CureMD

HOW TO MASTER ICD-10

DOCUMENTATION IN 10 DAYS

- ☑ Specialty Clinical Scenarios
- ☑ Documentation Gap Analysis
- ☑ Glossary of Most Common ICD-10 Codes

About this **Workbook**

Dear Provider,

ICD-10 is a watershed moment in US Healthcare. There is no consensus, at the moment, about the exact magnitude of impact this transition will have on your practice. Thus, the writing on the wall is to prepare for the worst. We agree, it's easier said than done. But it's possible. Simply use your time, whatever remains of it, wisely.

*If **CureMD ICD-10 eBook** was a good start to understand the transition process, this ICD-10 Documentation Worksheet will help you in the last leg of the race and beyond.*

We are confident that this publication will be your best friend for the next few months.

Best of Luck,

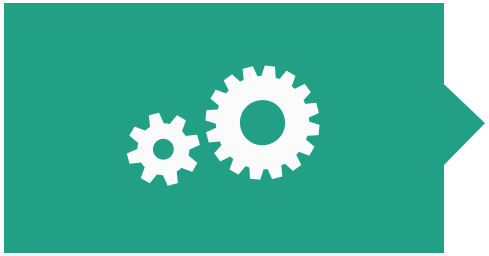
Team CureMD

We just made your **Life Easier!**

Providers will have to make the most adjustments post ICD-10 and have the least time to prepare for it. Read on for a comprehensive ICD-10 Documentation coverage.

Specialty based Document Gap Analysis

A walk through the ICD-10 clinical documentation changes, for common conditions associated with your Specialty.



Clinical Scenario

This section has sample, outpatient focused, scenarios that illustrate the proper level of detail required for a specific diagnosis; for creating an acceptable claim for the service rendered.

Common Codes for your specialty

A glossary of common ICD-9 and related ICD-10 codes to guide you in the initial days of documentation.

ICD-10 **Introduction**

The current ICD-9 diagnosis codes (International Classification of Diseases, 9th Edition) for patient encounters have been in use in the U.S. since 1979. The codes have become outdated, and many countries have replaced these codes with a newer, more flexible, and up-to-date version; ICD-10, the 10th edition of the International Classification of Diseases.

In March last year, a U.S. Senate vote concluded that ICD-10 would replace ICD-9, and be implemented in all practices across the country on October 1, 2015. In simpler terms, starting October, insurance carriers will only reimburse you for services provided if you send out bills containing the relevant ICD-10 codes.

How is this **Code Set Different?**

The ICD-10 code set is structurally and conceptually different from its ICD-9 counterpart. This eBook has been created with the purpose to notify, educate, and train your team so that you can effectively manage clinical documentation for your specialty prior to October 1, 2015.

ICD-9 vs. ICD-10: The Differences in Diagnosis Code Sets

Before we progress to the clinical adjustments that you need to make for these codes, here is an overview of how these code sets differ.

Code Sets	ICD-9	ICD-10
More codes	13,000 codes	68,000 codes
Longer Codes	3-5 characters	3-7 characters
More complex codes	1st digit: alpha/numeric, digits 2-5: numeric	1st digit: alpha, digits 2-3: numeric, digits 4-7: alpha/numeric
Allow addition	Limited space for new codes	Flexibility for code addition
Have laterality	Lacks laterality	Codes differ for different sides of the body

Gap analysis of **Physician Documentation**

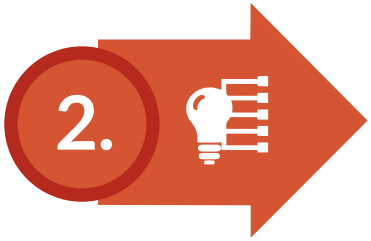
Where should you focus?

Physician documentation will be considerably altered as a result of the ICD-10 implementation. If you do not appropriately document a patient encounter, your medical biller or coder will not be able to assign an accurate ICD-10 code to correspond with the encounter.

If that happens, you simply won't get paid. To avoid the hassle of claim rejections and denials, you must prioritize training your clinical staff for ICD-10 documentation. Here's how to go about it:

Review existing documentation

Step 1 is to see how your practice is currently documenting records. View several patient encounters and check how well your documentation would fare with respect to the ICD-10 requirements. This will help identify inadequacies in your existing documentation.



Immediately upgrade your documentation techniques

Begin implementing the ICD-10 documentation requirements right now; this way you'll be able to avert much of the pressure the October 1 conversion will bring. This would mean that you'd have to document more information for every encounter, even before October 1, however; you'd end up getting more practice.

Post-October Review

After the conversion date, you must periodically review your documentation to identify areas where your staff is falling behind. Your EHR Report & Analytics feature should help you with this.

Where do you stand?

For any process, preparation is the key. ICD-10 is no different; the more time you spend, the better off you'll be. Get acquainted with the documentation requirements, the new codes, and a reformed practice workflow for the conversion.

This e-book has been designed to assist your specialty in understanding the documentation requirements for ICD-10, introduce you to the new codes that your practice will need to learn, and prepare you for a smoother ICD-10 transition. If you require additional guidance , you can contact our ICD-10 implementation experts.

The devil is in the detail

There were only 13,000 ICD-9 codes. The figure stands at around 68,000 for ICD-10. The 55,000 additional codes all point towards specificity in diagnosis. Additional details will be required to distinguish one diagnosis code from the other.

For example, a mere 'pain in limb' associated with ICD-9 code 729.5 will not be enough to get you paid. For your coder to send out the correct code, you will have to provide a more detailed account specifying which limb has been affected (arm, leg, etc).

Additionally, if the pain is in the left upper arm, its code will differ from that of the patient's left arm, the code for the right upper arm won't be the same as pain in fingers, thighs, and so on. In short, if you're not specific in your documentation, your billers won't have much of a chance of getting you reimbursed for services provided.

