

Physician's Documentation Prescription

2024

Physician's Documentation Prescription

**For physicians
who just want to know
how to**

Write it Right the 1st Time

2024 Edition

Pamela P. Bensen, MD, MS, FACEP

Copyright © 2023 Medical Education Programs
All rights reserved.

ALL SET DOC?™ is a trademark of Medical Education Programs (MEP)
No part of this publication may be reproduced or transmitted in any form or by any
means without prior written consent of Medical Education Programs (434-738-5584).
Please notify MEP immediately if you have received an unauthorized copy.
Independently published.

Disclaimers

This material is intended for clinical documentation education but NOT for coding or medical instruction. It does not recommend or establish any standard of care or medical practice. Only the attending physician may determine the diagnosis of medical conditions of individual patients.

This book is not intended to settle medical, coding, or payment disputes.

The ICD-10-CM codes [] and DRG values, (), (CC)/(C), (MCC)/(M) contained in this document are for the period October 1, 2023 to September 30, 2024. The Hierarchical Condition Category values, { }, {HCC}/{H} is in transition, so no updates have been included.

Codes and their descriptors are based on documents available on the Centers for Disease Control (CDC) and Center for Medicare & Medicaid (CMS) web sites.

Code values are based on documents published on the CMS web site.

Nothing in this book is intended to modify or replace any of the sources it is based on, including the ones identified above or the ICD-10-CM or ICD-10-PCS code books of the corresponding year.

Severity of illness (SOI) in this document is represented using Medicare DRG related SOI indicators for comorbid conditions - (MCC), (CC), and () - and Hierarchical Condition Category designators - {HCC}, and {} - however, there are multiple other proprietary severity of illness systems in use by payors, quality reviewers, registries, and other organizations.

Views expressed here are the opinions of the author, based on education, experience, and analysis. Medical Education Programs is committed to providing accurate information available on the date of publication. Every effort has been made to ensure this accuracy. However, we make no guarantee that this book is error-free. Please

report corrections to icd10MD@gmail.com

DEDICATION

To Cornelius Wesley Bensen III

March 20, 1944 – September 17, 2023

This book is dedicated to my beloved husband, Kork, who was at my side encouraging me at every step, moderating my often-crazy ideas, and patiently filling in the gaps for the last sixty three years; none of this could have happened without his ever-present love and support. I thank him with all my mind, heart, and soul.

I miss you terribly, dear.

CONTENTS

Acknowledgments	i
1 Glossary	1
2 Facts	7
3 ICD-10 & ICD-10-CM	8
4 ICD-10-CM Guidelines	9
5 Medical terms without ICD-10-CM codes	11
6 Diagnostic values	12
7 CPT® & ICD-10-CM	13
8 Documentation simplified	14
9 ALL SET DOC?™ mnemonic	15
10 Uncertain diagnoses	24
11 Quick Tips overview	25
12 ALL SET DOC? Quick Tips	28
13 Terms to Avoid	239
About the Author	242

This book has no index.
Topics in ALL SET DOC? Quick Tips are alphabetized.

Physician's Documentation Prescription 2024

ACKNOWLEDGMENTS

In the late 1990s, **Val Morgan, M. Ed., RHIA, RN** taught me basics of documentation for ICD-9-CM coding. She showed me how physician documentation turns into hospital payment and trained me to write complete diagnoses that met both medical and coding requirements. Val introduced me to coders and encoders, software that takes individual diagnoses and turns them into DRGs for the Medicare Inpatient Prospective Payment System. She taught me how to craft written and oral queries for physicians, so I stayed in compliance and did not ask leading questions. Val convinced me to rely only on primary sources, rather than the opinions of others regarding coding issues. She grounded me in medicine when it looked like coding was taking over the world. I still marvel that she not only understood illnesses I had never heard of but also knew their ICD-9-CM codes without looking them up. Thank you, Val, for making my career in ICD-10-CM possible. I especially appreciate you for being such a great traveling companion; you always make the world smarter, better, and nicer wherever you are.

Clinical indicators (CIs), the symptoms, signs, and test results, that support the selection of one diagnosis over another have gained new prominence since the advent of diagnosis codes. **James S. Kennedy, MD, CCS** is the guru when it comes to explaining and organizing CIs. I had the good fortune not only of taking Jim's annual course at ACDIS but also of working onsite with him as I developed my slide deck of CIs and integrated them into my presentations. I got to see Jim present CIs to physicians as the building blocks for a diagnosis, just as they learned in medical school, and as the clinical validation demanded by nonclinical coders and auditors to prove the presence of that diagnosis. Thank you, Jim, for illustrating the importance of explicitly documenting the evidence of a diagnosis and for providing up to date, well organized summaries of acceptable CIs for all of us to use.

Physician's Documentation Prescription 2024

When **Lynne Spryszak, RN** and I worked on-site together, she modeled successful formal education of coders and CDISs on the fine art of communicating with physicians. Using her vast clinical knowledge, she skillfully walked novice non-clinicians and experienced clinicians alike through the most complicated patient charts to identify documentation opportunities. She would prioritize and organize the issues and carefully craft compliant queries physicians could understand. As her non-physician audience learned to interact productively with physicians, I learned how to turn clinical indicators into persuasive, compliant arguments for more specific diagnoses, an expertise I used extensively as I prepared physicians nationwide for the transition to i10. Using Lynne's logical simplicity, I devised teaching tools to show physicians of all specialties how the specificity of ICD-10-CM could help improve medical care and ensure appropriate payment for hospitals. Thank you, Lynne, for guiding me between medical and coding terminology and providing tools for me to help physicians better understand the difference. You made life easier and more efficient for thousands of physicians. I still thank you daily for being my go-to i10 person and good friend.

There comes a time when random thoughts must be expressed and organized if they are to be productively implemented. When **Eileen M. Clifford, MD**, realized the very survival of her beneficent St. Joseph's Hospital was jeopardized by poor documentation of excellent medical care, she invited me to work with her medical staff. Her insightful evaluation, of her colleagues' medical and documentation skills, identified those most in need and provided sample charts for me to use in one-on-one sessions with those physicians. Politically astute, she integrated me into the medical staff meeting agenda to present a five-minute documentation improvement lecture and to chronicle the positive impact their documentation changes were having. When i10 implementation was delayed a year, she contracted all my available time to prepare her doctors for i10 documentation requirements. Thank you, Dr. Clifford, for your faith in my teaching abilities and for giving me the opportunity to work with your entire medical staff, for coaching me how best to approach each physician, and for heralding their accomplishments. You were the first ALL SET leader paving the way to i10 success. And, you made me part of the wonderful St. Joe's family, for which I will be eternally grateful.

