifier to Physician fee Schedule**
  - Jan 2015
- **EHR Meaningful Use must be achieved or Medicare Reimbursement Penalties**
  - Jan 2015

*19 months to compliance and financial impact 10/1/14*
Resources

- http://www.jmedicalcasereports.com/content/6/1/272/abstract
- http://www.surgery.usc.edu/clerkship/case_studies.htm
Questions and Wrap-Up

Thank you for attending our webinar!

Please complete the survey, your feedback helps us to design training to meet your needs.

The Power Point slides and CE Certificate for this webinar can be downloaded from:

http://icd-10online.com/rcc-web-certification

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