"More is better" . Don't leave out the small details, as they could be crucial for coding

Must Know Secrets for Easier **EHR Documentation**

Learn what EHR Champions are doing right

ICD-10: **Interactive Guide Menu**

Please click on your specialty below

Family Medicine

OB/GYN

Dermatology

Pediatrics

Cardiology

Family Medicine

Documentation Analysis

Clinical Scenario

Most Common Codes

Documentation **Analysis**

Specialty: Family Practice

The clinical staff at a Family Practice must adequately document these fields in order to fulfill the ICD-10 coding requirements:

Laterality

- Bilateral
- Right
- Left
- Multiple locations

Infections

Linkage between disease process & infective organism

Disease Status

- Primary
- Secondary
- Acute
- Intermittent
- Transient
- Chronic
- Recurrent

Diabetes

- Type I, Type II - long-term insulin use or other cause
- Due to other disease/drug: specify other disease, or drug/chemical if any
- Linkage with complications

Nervous System

- Primary vs. secondary: cause & disease
- Intractable disease
- Paralysis: type & level

Respiratory System

- Chronic disease exacerbation
- Asthma: intermittent vs. persistent & mild, severe or moderate

Circulatory System

- Heart failure: Systolic vs. diastolic, right vs. left
- Acute myocardial infarction (time period = 4 weeks)
- Disease: Rheumatic vs. nonrheumatic
- Atherosclerosis: Native artery (or vein) vs. graft
- Linkage of complications with hypertension
- Cerebral hemorrhage: traumatic vs. nontraumatic, cause of hemorrhage/infarction, artery

Documentation **Analysis**

Skin

- Disease linkage with cause or infectious agent
- Pressure ulcer: laterality, stage, & site
- Non pressure ulcer (chronic): laterality, site, skin breakdown, muscle necrosis, bone necrosis, fat-layer exposed

General Injuries

- Location: head, proximal, shaft, etc
- Tendon type: flexor / extensor
- Care episode: initial/ subsequent/ sequela

Injury Cause

- Reason: e.g. fell from stairs
- Location: e.g. stadium
- Activity: e.g. collecting tickets

Dislocations

- Traumatic vs. stress: open vs. closed, displaced vs. non-displaced
- Healing: routine, nonunion, delayed, malunion
- Pathological fracture (with osteoporosis)A
- Age relation vs. other category

Genitourinary

- Disease: primary vs. secondary
- Stage: chronic kidney disease
- Disease linkage with cause or infectious agent

Digestive System

- Linkage of complications with disease: bleeding, fistula, perforation, obstruction, abscess, gangrene
- Hernia: unilateral vs. bilateral
- Constipation: slow transit / outlet dysfunction

Neoplasms

- Malignant vs. benign, in situ, primary, secondary
- Locations details
- Overlapping vs. distinct locations
- Leukemia: in remission / in relapse

Eye & Ear

- Upper vs. lower eyelid
- Cataract: age, drug-related, or traumatic
- Disease: primary vs. secondary
- Tobacco usage/ exposure impact on ear disease

Musculoskeletal

- Previous trauma, infection, other disease courses
- Disease linkage with cause or infectious agent
- Primary, secondary, or post-traumatic disease
- Cause: pathological fracture due to osteoporosis, neoplastic disease, or other

Clinical **Scenario**

Chief Complaint

Stomach ache, feeling gassy and queasy.

History

- 40 year old Caucasian male with mid abdominal epigastric pain, coupled with severe vomiting and nausea; not able to keep down any liquid or food. Pain is severe & constant.
- Weight loss over past 40 days estimated at around 17 pounds.
- Patient believes consuming around 6 pieces of meat at home four days ago for lunch at home triggered his symptoms.
- Patient validated alcohol dependence history. Consuming 4-5 beers per day at the moment, previously 9-11 each day around six months ago. Reports being nauseous, sweaty & shaky when he does not consume beer.

Exam

- Vitals: temperature 99.8; otherwise normal.
- Mild-jaundice noted.
- Oral mucosa dry, chapped lips, decreased skin turgor.
- Abdomen distended & tender across upper abdomen. Guarding is present. Bowel sounds diminished in all (4) quadrants.

Assessment & Plan

- Suspected acute pancreatitis & dehydration.
- 1L IV NS started in office. Blood drawn for labs.
- Hospital admission orders written & forwarded to on-call hospitalist.
- Recommendation of behavioral health therapy for substance abuse estimation & possible treatment.
- Patient's relatives notified of arrangement; they will arrange private transport to hospital.

Clinical **Scenario**

ICD-10 CM Impacts

Clinical Documentation

- Pain needs to be described comprehensively (specifically), and including location details to the maximum extent.
- Alcohol-related disorders must be distinguished according to: use, abuse, & dependence. ICD-10-CM terminology and requirements for coding substance abuse disorders is new. In this case, based on suspected acute pancreatitis, and his alcohol consumption status, the relevant alcoholism code is given.
- Abdominal tenderness should be included in coding. While more specificity is preferred (including laterality) to generate a more specific code, R10.819 for Abdominal tenderness, unspecified site is used here as we do not have more information to make a more thorough judgment.

ICD-9 CM Diagnosis Codes		ICD-10 CM Diagnosis Codes	
789.06	Abdominal pain, epigastric	R10.13	Epigastric pain
789.60	Abdominal tenderness, unspecified site	R10.819	Abdominal tenderness, unspecified site
782.4	Jaundice NOS	R17	Unspecified jaundice
276.51	Dehydration	E86.0	Dehydration
303.90	Other and unspecified alcohol dependence, unspecified	F10.20	Alcohol dependence, uncomplicated

Other Impacts

None

Common **Codes**

List of the most common ICD-10 codes for the Family Practice specialty.
*Always utilize more specific codes first.