ACKNOWLEDGMENTS

Denise Bino, former Director of Medical Records was the embodiment of the unique, compassionate, and progressive St. Joseph's Healthcare System. In her fifty years there, she worked at least 200,000 hours. When Dr. Clifford first turned me over to this energetic, petite woman, I was immediately impressed by her organizational skills and expertise; and I was overwhelmed by her friendliness and knowledge. Denise was like the ring master in a three-ring circus who doubles as the lion tamer, the trapeze artist, the clown, a juggler balanced on a unicycle, food hawker, costume designer, and mom. Everyone who knows her is sure she must have multiple clones, for no one person could possibly accomplish so much. Denise knew everyone and about everything St. Joes. She is everybody's coach, counselor, mentor, and fan. Thank you, Denise, for taking me under your wing, fostering the development of the system-wide i10 ALL SET DOC-U-Mentation® documentation education program, encouraging reluctant physicians, keeping me organized, and putting the fun back into dysfunctional. I especially want to thank you for nurturing the ALL SET DOC? mnemonic and making St. Joes my home away from home.

My amazing, accomplished, and patient internist daughter **McKay Bensen Crowley, MD**, deserves the credit for my understanding of the documentation challenges faced by 21st century admitting physicians. She has answered hundreds of questions to help me better translate my emergency physician ICD-10-CM expertise into practical documentation solutions for inpatient use. Her breadth of knowledge and depth of experience has proven invaluable to modernize my clinical thinking and database. Her expertise in concise, clear expression of ideas helped me focus and stress the most important concepts physicians need. Thank you, McKay, for gracing my life with your intellect, humor, caring, and assistance. You always keep me grounded, despite my gravitation toward the 'if only'.

My 1973 teaching tools progressed from handwritten acetates and overhead projectors to slides, to successive generations of electronics, which are inherently incompatible with my electromagnetic field. Since 1984, my son **Neil Bensen** has compassionately supported my computers and other electronic

Physician's Documentation Prescription 2024

devices. Polite when awakened in the wee hours, resigned when my panic supersedes logic, and tolerant when a simple reboot solves the problem, Neil is an artist at resisting Ctrl-Alt-Del; and, so far, he has refrained from the human equivalent, matricide. After three plus decades, he still patiently explains, for the umpteen thousandth time, why my computer is confused by my expectations, then he “fixes my problem” (often, magically, from over thousands of miles away), so I can carry on my educational tasks. During rescue efforts, Neil has gotten to know tech support at every hospital I’ve taught at, learned where the today’s nearest BestBuy is, and can remind me where, in my computer case, I misplaced each elusive piece of equipment. Thank you, Neil, for rescuing me from myself and making my presentations look effortless to my students. You keep my world turning even when I forget to plug it in.

Crucial to every book is its title. Selecting a title should be easier than writing a book, right? Wrong! Even as we designed the cover for the first edition, I couldn’t settle on a title that really described it. Then, thanks to the perfect suggestion by long term emergency medicine friends, **Paul (WEMT-P)** and **Evie (MD, FACEP) Marcolini**, the book had a title that fit the contents exactly. Thank you, Evie and Paul, for the most prominent three words on these pages.

To all **my students**, thank you for giving me your time, for listening, and for asking questions that prompted me to rewrite, rephrase, and rethink how to best explain the components of efficient 21st century medical documentation. Thank you for your faith in me and for prompting me to develop a more efficient way for us to remember the specifics of ICD-10-CM. Thank you for being the inspiration for the ALL SET DOC?™ mnemonic and the *Physician's Documentation Prescription*.

The cover of this book was designed by a talented young artist, **McKayla Moxcey**. My granddaughter, McKayla’s creativity is evident in all of her projects. She created a book cover depicting my prescription for the transformation of disconnected signs, symptoms, tests, and treatment responses into a structured ICD-10-CM

ACKNOWLEDGMENTS

diagnosis; from chaos through physician to coherent ALL SET DOC?™
Diagnosis. Thank you, McKayla, for joining my professional team and
decorating my book as you have my refrigerator. I love how you and
your artwork brighten my life.

1: GLOSSARY

Clinical documentation incorporates many unfamiliar terms. For those readers unfamiliar with CDI related abbreviations, acronyms, and phrases, I have placed them as Chapter 1 in this book. I hope this unusual arrangement will enhance the usefulness of this text.

7CE	7 th Character Encounter
Ac	Acute
AISS	Acute illness with systemic symptoms (general or single system): untreated has high risk of morbidity
Ambidextrous	Ability to use right and left hands equally well
Antibiogram	A table comparing bacteria and their antibiotic sensitivities*
ASD	ALL SET DOC?
AUI	Acute, uncomplicated illness or injury: recent/new short-term problem, low risk of morbidity/mortality w tx, full recovery wo functional impairment expected
C19	COVID-19
CC	Comorbid Condition with a severity of illness higher than other diseases*
CDI	Clinical Documentation Integrity
CD	Clinical Documentation
CDIS	Clinical Documentation Integrity Specialist
CDS	Clinical Documentation Specialist
CIE	Chronic Illness w exacerbation/progression
ClIs	Clinical Indicators: Risk factors, history, symptoms, signs, test results, and responses to treatment that support a diagnosis
CISE	Chronic Illness w Severe Exacerbation/Progression

Physician's Documentation Prescription 2024

CMC	Current Medical Condition
CMH	Current Medical History, includes ALL diseases still present*
COMDM	Complexity of Medical-Decision-Making for CPT®
COVID-19	Disease caused by SARS-CoV-2, identified in 2019
CPPA	Correctly-prescribed administered/taken* properly-
CPT®	AMA publication <i>Current Procedural Terminology</i>
CV	Clinical Validation: criteria used to verify, for lay readers, that a <u>Diagnosis</u> is present
Diagnosis*	Diagnosis, condition, or disease
DL	Diagnosis List, a crucial section of the H&P, progress notes and Discharge Summary
Dt, d/t	Due to
Dx	Diagnosis
dX	Used to represent a generic diagnosis for illustrative purposes
E&M	Evaluation & Management
EHR	Electronic Health Record or Electronic Medical Record
EO	Evidence of
eX	Used to represent a generic etiology for illustrative purposes
FT	Function threatening
GLF	Ground level fall
Handedness	The tendency to use either the right or the left hand more easily or skillfully than the other
HCC	Hierarchical Condition Category, a relative value calculated annually for each i10 code from actual billing data and used, in a risk-adjustment model.

GLOSSARY

	to estimate future health care costs for managed care patients
HCPCS	Healthcare Common Procedure Coding System
H&P	History and Physical, the first note for an admitted patient; for CPT® it must be done on the date of the admission
i10	Short-hand for ICD-10-CM (diagnosis codes), ICD-10-PCS (procedure codes) or both (ICD-10-CM/PCS)
i10talk	Context or definition of terms are unique to i10
KRT	Kidney replacement therapy
LOS	Length of stay
LT	Life Threatening
MCC	Major Comorbid Condition with the highest severity of illness*
MEAT	Monitored, evaluated, assessed, or treated
Mnemonic	A tool, such as a pattern of letters, ideas, or associations that assist learning or remembering something
MOD	Multi Organ Dysfunction with sepsis
MP	Minimal problem: may not require a physician but service is provided under their supervision
Not-CPPA	The drug was either not correctly-prescribed or not properly-administered/taken
Other, Specified, Named	In an i10 code descriptor, these terms mean you need to document a specific disease name as the <u>Diagnosis</u>
OQHP	Other qualified health care professional
Physician	Per ICD-10-CM Guidelines: “physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis.”

Physician's Documentation Prescription 2024

PMH	Past Medical History: the conditions that are over and gone
PSI	Patient Safety Indicator
QHP	Qualified Health Professional (qualified to make a diagnosis)
RAF	Risk Adjustment Factor
ROM	Risk of Mortality, a relative value calculated annually for each i10 code from actual mortality data
RUQ	Abdomen: Right upper quadrant
RLQ	Right lower quadrant
LUQ	Left upper quadrant
LLQ	Left lower quadrant
SAI	Stable acute illness: new/recent treatment initiated, patient improving
SCI	Stable chronic illness: expected duration >1yr/patient death, patient at treatment goals
SDOH	Social determinants of health (impact MDM)
SLP	Self-limited problem: runs a definite/prescribed course, is transient, not likely to permanently alter health status
SOI	Severity of illness, a relative value calculated annually for each i10 code from actual billing data and used to determine how sick a patient is*
<u>SOI</u>	CMS SOI values used throughout this book C = Comorbid condition M = Major comorbid condition H = Hierarchical Condition Category () {} = No C/M/H / = Multiple codes and SOI values
SPL	'Suspect,' 'probable' or 'likely'
Syn	Syndrome
Term	A word or group of words
UNP	Undiagnosed New Problem w uncertain prognosis

Unspecified	Strike through indicates a term that should be avoided, if possible
W	With
Wo, w/o	Without
Write	Write, dictate, click, type, copy-paste, & all methods of creating the permanent medical record
'Write it like this'	The combination of 'single quotes,' ' Bold ,' and ' <i>Italics</i> ' indicate you should ' 'Write it like this' ' and ' 'use these terms' '
	This symbol indicates a CAUTION note explaining why certain documentation specifics are so very important
[]	CAUTION this term has no i10 code
∞Link this∞	Terms enclosed in this symbol should be linked to, rather than substituted for, a <u>Diagnosis</u>
-	A dash at the end of an i10 code means there are multiple codes in this subcategory [X12.3-]
-	A dash in the SOI list means the code has the base value of SOI; it is not an MCC/CC or HCC
[X12.3]	Square brackets contain i10 codes, not to teach coding but to illustrate why documentation of diagnostic specificity is needed, so the accurate ICD-10-CM code can be selected
[]	Square brackets with no code inside indicate this term has no ICD-10-CM code
[/]	Square brackets around a forward slash means there are multiple codes representing this condition, too many to list here
(MCC)	A Major Comorbid Condition with the highest SOI
(M)	and ROM values
(CC) (C)	A Comorbid Condition with high SOI & ROM
()	A condition with only a baseline SOI and ROM value

Physician's Documentation Prescription 2024

GLOSSARY

(/)	Forward slash in parentheses is used when conditions in the code set have multiple different SOI and ROM values; some are (), (C), and others (M)
{HCC}	This condition counts as an outpatient Hierarchical Condition Category with a higher SOI
{H}	Not a Hierarchical Condition Category (HCC)
{/}	Some codes in this subset are a Hierarchical Condition Category (HCC), others are not {}
(D)	Document it if it applies
(D+C)	Document and code these items
+	When found between two items, this indicates both must be included
<PSI#>	Patient Safety Indicator number

2: FACTS

1. Regardless of specialty, documentation is the only skill needed for every patient encounter.
2. Medically accurate clinical documentation improves medical care.
3. Medical records must communicate concisely for other clinicians to effectively care for our patients.
4. Physicians control the words they enter into the medical record, regardless of the media used.
5. The patient should look as sick in the notes as they look in the orders.
6. Physicians write diagnoses in words, but only the code assigned to those words have a value.
7. Medical-documentation is not clinical-documentation
 - a. Medical-documentation is medical terminology facilitating analysis, interpretation, extrapolation, and diagnostic deduction by medically knowledgeable readers in a matrix of evolving observations and facts about disease progression.
 - b. Clinical-documentation is terminology defined by non-clinicians who dictate what terms to use, by whom, and where; and who determine when to query physicians because coder analysis and deduction are prohibited.
8. A Diagnosis List ensures that no condition gets overlooked.
9. Every order should have a documented ‘suspected’ diagnosis.
10. Physicians are expected to know all medical documentation, coding, and fraud rules; ignorance is no excuse.
11. A pattern of inappropriate or inaccurate medical documentation is considered healthcare fraud.

3: ICD-10 and ICD-10-CM

1. ICD-10 is the World Health Organization's (WHO) International Classification of Diseases (ICD) version 10 used to standardize diseases worldwide for epidemiology and statistical analysis.
2. Most countries modify the current ICD version to represent their own disease load for epidemiology and death statistics.
3. ICD-10-CM is the Centers for Disease Control (CDC) clinically modified (CM) version of ICD-10 designed for payment, quality review, and statistical analysis in the United States medical system.
4. CDC updates ICD-10-CM codes annually on October 1st, and occasionally on April 1, as in the case of COVID-19 codes.
5. ICD-10-CM contains guidelines that dictate code assignment.
6. Quarterly, the AHA publishes *Coding Clinic* to officially resolve general coding issues and answer ICD-10-CM coding questions.
7. In January 2022, the WHO replaced ICD-10 with ICD-11.
8. The US government does not plan to introduce ICD-11-CM to the American medical care payment system in the near future.

4: ICD-10-CM GUIDELINES

1. ICD-10-CM guidelines are rules (updated annually) that control what ICD-10-CM code is applied to the documentation of a medical diagnosis (disease, condition, circumstance, etc.).
2. The guidelines dictate how codes are assigned and sequenced and when to query the physician.
3. **Who:** Codes may only be applied to the diagnoses documented by the patient's physician ("or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis").
4. **What:** Coding Guidelines: Section I.A.19.: "Diagnosis code assignment must be based on the **provider's diagnostic statement** that the condition exists and is not based on clinical criteria used by the provider to establish the diagnosis."
5. Diagnoses must be **clinically significant** and affect patient care by requiring:
 - "clinical evaluation; or
 - therapeutic treatment; or
 - diagnostic procedures; or
 - extended length of hospital stay; or
 - increased nursing care and/or monitoring."
6. The following may also be assigned an ICD-10-CM code when the physician documents an associated **Diagnosis**:
 - a. Documented
 - i. BAL (blood alcohol level)
 - ii. Body Mass Index (BMI)
 - iii. Glasgow coma scale (GCS)
 - iv. Laterality
 - v. NIH stroke scale (NIHSS)
 - b. Wound care team reported pressure ulcer stage and non-pressure ulcer depth when the physician documents the wound **Site** and **Etiology**
 - c. Social determinants of health (SDOH)
 - d. Test results if reported by a hands-on physician who performed the test (cath report)