ABDOMINAL PAIN	ICD-9-CM Codes: 789.00 - 789.09	ACUTE RESPIRATORY INFECTIONS	ICD-9-CM Codes: 462, 465.9, 466.0
ICD-10-CM Codes	Diagnosis	ICD-10-CM Codes	Diagnosis (Specify organisms where possible)
R10.0	Acute abdomen	J02.8	Acute pharyngitis due to other specified organisms
R10.10	Upper abdominal pain, unspecified	J02.9*	Acute pharyngitis, unspecified
R10.11	Right upper quadrant pain	J06.9*	Acute upper respiratory infection, unspecified
R10.12	Left upper quadrant pain	J20.0	Acute bronchitis due to Mycoplasma pneumonia
R10.13	Epigastric pain	J20.1	Acute bronchitis due to Hemophilus influenza
R10.2	Pelvic and perineal pain	J20.2	Acute bronchitis due to streptococcus
R10.30	Lower abdominal pain	J20.3	Acute bronchitis due to coxsackievirus
R10.31	Right lower quadrant pain	J20.4	Acute bronchitis due to parainfluenza virus
R10.32	Left lower quadrant pain	J20.5	Acute bronchitis due to respiratory syncytial virus
R10.33	Periumbilical pain	J20.6	Acute bronchitis due to rhinovirus
R10.84	Generalized abdominal pain	J20.7	Acute bronchitis due to echovirus
R10.9*	Unspecified abdominal pain	J20.8	Acute bronchitis due to other specified organisms
		J20.9*	Acute bronchitis, unspecified

Common **Codes**

BACK AND NECK PAIN (SELECTED)	ICD-9-CM Codes: 723.1, 724.1, 724.2, 724.5	CHEST PAIN	ICD-9-CM Codes: 786.50 - 786.59
ICD-10-CM Codes	Diagnosis	ICD-10-CM Codes	Diagnosis
M54.2	Cervicalgia	R07.1	Chest pain on breathing
M54.5	Low back pain	R07.2	Precordial pain
M54.6	Pain in thoracic spine	R07.81	Pleurodynia
M54.89	Other dorsalgia	R07.82	Intercostal pain
M54.9*	Dorsalgia, unspecified	R07.89	Other chest pain
		R07.9*	Chest pain, unspecified

DIABETES MELLITUS W/O COMPLICATIONS TYPE 2	ICD-9-CM Code: 250.00	GENERAL MEDICAL EXAMINATION	ICD-9-CM Code: V70.0
ICD-10-CM Codes	Diagnosis	ICD-10-CM Codes	Diagnosis
E11.9	Type 2 diabetes mellitus	Z00.00	Encounter for general adult medical exam without abnormal findings
	without complications	Z00.01	Encounter for general adult medical exam with abnormal findings

HEADACHE	ICD-9-CM Code: 784.0	HYPERTENSION	ICD-9-CM Codes: 401.9
ICD-10-CM Codes	Diagnosis	ICD-10-CM Codes	Diagnosis
R51	Headache	I10	Essential (primary) hypertension
	without complications		

View the complete list of codes here

OB/GYN

Documentation Analysis

Clinical Scenario

Most Common Codes

Documentation **Analysis**

Specialty: Obstetrics & Gynecology

The clinical staff at an Obstetrics & Gynecology practice must adequately document these fields in order to fulfill the ICD-10 coding requirements:

Laterality
- Bilateral
- Right
- Left
- Multiple locations

Infections
- Linkage between disease process & infective organism

Disease Status
- Acute
- Sub-acute
- Intermittent
- Transient
- Chronic
- Recurrent

Obstetrics
- C-section reason (as principal diagnosis)
- Trimester (when complication arose)
- Abortion: completion, success, & related complications
- High-risk pregnancy: Hx of infertility, molar, or ectopic pregnancy
- Condition: gestational vs. preexisting (if gestational diabetes is controlled)
- Multiples: Fetuses, fetus identification (one with complication)

Nutritional
- Specify deficiencies
- Malnutrition: complications & severity
- Overweight vs. obesity vs. morbid obesity

Female Reproductive
- Infertility source
- Prolapsed extent & location: Midline/ lateral, incomplete/ complete

Neoplasms
- Malignant vs. benign, in situ, primary, secondary
- Locations details, laterality
- Overlapping vs. distinct locations

Diabetes
- Type I, Type II, or due to other cause (disease/ drug)
- Due to other disease/ drug: specify other disease, or drug/ chemical if any
- Linkage with complications
- Gestational vs. pre-pregnancy

Others
- Metabolic Disease: Hyper- & Hypo- don't document ^ or v
- Skin: Disease linkage with cause or infectious agent

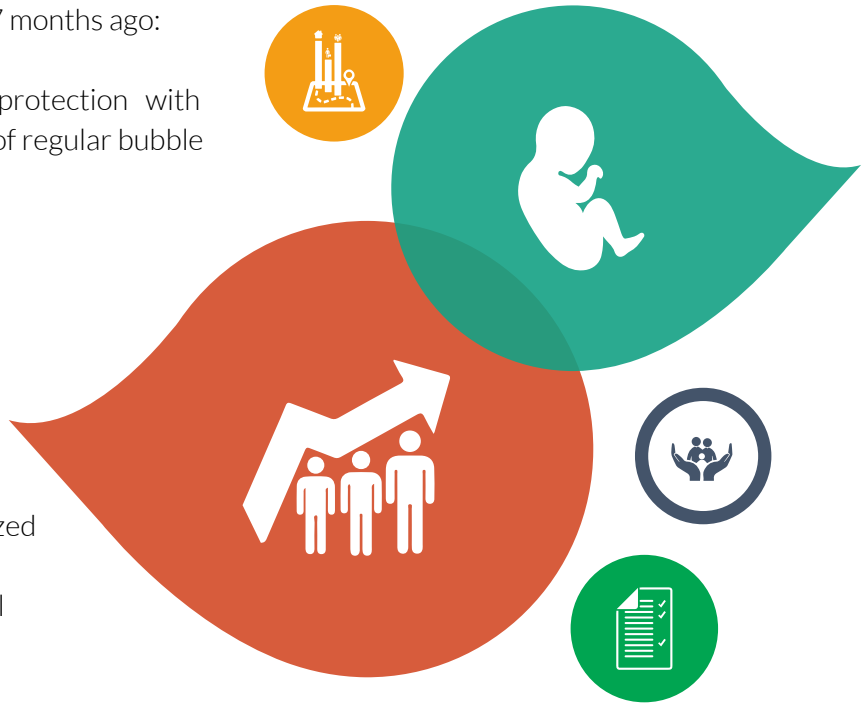
Clinical **Scenario**

Chief Complaint

Vaginal discharge accompanied by odor since one week.

History

- 32 year old female, mother, complains of a watery, whitish-gray vaginal discharge, accompanied by a bitter-fishy smell and an itchy vulva. Symptoms were observed about 8 days back. She affirms that symptoms have never appeared before, and that she tried self-treatment using an OTC (over the counter) yeast mix ture about 5 days ago. Method was ineffective.
- LMP: two-weeks ago: normal. Mammograms: none, previously. Previous PAP examination 7 months ago: normal.
- Social history: Physically and sexually active. Patient is in a sexually active relationship with protection with new male partner since 6 weeks (one partner). Denies history or presence of STIs. Informs of regular bubble baths & douching.
- She does not take alcohol, tobacco, or other drugs.
- Patient is not immunized for Human papillomavirus (HPV).



Exam

- Vitals: T 98.7, BP 126/62, Weight: 115 lbs.
- Well groomed, A&O x3.
- Pelvic: External exam-vulvar redness, negative for vulvar edema, and negative for adherent white clumps.
- Bimanual exam: patient has no pelvic tenderness, the uterus (smooth) & adnexa are both sized normal, and ovaries aren't palpable.
- Speculum exam: pink vaginal-walls, cervix is intact, os is closed, thin gray-white & sharp, foul smelling discharge observed in vaginal canal. Swab specimen has been obtained for her microscopy exam.
- In-office lab tests: Urine hCG - Negative; Yeast - negative; Wet Prep - Positive whiff test, leukocytes and clue cells present; Vaginal-pH - elevated.

Assessment and Plan

- Patient has bacterial vaginosis.
- She has been prescribed metronidazole (7 days).
- HPV vaccine administered today after discussion in office.
- Vaginal hygiene leaflet handed to her.

Clinical **Scenario**

Summary of ICD-10-CM-Impacts

Clinical Documentation

1. In ICD-10-CM, there are 4 choices in contrast to ICD-9's single code for Vaginitis and vulvovaginitis, unspecified, 616.10. The alternatives are N76.0 for acute vaginitis, N76.1 subacute & chronic vaginitis; N76.2 acute vulvitis; & N76.3 subacute & chronic vulvitis. As the patient shows no trends or history of ongoing care or previous episodes, we have selected Acute vaginitis.
2. Moreover, as bacterial vaginosis is not frequently connected to itching, irritation or soreness, it will be assigned a separate code.
3. Although bacterial vaginosis is not an STI. The physician has recommended refraining from intercourse.
4. In ICD-9, there are several vaccination codes while ICD-10 contains only one general code for immunization.
5. The note intentionally does not include a discussion of STI or reproductive planning as it is expected to be commonly denoted in the evaluation & counselling of females of this age.

ICD-9 CM Diagnosis Codes		ICD-10 CM Diagnosis Codes	
616.10	Vaginitis and vulvovaginitis, unspecified	N76.Ø	Acute Vaginitis
698.1	Pruritis, vulvar	L29.2	Vulvar, pruritis
V04.89	Need for prophylactic vaccination and inoculation against other viral diseases	Z23	Encounter for Immunization

Common **Codes**

List of the most common ICD-10 codes for an Obstetrics & Gynecology practice.
*Always utilize more specific codes first.

ABNORMAL FEMALE GENITAL CYTOLOGY (excluding neoplasia and malignancy codes)

ICD-9-CM Codes: 622.10, 622.11, 622.12,792.9, 795.01 - 795.19, 795.4

ICD-10-CM Codes	Diagnosis
R87.610	Atypical squamous cells of undetermined significance on cytologic smear of cervix (ASC-US)
R87.611	Atypical squamous cells cannot exclude high grade squamous intraepithelial lesion on cytologic smear of cervix (ASC-H)
R87.612	Low grade squamous intraepithelial lesion on cytologic smear of cervix (LGSIL)
R87.613	High grade squamous intraepithelial lesion on cytologic smear of cervix (HGSIL)
R87.615	Unsatisfactory cytologic smear of cervix
R87.616	Satisfactory cervical smear but lacking transformation zone
R87.618	Other abnormal cytological findings on specimens from cervix uteri
R87.619*	Unspecified abnormal cytological findings in specimens from cervix uteri
R87.620	Atypical squamous cells of undetermined significance on cytologic smear of vagina (ASC-US)
R87.621	Atypical squamous cells cannot exclude high grade squamous intraepithelial lesion on cytologic smear of vagina (ASC-H)
R87.622	Low grade squamous intraepithelial lesion on cytologic smear of vagina (LGSIL)
R87.623	High grade squamous intraepithelial lesion on cytologic smear of vagina (HGSIL)
R87.625	Unsatisfactory cytologic smear of vagina
R87.628	Other abnormal cytological findings on specimens from vagina
R87.629*	Unspecified abnormal cytological findings in specimens from vagina
R87.69	Abnormal cytological findings in specimens from other female genital organs
N87.0	Mild cervical dysplasia
N87.1	Moderate cervical dysplasia
N87.9	Dysplasia of cervix uteri, unspecified
R87.810	Cervical high risk human papillomavirus (HPV) DNA test positive
R87.811	Vaginal high risk human papillomavirus (HPV) DNA test positive
R87.820	Cervical low risk human papillomavirus (HPV) DNA test positive
R87.821	Vaginal low risk human papillomavirus (HPV) DNA test positive