ICD-10 and ICD-10-CM, ICD-10-CM GUIDELINES

7. If a definitive diagnosis has not been established by the end of the encounter, documented signs and symptoms may be coded.
8. Medically equivalent terms, synonyms, abbreviations, and slang are not assigned codes unless they are listed in the published code set.
9. **Where:** ICD-10-CM codes are applied to diagnoses primarily documented in the ASSESSMENT/DIAGNOSIS section of physician notes.
10. For inpatient admissions, codes are applied to confirmed and suspected diagnoses documented in the Diagnosis Lists of progress notes and the discharge summary.
11. Codes are not generally applied to diagnoses found in:
 - a. Dietary, imaging, laboratory, pathology, wound care, or other reports even if signed by a physician;
 - b. Past Medical History (PMH), problem lists, hospital course or other parts of the chart;
 - c. Previous charts
12. Because it is over and gone, a condition following the term '~~History of~~' or '~~Past Medical History (PMH)~~' is not usually coded.
13. Personal History of (PHO) conditions are coded with Z-codes because, although not current, monitoring is still required.
14. The physician must be queried:
 - a. If documentation is conflicting, confusing, or missing
 - b. To link conditions when their relationships are unclear
 - c. When it is not clear whether the condition was present on admission (POA)
 - d. When the etiology of organ failure is unclear
 - e. When the etiologic organism is not linked to an infection
 - f. When remission status is unclear
 - g. When 'sepsis' is documented in the presence of a negative/inconclusive blood culture
 - h. When the term '~~urosepsis~~' [] is used

5: MEDICAL TERMS WITHOUT ICD-10-CM CODES

1. Almost every diagnosis has an ‘unspecified’ code for use when specifics, such as acuity, laterality, site, etiology, and type are not documented.
2. Diagnoses with nondescript documentation, “dysfunction” and “insufficiency” in particular, tend to have unspecified codes.
3. Most unspecified codes are low severity of illness (SOI), low risk of mortality (ROM), and trigger payment denials.
4. There are also ‘other’ codes for a recognized variation of a diagnosis before it is assigned its own code. These other codes require a “name” or “descriptor” to distinguish them from the common conditions already included in the ICD-10-CM code set.
5. In this book square brackets [] with no code inside indicate that a term doesn’t have its own ICD-10-CM code.
6. The following common terms do not have their own ICD-10-CM code.

Terms Without ICD-10-CM Codes

Acute ischemic stroke (AIS)	Midline shift
Anemia of chronic disease	Multifactorial anemia
Buckle fracture	Multifactorial anything
Cachexic	Normocytic anemia
Coma Recovery Scale-Revised (CRS-R)	Obtunded
Community acquired pneumonia (CAP)	Pulmonary effusion
Debility	Sepsis syndrome
Deconditioning	SIRS from infection
Demented	Troponin leak
GI abscess	Troponinemia
GI obstruction	Troponin slang terms
GI perforation	Type2 NSTEMI
Healthcare acquired pneumonia (HAP/HCAP)	
Hospital acquired pneumonia (HAP)	Type2 STEMI
Macrocytic anemia	Unresponsive
Malnourished	Urosepsis
Mass effect	Vent acquired pneumonia
Microcytic anemia	

MEDICAL TERMS WITHOUT ICD-10-CM CODES

7. Alternative terms, suggested in the Quick Tips chapter should be used instead of these.

6: DIAGNOSTIC VALUES

1. Diagnostic terminology is NOT assigned values; only the ICD-10-CM code representing the documented condition has value.
2. Severity of illness (SOI) is based on the number, severity, and interaction of diseases, conditions, and complications documented by the physician as represented by the ICD-10-CM codes assigned to the encounter.
3. Risk of mortality (ROM) reflects the expected mortality based on the ICD-10-CM code.
4. Logically, a low SOI will have a correspondingly low expected-ROM.
5. Unspecified codes, derived from unspecific diagnostic terminology have a low SOI and ROM.
6. When a patient with a low SOI and low expected-ROM dies the chart is flagged for quality-of-care review; you want to get it right, so no one dies of a “UTI”.
7. Length of stay (LOS) is an average of the LOS of patients with similar medical conditions in “a” (but not “the”) previous year.
8. SOI, ROM, and LOS values are recalculated annually using actual patient data collected from medical bills.
9. Complexity of medical-decision-making (COM/COMDM) is now the criterion for determination of CPT® Level of E&M service (LOES) and is designated straightforward, low, moderate, or high by the AMA based on the number and complexity of problems addressed; amount/complexity of data reviewed/analyzed; and risk of complications or morbidity/mortality of patient management.
10. The risk adjustment factor (RAF) is a numeric value assigned to almost 10,000 ICD-10-CM codes by CMS to determine annual Advantage Medicare patient payments.
11. Assignment of the SOI, ROM, LOS, COM, LOES, RAF to a patient (encounter) depends solely on correct coding of accurate, complete, and ICD-10-CM compatible physician documentation.
12. The ALL SET DOC?™ mnemonic facilitates compliant documentation for determination of these values.

MEDICAL TERMS WITHOUT CODES & DIAGNOSTIC VALUES

7: CPT® and ICD-10-CM

1. The 1995/1997 CMS Documentation Guidelines have been replaced with guidelines developed jointly by CMS and the AMA to coordinate with the AMA's 2021/2023 CPT® revisions.
2. Documentation requirements for the level of E/M service (LEOS) codes are based on time or complexity of medical-decision-making (COM/COMDM) as found in the MDM table.
3. ED codes are only based on COM, never on time, thus prolonged time codes cannot be used with ED codes.
4. Level of MDM is ranked Straightforward, Low, Moderate, or High across two of three Elements:
 - a. Number and complexity of problems addressed at the encounter,
 - b. Amount/complexity of data to be reviewed and analyzed,
 - c. Risk of complications or morbidity/mortality of patient management.
5. Complexity of a condition is expressed in ICD-10-CM by common concepts and terms (self-limited, minor, stable, chronic, uncomplicated, acute, exacerbation, progression, side effects of treatment, undiagnosed, new, systemic, complicated, test interpretation, and social determinants of health) making it essential to use accurate ICD-10-CM terminology.
6. DO NOT rely on your current knowledge of CPT® E/M documentation; it has all changed! Get the 2023 update.
7. With increased clinical experience MDM does not get less complex, it only gets faster.
8. Make your MDM comprehensive and transparent, only use specific and comprehensive ICD-10-CM Diagnosis documentation.

8: DOCUMENTATION SIMPLIFIED

1. Organize your thoughts into a medical story that flows to logical medical conclusions to facilitate treatment.
2. Document every suspected-diagnosis in a Diagnosis List (DL) and indicate which of those diagnoses were present on admission (POA).
3. Include a DL in the H&P, all progress notes, and the Discharge Summary.
4. A Problem List generated by multiple staff members is not a Diagnosis List and cannot be used for coding.
5. Write the Diagnosis List with coding in mind to eliminate Clinical Documentation Integrity (CDI) queries that require physician rework.
6. Include suspected diagnoses in the DL until confirmed, resolved, or supplanted by an alternative.; state '**Evidence of dx.**'
7. Use the ALL SET DOC?™ mnemonic as a guide to accurate, complete, and comprehensive diagnostic terminology.
8. Document successfully treated diagnoses as '**resolved**,' retire them from further notes, then include them again in the Discharge Summary Diagnosis List.
9. Immediately respond to CDI queries by documenting additional requested information in the next note or in an addendum.
10. If you don't understand a query, request education until you know what is being asked.
11. If the EHR (Electronic Health Record) does not support your documentation, free-text details.
12. Request EHR changes to make you more efficient.
13. Write comprehensive, cogent summaries of all conditions in the discharge summary to ensure continuity of care, transparent medical-decision-making, and accurate coding.
14. Take credit for sick patients, document SOI accurately:

Write it right the 1st time!

Physician's Documentation Prescription 2024

9: ALL SET DOC?™ MNEMONIC

The **ALL SET DOC?**™ mnemonic is designed to help physicians remember the crucial components for comprehensive ICD-10-CM documentation to accurately represent patient severity of illness (SOI), risk of mortality (ROM), and complexity of medical-decision-making (COMDM). As you complete each note, ask yourself if it is, “**ALL SET DOC?**”

ALL: Acuity, Links; Laterality

SET: Site, Etiology, Type

DOC: Diagnosis, Occurrence, Comorbidity/Complication

Acuity: is determined from the patient’s history and contributes to current SOI; acute on chronic being the most severe. i10 Acuity terms include ‘**status**’ (asthma, epilepsy, migraine); ‘**acute on chronic**/‘**exacerbation**’; ‘**acute**’; ‘**chronic**’; ‘**subsequent**’, ‘**old**’ and ‘**congenital**.’ Use the word ‘**acute**’ to indicate “**new-onset**”, “**recent onset**”, and other terms that indicate a condition is a change from the patient’s baseline. ‘**Old**’ is terminology applied to burns; CVAs; MIs; and other medical, surgical, and traumatic diagnoses all of which are not current but impact medical-decision-making.

Links: SOI is often increased when a Diagnosis is Linked to an Etiology or Complications using the terms ‘**due to**’ (dt or d/t), ‘**with**’ (w or c), ‘**from**’, or ‘**in**.’ When the EHR prevents linking, free-text linked conditions; DO NOT just create a list of individual diagnoses. Multiple interrelated conditions should be linked (∞) into a chain (∞∞∞). Linking is crucial for associated conditions, especially those that provide clinical validation (CV) of a diagnosis.

‘Sepsis due to pneumococcal pneumonia with tachycardia (120), tachypnea (22), & leukocytosis (16,000) despite a negative blood culture’

Laterality: ‘**Right**,’ ‘**left**’ or ‘**bilateral**’ is needed for diagnoses associated with paired anatomic structures. For neurological disorders, document both the side of the impairment and the patient’s handedness (right/left/**ambidextrous**):

‘Right hemiparesis, left-handed’

For eyelids, also include ‘**upper**/‘**lower**.’

Site: Be specific, use precise anatomy including laterality. Some specialties, such as orthopedics, have ICD-10-CM specific anatomic terminology to differentiate between diagnostic codes.

Special Note: CMS is considering dropping (MCC)/(CC) status if Laterality or Site is missing from a Diagnosis.

Etiology: Link the Diagnosis to the cause. When uncertain about the exact cause, it is acceptable to document '**evidence of an etiology**'. For infections determine a '**suspected**' organism (the one you are treating). When there are multiple etiologies, link the disease to each one individually.

'Acute hypoxic respiratory failure d/t COPD exacerbation and d/t suspected mycoplasma pneumonia'

'CDK4 d/t hypertension & DM2'

Type/degree/severity/stage: Document distinct Types of medical conditions, since this information may affect treatment, prognosis, SOI, ROM, and LOS and will determine ICD-10-CM codes. Sometimes Type is also the Etiology.

- Abortion **type**: induced, failed induced, threatened, spontaneous-complete, spontaneous-incomplete.
- Burn **degree**: 1°, 2°, 3°
- Chronic kidney disease **stage**: CKD1, CKD2, CKD3, CKD4, CKD5, ESRD.
- Diabetes (DM) **type**: DM1, DM2, gestational (GDM), drug/ chemical induced, d/t other condition. [~~insulin dependent~~ and ~~non-insulin dependent~~ are not ICD-10-CM diabetes Types.]
- Non-traumatic or traumatic **type**: Fracture, hematoma, ruptured spleen, SAH.
- Injury **type**: non-traumatic or traumatic (acute kidney/myocardial).
- Malnutrition **degree**: mild, moderate, severe.
- Neoplasm **type**: benign, in situ, uncertain behavior, malignant primary, malignant secondary (metastatic).
- Obesity **degree**: mild, moderate, severe (morbid).
- Shock **type**: anaphylactic, cardiogenic, hypovolemic, neurogenic, septic.

DOCUMENTATION SIMPLIFIED, ALL SET DOC?™ MNEMONIC

- Stroke **type**: non-traumatic; postprocedural; traumatic.

Diagnosis: The diagnostic process is complex and difficult. Diagnosis stewardship improves the process of diagnosing diseases by using healthcare teams in a joint effort to improve patient and resource management at all stages. Analysis, processes, tools, and technologies to improve patient care and save lives can't achieve this goal without the efforts of a lead healthcare professional to coordinate team efforts improving patient management and outcomes.

Accountability for this overarching Diagnosis Stewardship is assigned to a designated leader by Section III ICD-10-CM Official Guidelines for Coding and Reporting FY 2023: "The listing of the diagnoses in the patient record is the responsibility of the attending (medical) provider."

The attending physician must document every diagnosis/condition in evidence, monitored, treated, or 'suspected.' Whenever possible document signs, symptoms, and test results linked-to, but NOT instead-of, a diagnosis. Use medical words (hypernatremia, hypokalemia) NOT numbers (#), arrows (↑ ↓), or the terms 'high,' 'low,' 'elevated,' 'increased,' 'decreased.'

Don't use ~~history of, Past Medical History or PMH~~ terminology for a chronic condition. Current medical condition (CMC) should be used to describe conditions the patient currently has; while Personal History of (PHO) is for conditions no longer present but still being monitored.

On diagnostic test requisitions, to meet medical necessity (MN) for the test, document the '**suspected-diagnosis**' and Link it to the signs and symptoms, the '**evidence**' of that Diagnosis.

A Diagnosis without ALL SET specifics is considered "unspecified" and will have an unspecified code (generally of low SOI).

Occurrence: Occurrence encompasses all circumstances of the encounter which apply to the Diagnosis being documented.

Link findings (evidence) to the Diagnosis. Criteria and clinical indicators that apply to this disease Occurrence provide clinical validation (evidence) of a (suspected) Diagnosis; support medical necessity for resource expenditures; show complexity of MDM; and often trigger thoughts of another likely Diagnosis.