Common **Codes**

EXCESSIVE, FREQUENT, AND IRREGULAR MENSTRUATION	ICD-9-CM Codes: 626.2 - 626.6, 627.0	GENERAL MEDICAL AND GYNECOLOGICAL EXAMINATIONS	ICD-9-CM Codes: V70.0, V72.31, V72.32 (excluding contraceptive and procreative encounter codes)
ICD-10-CM Codes	Diagnosis	ICD-10-CM Codes	Diagnosis
N92.0	Excessive & frequent menstruation with regular cycle	Z00.00	Encounter for general adult medical exam without a ab
N92.1	Excessive & frequent menstruation with irregular cycle	Z00.01	Encounter for general adult medical exam with ab
N92.2	Excessive menstruation at puberty	Z01.411	Encounter for gynecological examination (general) (routine) w ab
N92.3	Ovulation bleeding	Z01.419	Encounter for gynecological examination (general) (routine) w/o ab
N92.4	Excessive bleeding in the premenopausal period	Z01.42	Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear
N92.5	Other specified irregular menstruation		
N92.6*	Irregular menstruation, unspecified		*abnormal findings=ab

View the complete list of codes here

Dermatology

Documentation Analysis

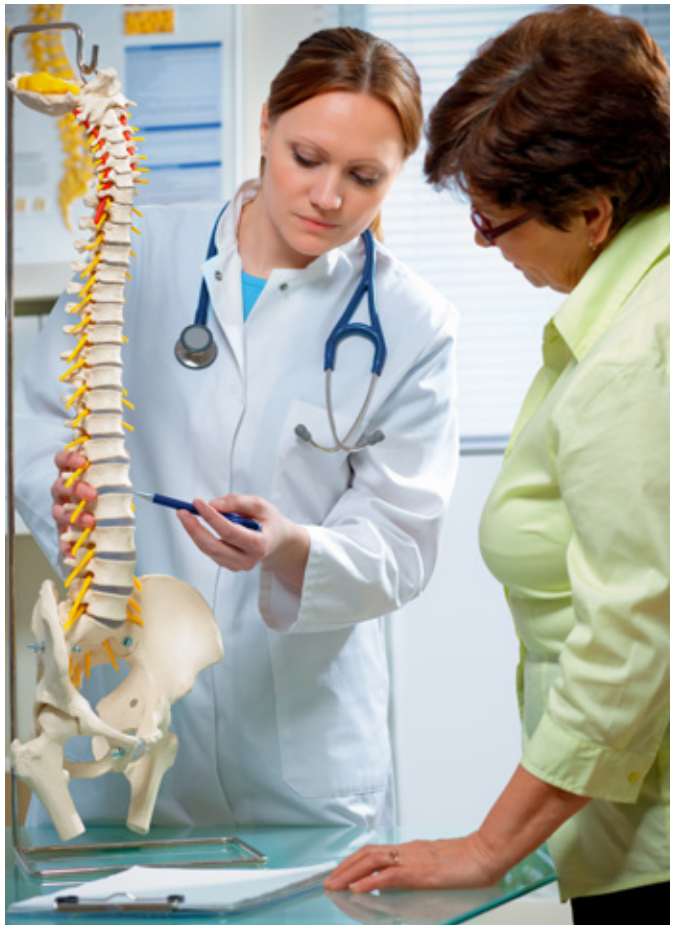
Clinical Scenario

Most Common Codes

Documentation **Analysis**

Specialty: Dermatology

The clinical staff at a Dermatology practice must adequately document these fields in order to fulfill the ICD-10 coding requirements:



Laterality

- Bilateral
- Right
- Left
- Multiple locations

Infections

- Linkage between disease process & infective organism

Disease Status

- Primary
- Secondary
- Acute
- Intermittent
- Transient
- Chronic
- Recurrent

Musculoskeletal

- Previous trauma, infection, other disease courses
- Disease linkage with cause or infectious agent
- Primary, secondary, or post-traumatic disease
- Cause: pathological fracture due to osteoporosis, neoplastic disease, or other
- Arthritis: osteoarthritis vs. rheumatoid

Diabetes

- Type I, Type II, or due to other cause (disease/ drug)
- Linkage with complications

Skin

- Disease linkage with cause or infectious agent
- Pressure ulcer: laterality, stage (I to IV), & site
- Non pressure ulcer (chronic): laterality, site, skin breakdown, muscle necrosis, bone necrosis, fat-layer exposed

General Injuries

- Location: head, proximal, shaft, etc
- Care episode: initial / subsequent/ sequela
- Document reason for contact dermatitis

Injury Cause

- Reason: e.g. fell from stairs
- Location: e.g. stadium
- Activity: e.g. collecting tickets
- External cause: civil, military, leisure, work related

Neoplasms

- Malignant vs. benign, in situ, primary, secondary
- Location details
- Overlapping vs. distinct locations

Clinical **Scenario**

Subjective

- A 78-year-old returning female patient came in today on Dr. Andrew's request. Patient recovering from a fall (from stairs) while walking in her home. Patient complaining of pain in lower back; just above her hips.
- Following up last week on an ulcer, the nurse requested Dr. Andrew to inspect the patient's nose which contains a multicolored lesion with unusual borders. It is usually covered using makeup. Patient said a beauty mark was always present there, but that it grew recently (over several months), and changed color.
- We conducted a biopsy last week, which is being returned to the patient along with its results. The complete lesion wasn't taken last week; because of its size. All other systems came out as negative.

Objective

- Vitals: BP 120/80, temperature 98.9, and BMI 20.1.

Exam

- GEN: Patient is alert but appears somewhat uncomfortable.
- CV: No murmur reported.
- RESP: No crackles, wheezing, or rales.
- ABD: Abdomen not tender to palpitation. Though, pressure on ulcer center on sacrum was present (specify). Fat layer was exposed (specify detailed stage) because patient's skin was vulnerable to breakdown and very thin. There was not any exposure, nor was there necrosis of muscle or bone.
- EXT: No bruising or edema.
- FACE: Lesion observed on her nose on the right side of the nasal bridge. It was above the supratip break on the other side of the nose to the tear trough of the patient's right side (location in detail). About 2.6 cm across, and having a reddish appearance lacking clear borders.