Use of the term '**evidence of**' for a suspected diagnoses shows your thought process for MDM. Documentation should include **pertinent** history, symptoms, signs, test results, and clinical indicators (CIs), specific to this note. The examples below illustrate how to capture 'evidence of' the patient's current condition for SOI:

- Abnormal findings, especially if newly identified, should always be documented using medical terminology; document when the diagnosis is only suspected and the prognosis is uncertain.
- American Society of Anesthesiologist (ASA) Physical Status Classification

American Society of Anesthesiologist (ASA) Physical Status Classification

ASA I Normal healthy patient

ASA II Patient w mild systemic disease

ASA III Patient w severe systemic disease

ASA IV Patient w severe systemic disease & constant threat to life

ASA V Moribund patient not expected to survive wo operation

ASA VI Brain-dead patient, organs being removed for donation

- Clinical indicators are the evidence of a Diagnosis: Symptoms, history, risk factors, findings (signs, test results, etc.) that point to a Diagnosis. By also documenting criteria used to make a Diagnosis, you lay out the medical-decision-making.
- Concurrent and related diagnoses should be Linked using '**due to**', '**from**', '**in**', or '**with**'.
- Concurrent but unrelated diagnoses should be listed individually.
- Current medical conditions (CMCs) are still present, although they may be chronic; they are NOT past medical history; they are not over and done. Include CMCs in the Diagnosis List so they reflect medical-decision-making.
- CURRENT MEDICAL HISTORY (CMH): This is a note-heading intended to separate current medical conditions (CMCs) from PMH, those that are over and done. Don't continue the 20th-century practice of including CMCs in the PMH. Conditions that are listed only in PMH may not get coded and thus would not contribute to SOI or MDM.

- Current status: Details about alcohol, tobacco and substance use; blood sugar (BS) control; use of insulin, oral diabetic, and other medications; remission; and intractability reflect the ‘current status’ of a disease.
- Diagnosis status for CPT®: complicated, function threatening, life threatening, minor, progression, self-limited, severe, stable, systemic symptoms, treatment side effect, uncertain prognosis, uncomplicated, undiagnosed
- Decisions regarding de- escalate of care because of poor prognosis; DNR status; elective major surgery with/without identified patient or procedure risk factors; emergency major surgery; escalation of hospital- level care; hospice; hospitalization; minor surgery with identified patient or procedure risk factors;
- External causes: Mechanism of injury is crucial to evaluating the pathophysiology, seriousness, treatment, and prognosis of injuries and poisonings. Details about the circumstances, where and how an ‘injury’ occurred, are needed only once in the record. External causes should be recorded in the ED chart. For completeness include them in the H&P, since they affect ongoing care; treatment of **‘thermal burns with smoke inhalation sustained in an explosion of a chemical factory’** will differ from **‘thermal burns from spilling hot coffee on the lap.’**
- ICD-10-CM ‘intent’: Document injuries/poisonings as **‘accidental,’** an **‘assault,’** **‘intentional self-harm,’** or is still **‘undetermined.’**
- Intractable: For asthma, migraines, pain, seizures, etc. indicate whether during this episode, it is **‘intractable’** or **‘tractable’**.
- Obstetrical (OB) timing: Documentation of a pregnancy-related condition must include the timeframe in which it started (**‘pre-existing’** or during trimester 1, 2 or 3 (**‘T1,’ ‘T2,’ ‘T3’**), **‘during childbirth,’** or **‘during the puerperium’**).
- Personal history of (PHO): ICD-10-CM has very specific terminology for conditions the patient no longer has, but which require continued monitoring and therefore are billable diagnoses: **‘PHO uterine cancer (total hysterectomy 2016).’**

NEVER document these conditions as history of; ALWAYS use '**personal history of**' or '**PHO**.'

- PO intolerant: Indicates the patient requires an IV.
- PQRST Palliative/provocative features, Quality, Radiation, Severity, and Timing of signs and symptoms are crucial elements of evidence.
- Present on admission (POA): Indicates the condition, or precursor, was present at the time of the admission order. Diagnoses and conditions documented in the ED chart or in an H&P on the date of admission are POA. An H&P should contain all current acute and chronic conditions, the ED diagnoses, a diagnosis for each medication (home and ordered for ongoing administration), and any early signs of developing problems (stasis ulcers, UTIs from catheters, signs of sepsis, and evidence of early organ failure). If not recorded as POA, the condition may be attributed to the physician or negligence.
- Present prior to procedure (PPTP): Document all conditions the patient has prior to your procedural intervention; otherwise, you may be given credit for causing them.
- Procedural conditions: Document conditions that occur during a procedure ('**hemorrhage during splenectomy**') even when they resolve before the patient leaves the OR. These conditions usually increase the complexity of the procedure, SOI, and COMDM. These events are not considered complications unless you use the terms '**complication**' or '**accidental**' and link them to the procedure.
- Postprocedural conditions: Document '**postprocedural conditions**' that occur after the patient has left the procedure room ('**hemorrhage after splenectomy was completed**'). DO NOT use the terms ~~postoperative~~ or ~~post-op~~ since they are often misinterpreted to mean 'associated with' or 'due to' (caused by) the procedure, rather than occurring in the immediate postop time period.
- Recurrent: When a condition has occurred before, then resolved, and has returned, NOT for chronic conditions.
- Social determinants of health (SDOH) greatly impact MDM. These items were historically considered part of a patient's social

history (SH). They are now recognized as key components in the impact a Diagnosis will have on the patient. When. They are a problem they have an ICD-10-CM Z-code.

- **Physiological:** Air, water, food, shelter, sleep, clothing, reproduction, sanitation, physical activity genetics, gender, basic amenities, transportation
- **Safety:** personal, ethnic, racial, early childhood development, education, language skills, literacy, employment, income, resources, health (services), property
- **Love and belonging:** acceptance, friendship, intimacy, friends, social connection/inclusion/network
- **Esteem:** respect, self-esteem, status, recognition, strength, freedom
- **Self-actualization:** desire to become the most one can be

Social Determinants of Health (SDoH)

Problems related to

Z55-	Education and literacy
Z56-	Employment and unemployment
Z57-	Occupational exposure to risk factors
Z58-	Physical environment
Z59-	Housing and economic circumstances
Z60-	Social environment
Z62-	Upbringing
Z63-	Primary support group and family circumstances
Z64- & Z65-	Psychosocial circumstances

- 7th-character encounter: This is an ICD-10-CM term applied to codes of injuries, poisonings, sequela of diseases, and side effects of medical or surgical care. The 7th Character of these ICD-10-CM codes represent phases-of-care defined as:
 - ‘**Initial**’ encounter: Document this while the patient is receiving “active treatment”. ICD-10-CM redefined the word ‘initial’ (first one) by indicating there may be multiple ‘initial’ encounters during which a patient receives “active

Physician's Documentation Prescription 2024

treatment.” Do not confuse this with the CPT® ‘initial encounter’.

- ‘**Subsequent**’ encounter: Document this after the patient has completed “active treatment” and is receiving “routine care during the healing or recovery phase.” There is no medical description of hard stops between “active treatment” and “routine care during the healing or recovery phase,” each physician has to determine when that transition occurs for each condition, for each patient. Do not confuse this with the CPT® ‘subsequent encounter’.
- ‘**Sequelae**’: Document this when the patient is seen for a residual or late effect. The condition may have been present from the start or developed any time after the instigating condition occurred.

Comorbid conditions: Take credit for your sick patient, document all acute and chronic conditions/diagnoses to capture the true SOI/ROM/COMDM and trigger thoughts of other suspected-diagnoses. Document everything to support medical necessity (MN), length of stay (LOS), and use of resources. Some conditions count more than others, but, since their value is determined differently by each risk adjustment system and readjusted annually based on cost-of-care, don’t worry about their assigned values.

Complications: NEVER use the word “complication” unless the condition was a preventable event that should have been foreseen and that you want tracked for patient safety.

For both Comorbid Condition and Complications, use the word ‘**with**’ to link them to a Diagnosis.

Complications are NOT medical errors; they may be caused by the disease, patient characteristics, procedure risk, or medical misadventure. Many complications increase SOI/ROM/COMDM, so describe them in detail and Link them to related conditions (adhesions, congenital abnormalities, diabetes, obesity, scarring, etc) that contributed to or caused the complication.

For procedural complications, document ‘**X complication d/t the procedure**’ and include details of each of the following:

- ‘**Accidental d/t X**’ or ‘**complication**’
- ‘**Unavoidable d/t X**,’ ‘**anticipated d/t X**,’ or ‘**expected**’
- ‘**Intraprocedural**’ or ‘**postprocedural**’

Physician's Documentation Prescription 2024

- Whether the procedure and complication are '**on the same body system**' or '**on or different body systems**'
- Name these specific associated events 'complications': '**CVA**', '**infection**', '**hemorrhage**', '**hematoma**', '**MI**', '**seroma**'
- Describe complicating factors:
'Accidental, intra-procedural puncture wound R ureter d/t to obesity & adhesions obscuring the ureter during GI surgery'

Not every component of the ALL SET DOC?™ mnemonic is required for every Diagnosis. However, there is no penalty for including information for each component if it accurately reflects the clinical condition.

Example: Adult pneumonia diagnoses do not need Acuity. But, if 'acute' is included along with the Type, Etiology, Comorbid conditions, and Complications of pneumonia, you will not be asked to remove the Acuity.

Make sure your documentation is ALL SET DOC!

Think about it, then write it!

10: UNCERTAIN DIAGNOSES

1. **Uncertainty:** Physicians are seldom absolutely certain of a Diagnosis.
2. It is expected that most diagnoses will be clinical opinions, clinical judgements (educated guesses) based on evidence, not proof, of a disease.
3. Experience, test results, and disease progression improve diagnostic certainty; but generally, do not eliminate all uncertainty.
4. Documenting a differential diagnosis is acceptable early in the course of an encounter for both in and outpatient records.
5. When a diagnoses remains uncertain (cannot be definitively determined), it is always acceptable to document '**evidence of dx includes...**'
6. For an inpatient diagnosis, the additional terms '**suspect**,' '**probable**' or '**likely**' diagnoses may also be used, especially in the discharge summary, if you are still uncertain. These 'acceptable' uncertainty terms consistently pass audits but only for inpatients.
7. For outpatient uncertainty and diagnostic-test requisitions link signs and symptoms to the suspected-diagnosis ('**evidence of dx includes...**').
8. '**Evidence of dx includes...**' makes medical-decision-making transparent and ensures the uncertain Diagnosis (dX) is defensible on all in and outpatient records.
9. Since '**evidence of dx includes...**' is easy to remember and applies to every patient regardless of in or outpatient status, consider using it for every 'suspected' Diagnosis.

11: QUICK TIPS OVERVIEW

1. ALL SET DOC-U-Mentation™ summarized in Quick Tips applies to all medical and surgical specialties.
2. Quick Tips (Chapter 12) is an **alphabetical** list containing problematic diagnoses/conditions with disease variants that have different complexity of medical-decision-making (COMDM), clinical courses, treatments, and ICD-10-CM codes.
3. Abbreviations, acronyms, non-clinical terms, and symbols used in Quick Tips are listed in the Glossary, Chapter 1.
4. With a few exceptions (most notable AKI and CKD) diagnoses are under a general heading (renal failure) not under the acuity of the condition or the common abbreviations (AMI, NSTEMI, and STEMI are found under myocardial infarction).
5. Abbreviations are included to direct you to the general headings.
6. Do not memorize when to use each component of ALL SET DOC?™ mnemonic; avoid CDI queries by using the components you think are logical.
7. The ICD-10-CM code and relative severity of illness (MCC=M, CC=C, HCC=H) will depend solely on the diagnostic terms documented by the physician responsible for making the Diagnosis.
8. In the pages that follow Do Not let the tables with codes intimidate you. These tables merely illustrate the great variability in the ICD-10-CM codes of a single Diagnosis.

Examples:

Basic Heart Failure Documentation				
Acuity			Type	
A on C	Acute	Chronic		
MCC	MCC	CC	SOI	
I50.43	I50.41	I50.42	HCC	Combined
I50.33	I50.31	I50.32	HCC	Diastolic/preserved EF
I50.23	I50.21	I50.22	HCC	Systolic/reduced EF

<u>Other Types of Heart Failure</u>		
	<u>SOI</u>	
I50.9	- H	Congestive
Q22.5	M -	Ebstein's anomaly
E87.70	- -	Fluid overload
I43	C H	HF w cardiomyopathy
I50.83	- H	High output
I50.1	C H	Left ventricular
P29.0	- -	Neonatal
I50.89	- H	Other specified
I50.1	C H	Pulmonary edema w HF
J81.0	M H	Pulmonary edema, acute
J81.1	C -	Pulmonary edema, chronic
I50.81-	/ H	Right (ventricular)
Z91.89	- -	Stage A (personal risk factor)
E87.71	- -	Transfusion circulatory overload

9. ALL SET DOC? Quick Tips follow this pattern

- a. **Acuity:** Acuity will be expanded upon only when it differs from the standard (status, acute on chronic, acute, chronic, or congenital).
- b. **Link:** Even when not included in the Quick Tips, Links always apply to pull together clinical indicators (symptoms, signs, findings, test results, etc); temporal variations; and conditions, comorbidities, and complications to confirm their relationship to the linked Diagnosis.
- c. **Laterality:** Laterality (R, L, bilateral, ambidextrous) always applies for paired sites and neurologic insults.
- d. **Site:** Precise and appropriate to the condition, the specifics of Site may vary with the topic.
- e. **Etiology:** Organism, disease, etc.(anatomy & physiology) will be enumerated for each Diagnosis, often in tables to illustrate how Etiology affects code selection and value.