Assessment & Plan

- Patient has stage-2 pressure ulcer on sacrum. Skin lesion on nose confirmed malignant melanoma.
- Malignant melanoma: on the nasal bridge continuing to the right tear. Performed lesion's removal with complex closure. A total length of 3 cm was present.
  Sacral pressure ulcer stage 2.

Common **Codes**

List of the most common ICD-10 codes for Dermatology.
*Always utilize more specific codes first.

PSORIASIS	ICD-9-CM Code: 696.1	ATOPIC DERMATITIS AND RELATED CONDITIONS, OTHER	ICD-9-CM Code: 691.8
ICD-10-CM Codes	Diagnosis	ICD-10-CM Codes	Diagnosis
L40.0	Psoriasis vulgaris	L20.0	Besnier's prurigo
L40.1	Generalized pustular psoriasis	L20.8	Other atopic dermatitis
L40.2	Acrodermatitis continua	L20.81	Atopic neurodermatitis
L40.3	Pustulosis palmaris er plantaris	L20.82	Flexural eczema
L40.4	Guttate psoriasis	L20.83	Infantile (acute) (chronic) eczema
L40.5	Psoriasis, other	L20.84	Intrinsic (allergic) eczema
L40.50	Arthropathic psoriasis, unspecified	L20.89	Other atopic dermatitis
L40.51	Distal interphalangeal psoriatic arthropathy	L20.9	Atopic dermatitis, unspecified
L40.52	Psoriatic arthritis mutilans		
L40.53	Psoriatic spondylitis		
L40.54	Psoriatic juvenile arthropathy		
L40.59	Other psoriatic arthropathy		
L40.8	Other psoriasis		

View the complete list of codes here

Pediatrics

Documentation Analysis

Clinical Scenario

Most Common Codes

Documentation **Analysis**

Specialty: Pediatrics

The clinical staff at a Pediatrics practice must adequately document these fields in order to fulfill the ICD-10 coding requirements:

Laterality
- Bilateral
- Right
- Left
- Multiple Locations

Infections
- Linkage: disease process & infective organism

Disease Status
- Acute
- Recurrent
- Intermittent
- Chronic
- Transient

Newborns
- Newborn-conditions codes differ from 28 day (and older) babies
- Specify maternal conditions: affected & suspected

Anomalies, Congenital
- For syndromes, anomalies (additional) must be documented

Neoplasms
- Type: in situ, malignant vs. benign, primary, & secondary
- Locations: overlapping & distinct
- Leukemia: in relapse or in remission

Nervous System
- Primary vs. secondary: cause & disease
- Epilepsy type: seizure is a single event (or yet to be diagnosed), seizure disorder is epilepsy
- Drug-induced disorders: drug name / type
- Migraine type & aura presence
- Hydrocephalus type
- Intractable disease presence
- Paralysis: type & level

Digestive System
- Linkage of complications with disease: bleeding, fistula, perforation, obstruction, abscess, and gangrene
- Hernia: unilateral vs. bilateral
- Constipation: slow transit / outlet dysfunction

Respiratory System
- Chronic disease exacerbation
- Asthma: intermittent vs. persistent & mild, severe or moderate

Documentation **Analysis**

Circulatory System

- Rheumatic vs. nonrheumatic disease

Eye & Ear

- Upper vs. lower eyelid
- Cataract: age, drug-related, or traumatic
- Disease: primary vs. secondary
- Tobacco usage/ exposure impact on ear

Musculoskeletal

- Previous trauma, infection, other disease courses
- Disease linkage with cause or infectious agent
- Primary, secondary, or post-traumatic disease
- Arthritis: osteoarthritis vs. rheumatoid

Diabetes

- Type I, Type II, or due to other cause (disease/ drug)
- Linkage with complications

Skin

- Disease linkage with cause or infectious agent

General Injuries

- Location: head, proximal, shaft, etc
- Care episode: initial / subsequent/ sequela

Genitourinary

- Disease: primary vs. secondary
- Disease linkage with cause or infectious agent

Clinical **Scenario**

Chief Complaint

Watery (thin) diarrhea accompanied by vomiting and fever since 1 day.

History

31 month-old female came in with dehydration after 2 days of vomiting, watery diarrhea, & fever. She did not show nauseous symptoms, but she kept crying without any tears. According to her father, she is unimmunized for all vaccines. Her parents also reported that she was urinating lesser than before. The father is of the view that symptoms began after a swimming pool outing with her siblings where she could have swallowed water from the swimming pool.

Exam

- She is in evident acute distress, appears dehydrated, and is continuously holding her stomach.
- Vitals: T 100.0, BP 90/55, P 135, R 36. BS hyperactive times all 4 quadrants. Abdomen appears swollen and diffusely tender to palpation. Rebound tenderness, organomegaly or masses not present.
- Both mouth and tongue are dry, and her membranes are mildly pale. Her capillary refill is less than 3 seconds. Skin is dry and skin turgor poor.

Assessment and Plan

- After resolution of current episode, parents will be addressed of her unvaccinated status, which is a concern.
- The patient needs IV hydration. IV fluids & observation at hospital, for which admission orders have been ordered.
- Rotavirus seems likely. Order rotavirus with EIA & RT-PCR, electrolyte panel.

ICD-10-CM Impacts

Clinical Documentation

1. The symptoms of dehydration, diarrhea, dry mouth, vomiting, and fever must be coded. After the determination of nausea (if the patient feels nauseous), the appropriate codes will be entered. Nausea & vomiting differ in codes, as does vomiting unaccompanied by nausea.

2. Establishing why the patient remains unimmunized is necessary for documentation. It is important to determine why the patient was unimmunized & to document it here as this is a significant public health issue. ICD-10-CM has multiple codes to explain why a child has not been immunized.

ICD-9 CM Diagnosis Codes	Name	ICD-10 CM Diagnosis Codes	Name
787.91	Diarrhea	R19.7	Diarrhea, unspecified
780.60	Fever, unspecified	R50.9	Fever, unspecified
787.03	Vomiting alone	R11.11	Vomiting without nausea
276.51	Dehydration	E86.0	Dehydration
789.67	Abdominal tenderness, generalized	R10.817	Generalized abdominal tenderness
V64.ØØ	No vaccination, not otherwise specified	Z28.3	Under-immunization status

Other Impacts

None.

Common **Codes**

List of the most common ICD-10 codes for a Pediatrics practice.
*Always utilize more specific codes first.

ABDOMINAL PAIN	ICD-9-CM Codes: 789.00 - 789.09	ACUTE BRONCHITIS	ICD-9-CM Codes: 466.0, 466.11, 466.19
ICD-10-CM Codes	Diagnosis	ICD-10-CM Codes	Diagnosis
R10.0	Acute abdomen	J20.0	Acute bronchitis due to Mycoplasma pneumoniae
R10.10	Upper abdominal pain, unspecified	J20.1	Acute bronchitis due to Hemophilus influenzae
R10.11	Right upper quadrant pain	J20.2	Acute bronchitis due to streptococcus
R10.12	Left upper quadrant pain	J20.3	Acute bronchitis due to coxsackievirus
R10.13	Epigastric pain	J20.4	Acute bronchitis due to parainfluenza virus
R10.2	Pelvic and perineal pain	J20.5	Acute bronchitis due to respiratory syncytial virus
R10.30	Lower abdominal pain	J20.6	Acute bronchitis due to rhinovirus
R10.31	Right lower quadrant pain	J20.7	Acute bronchitis due to echovirus
R10.32	Left lower quadrant pain	J20.8	Acute bronchitis due to other specified organisms
R10.33	Periumbilical pain	J20.9*	Acute bronchitis, unspecified
R10.84	Generalized abdominal pain		
R10.9*	Unspecified abdominal pain		

CHEST PAIN	ICD-9-CM Codes: 786.50 - 786.59	CHEST PAIN	ICD-9-CM Codes: 786.50 - 786.59
ICD-10-CM Codes	Diagnosis	ICD-10-CM Codes	Diagnosis
R07.1	Chest pain on breathing	R07.82	Intercostal pain
R07.2	Precordial pain	R07.89	Other chest pain
R07.81	Pleurodynia	R07.9*	Chest pain, unspecified

Common **Codes**

ASTHMA	ICD-9-CM Codes: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82 , 493.90, 493.91, 493.92
ICD-10-CM Codes	Diagnosis
J45.20	Mild intermittent asthma, uncomplicated
J45.21	Mild intermittent asthma with (acute) exacerbation
J45.22	Mild intermittent asthma with status asthmaticus
J45.30	Mild persistent asthma, uncomplicated
J45.31	Mild persistent asthma with (acute) exacerbation
J45.32	Mild persistent asthma with status asthmaticus
J45.40	Moderate persistent asthma, uncomplicated
J45.41	Moderate persistent asthma with (acute) exacerbation
J45.42	Moderate persistent asthma with status asthmaticus
J45.50	Severe persistent asthma, uncomplicated
J45.51	Severe persistent asthma with (acute) exacerbation
J45.52	Severe persistent asthma with status asthmaticus
J45.901*	Unspecified asthma with (acute) exacerbation
J45.902*	Unspecified asthma with status asthmaticus
J45.909*	Unspecified asthma, uncomplicated
J45.990	Exercise induced bronchospasm
J45.991	Cough variant asthma
J45.998	Other asthma

HEADACHE	ICD-9-CM Code: 784.0
ICD-10-CM Codes	Diagnosis
R51	Headache
	without complications

Common **Codes**

CHRONIC TUBOTYMPANIC SUPPURATIVE OTITIS MEDIA	ICD-9-CM Code: 382.01	CHRONIC ATTICOANTRAL SUPPURATIVE OTITIS MEDIA	ICD-9-CM Code: 382.2
ICD-10-CM Codes	Diagnosis	ICD-10-CM Codes	Diagnosis
H66.10*	Chronic tubotympanic suppurative otitis media, unspecified	H66.20*	Chronic atticoantral suppurative otitis media, unspecified ear
H66.11	Chronic tubotympanic suppurative otitis media, right ear	H66.21	Chronic atticoantral suppurative otitis media, right ear
H66.12	Chronic tubotympanic suppurative otitis media, left ear	H66.22	Chronic atticoantral suppurative otitis media, left ear
H66.13	Chronic tubotympanic suppurative otitis media, bilateral	H66.23	Chronic atticoantral suppurative otitis media, bilateral

View the complete list of codes here

Cardiovascular

Documentation Analysis

Clinical Scenario

Most Common Codes

Documentation **Analysis**

Specialty: Cardiovascular

The clinical staff at a cardiovascular practice must adequately document these fields in order to fulfill the ICD-10 coding requirements:

Laterality

- Bilateral
- Right
- Left
- Multiple locations

Infections

- Linkage between disease process & infective organism

Status of Disease

- Primary
- Secondary
- Acute
- Intermittent
- Transient
- Chronic
- Recurrent

Diabetes

- Type I, Type II, other drug/disease related
- Linkage with complications

Circulatory System

- Heart failure: Systolic vs. diastolic, right vs. left
- Acute myocardial infarction (time period = 4 weeks)
- Disease: rheumatic vs. nonrheumatic
- Linkage of complications with hypertension
- Cerebral hemorrhage: traumatic vs. nontraumatic, cause of hemorrhage/infarction, artery rupture/ block

Respiratory System

- Chronic disease exacerbation
- Effects of tobacco

Nervous System

- Primary vs. secondary: disease & cause
- Intractable disease
- Paralysis: Type & level

Genitourinary

- Primary vs. secondary
- Stage: chronic kidney disease
- Disease linkage with cause or infectious agent

Clinical **Scenario**

Chief Complaint

Dr. Andrews said that you need to check my hypertension before my surgery.

History

- 77-year-old male patient scheduled for a Transurethral resection of the prostate (TURP) in 6 days. Dr. Andrews asked for the patient to be evaluated for hypertension & cardiac clearance assessment before surgery.
- Inferior wall MI, about one year and two months ago, received thrombolytic therapy which resolved his symptoms completely. The most recent EF, last month, was 50%.
- Patient partakes in swimming, golfing, and walking regularly; denies shortness of breath (SOB) with exertion.
- Patient has no prior history of cerebrovascular disease, and is also negative for CHF,DM, agina, or renal failure.
- Patient does have a history of essential hypertension for which he had been prescribed one daily dose of metoprolol succinate by his primary care physician; however, he has not been taking it citing expense related issues.

Exam

- Patient is in no acute distress.
- Vitals: BP at 157/92 is elevated. Weight & height are fine for age.
- EKG: non-specific t-wave changes.
- PE is normal, chest clear, and no pedal edema.
- Labs: creatinine is at 1.5, slightly increased from his baseline, and could be a possible indicator of early renal insufficiency.

Assessment and Plan

- A PCP will monitor Creatinine & BUN for renal function, and nephrology referral if needed.
- HTN probably from patient's failure to adhere to his daily metoprolol succinate requirements. Will talk to Dr. Andrews to determine if he knew of the patient's financial situation. Change to 2 tab PO daily of propranolol 20 mg, first tab administered in office. Provided 30-day free sample supply of proprano lol.
- Reevaluation of HTN after 3 days; if improved, then give go-ahead for surgery.

Summary of ICD-10-CM Impacts

Clinical Documentation

1. Documenting the need of the clinical encounter is essential, because the coders assign different codes for initial vs. routine vs. surgery clearance visits.
2. According to the lab results, there is a slight enhancement in the patient's baseline, and could be an indicator of early renal insufficiency. This allows the physician to report additional diagnoses that add validity to the abnormal test result.
3. If recognized, it is essential to document the patient's compliance with their prescribed medications. ICD-10-CM introduces a relatively new concept of 'underdosing', which can be captured in alongside diagnoses; in this case that is of metoprolol succinate. Also with underdosing, the physician must document if the undedosing is recurrent or new.
4. ICD-10 also allows coders to 'Use Additional Code' notes beneath the Hypertensive diseases (I10-I15). If recognized, you can document if patients have: exposure to environmental tobacco smoke, occupational exposure to environmental tobacco smoke, history of tobacco use, tobacco use, and/or dependence.

ICD-9 CM Diagnosis Codes	Name	ICD-10 CM Diagnosis Codes	Name
401.9	Unspecified essential hypertension	I10	Essential (primary) hypertension
794.31	Nonspecific abnormal Electrocardiogram (ECG)(EKG)	R94.31	Abnormal electrocardiogram [ECG] [EKG]
794.4	Nonspecific abnormal results of function study of kidney	R94.4	Abnormal results of kidney function studies
412	Old myocardial infarctions	I25.2	Old myocardial infarction
N/A		T46.5X6A	Underdosing of other antihypertensive drugs, [initial encounter]
N/A		Z91.120	Patient's intentional underdosing of medication regimen due to financial hardship
V72.81	Pre-operative cardiovascular examination	Z01.810	Encounter for pre-procedural cardiovascular examination

Other Impacts

In Medicare Advantage Risk Adjustment plans, specifically hierarchical condition categories (HCC), some diagnosis codes are considered to determine severity of risk, illness, and resource utilization. These HCC effects are unnoticed by many in the ICD-9 to ICD-10 conversion. For this, physicians need to examine patients each year and subsequently document the latter's chronic and acute condition statuses accordingly. These HCC codes are considered payment multipliers.

Common **Codes**

List of the most common ICD-10 codes for the Cardiovascular specialty.
*Always utilize more specific codes first.

NONRHEUMATIC VALVE DISORDERS	
ICD-10-CM Codes	Diagnosis
Aortic Valve Disorders	ICD-9-CM Code: 424.1
I35.0	Nonrheumatic aortic (valve) stenosis
I35.1	Nonrheumatic aortic (valve) insufficiency
I35.2	Nonrheumatic aortic (valve) stenosis with insufficiency
I35.8	Other nonrheumatic aortic valve disorders
I35.9*	Nonrheumatic aortic valve disorder, unspecified
Mitral Valve Disorders	**ICD-9-CM Code: 424.0**
I34.0	Nonrheumatic mitral (valve) insufficiency
134.0	Nonrheumatic mitral (valve) prolapse
134.1	Nonrheumatic mitral (valve) stenosis
134.2	Other nonrheumatic mitral valve disorders
134.8	Nonrheumatic mitral valve disorder, unspecified
134.9	Subsequent non-ST elevation (NSTEMI) myocardial infarction

Common **Codes**

CARDIAC ARRHYTHMIAS (OTHER)	ICD-9-CM Codes: 427.41, 427.42, 427.60, 427.61, 427.69, 427.81, 427.89, 427.9	CHEST PAIN	ICD-9-CM Codes: 411.1, 413.1, 413.9, 786.50 - 786.59
ICD-10-CM Codes	Diagnosis	ICD-10-CM Codes	Diagnosis
I49.01	Ventricular fibrillation	I20.0	Unstable angina
I49.02	Ventricular flutter	I20.1	Angina pectoris with documented spasm
I49.1	Atrial premature depolarization	I20.8	Other forms of angina pectoris
I49.2	Junctional premature depolarization	I20.9	Angina pectoris, unspecified
I49.3	Ventricular premature depolarization	R07.1	Chest pain on breathing
I49.40	Unspecified premature depolarization	R07.2	Precordial pain
I49.49	Other premature depolarization	R07.81	Pleurodynia
I49.5	Sick sinus syndrome	R07.82	Intercostal pain
I49.8	Other specified cardiac arrhythmias	R07.89	Other chest pain
I49.9*	Cardiac arrhythmia, unspecified	R07.9*	Chest pain, unspecified

View the complete list of codes here

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