- f. **Type:** ‘Named’ varieties of a Diagnosis that may have different genetics, etiologies, treatment, management, and prognoses. Like Etiology, Type usually affects code selection and value which will be expanded on in tables.
 - g. **Diagnosis:** Topic specific examples of how to write the Diagnosis in ICD-10-CM terminology are included. Examples do not include every possible literary variation. They are 1-2 topic specific illustrations of ALL SET DOC documentation specificity.
 - h. **Occurrence:** Standard variations of Diagnosis associated details, such as clinical indicators, onset, duration, etc. covered above in the mnemonic review, will not be copied into the Quick Tips except when needed to stress details most significant to the clinical topic. Accepted diagnostic criteria, may be included.
 - i. **Comorbidities/complications:** Common, but not all, concurrent conditions and manifestations of the Diagnosis will be listed.
10. Not every component of the ALL SET DOC?™ mnemonic is needed for every Diagnosis. Quick Tips includes those required to accurately document the clinical condition.
-  11. Caution: The lists of diagnoses in Quick Tips are not complete. There may always be ‘other named’ diagnoses.
12. ‘Write it right the 1st time’ to support severity of illness and medical necessity; show complexity of medical-decision-making; explain Risk of Mortality; and avoid CDI queries that require additional time, work, and documentation.

Prevent rework, ask yourself,

“Is this Diagnosis ALL SET DOC?”

12: ALL SET DOC? QUICK TIPS

1. **ABLA:** See Anemia, blood loss.

2. **Aberrant motor behavior/agitation**

Notes Exit-seeking, pacing, restlessness, rocking; anger, aggression, combativeness, profanity, shouting, threatening, violence, etc. should be linked to appropriate diagnoses.

3. **Abscesses** /{/}

Acuity

Link: to injury, procedure, tobacco/substance use, etc.

Laterality: for paired Sites.

Site: Cutaneous; organ; organ section (mastoid, vitreous of eye), para/peri/post/retro/sub (cutaneous, peritoneal, periosteal, phrenic); pleural; tendon sheath; thorax; etc.

Etiology: Anerobic; non-tuberculous; suspected fungus/organism/parasite/worm; etc.

Type: Brodie's abscess; operative/traumatic wound; stitch; etc.

Diagnosis: '*Amebic liver abscess*'.

Occurrence: Localized, generalized; obstetrical-timing; POA; post procedural; etc.

Comorbid Conditions: Abortion, amebiasis, appendicitis, cholangitis, Crohn's, diverticulitis, ectopic/molar pregnancy, lactation, mastitis, pneumonia, pilonidal cyst/sinus, pregnancy, Schistosomiasis, ulcerative colitis, etc.

Complications: Acute lymphangitis, bleeding, calculus, cellulitis, fistula, hydronephrosis, perforation, peritonitis, pylephlebitis, pyoderma gangrenosum, sepsis, sinus, etc.

**ALL
SET
DOC?** Notes Many abscesses, including cutaneous abscesses, are MCCs, CCs, and HCCs, so documentation of an abscess

with its ASD components can increase COMDM and SOI significantly.

4. **Acidosis [E87.2-](CC){}, [J96.02](M){H}, [J96.12](C){H}**

ALL
SET
DOC?

Acuity: Acute or chronic metabolic/respiratory acidosis

Etiology:

Etiology of Acidosis		
AKI	Dehydration	Malnutrition
Airway obstruction	Diabetes	Neurologic disease
Alcohol	Diarrhea	Obesity
ARDS	DKA	Poisoning
Aspirin	Exercise	Renal tubular disease
Asthma	Fasting	Respiratory failure
ATN	Heart failure	Sedation
Cancer	Hypoglycemia	Seizures
Chest deformity	Hypoxia	Sepsis
Ch alcohol use	Ketogenic diet	Shock
CKD	Kidney failure	Trauma
COPD	Liver failure	Vomiting
		Etc.

Acuity

Type: Metabolic, respiratory, or mixed

Diagnosis: '*Uncompensated respiratory acidosis d/t E'*

Occurrence: Compensated or uncompensated

Occurrence: ABGs, imaging, metabolic panel, PFT, UA results, etc.

Comorbid Conditions, especially those that could contribute to pH changes (heart, kidney, liver, lung disease).

Complications: Arrhythmias, coma, confusion, death, metabolic encephalopathy, organ failure, shock, etc.

Notes Acidosis, often underdiagnosed because it occurs with, but is not considered integral to, other diseases like sepsis, can also be reported as an additional diagnosis when clinically indicated.

5. Acute abdomen [R10.0]()

Acuity: Acute, acute on chronic

Link it to a (suspected) Diagnosis:

'Acute abdomen w RLQ tenderness, rigidity & rebound d/t acute ruptured appendix (POA) with generalized peritonitis'

Laterality & Site:

RUQ	Epigastric	LUQ	Generalized
RLQ	Perumbilical	LLQ	

Etiology:

Etiology of Acute Abdomen

Appendicitis	Neonate necrotizing enterocolitis
Bowel obstruction	Ovarian torsion
Cholecystitis	Pancreatitis
Diverticulitis	Pyelonephritis
Inflammatory bowel D.	Ruptured hollow viscus
Intussusception	Ruptured AAA
Malignancy	Ruptured ectopic pregnancy
Mesenteric ischemia	Ureteral colic
Neonatal midgut volvulus	Etc.

ALL
SET
DOC?

Diagnosis: The condition (Etiology), infection, inflammation, obstruction, or vascular occlusion, suspected of causing of the acute abdomen.

Occurrence: Related findings:

Findings this Occurrence - Acute Abdomen

Document all abnormal results

Symptoms	Signs	Test results
Abdominal pain	Distention	Increased WBC
Fever	Guarding	Ultrasound
Loss of appetite	Rebound	Imaging
Nausea	Rigidity	
Pelvic/perineal pain	Tenderness	
Vomiting		

Comorbid Conditions that will make surgery/recovery more difficult, diabetes, malnutrition, obesity, etc.

Complications: Dehydration, electrolyte imbalance, localized/generalized peritonitis, sepsis, etc.

Acute abdomen is a finding [R-codes], NOT a Diagnosis, and has a low SOI. Always Link findings to a Diagnosis to improve SOI and COMDM.



For 'acute abdomen' to code to an accurate SOI, it must be Linked to the Etiology.

Despite frequent documentation by physicians **guarding** has no ICD-10-CM code.

6. **Acute ischemic stroke (AIS)** [] has no i10 code. See CVA.
7. **Acute kidney/renal failure/AKI:** See kidney failure, acute.
8. **Acute myocardial infarction:** See myocardial infarction, acute.
9. **Acute myocardial injury:** See myocardial injury
10. **Acute pulmonary insufficiency:** See pulmonary insufficiency.
11. **Acute respiratory failure:** See respiratory failure, acute.
12. **Addiction ('Use disorder')** [F10-F19]{}{}

Etiology:

Etiology of Addiction

SOI depends on withdrawal treatment

F10-	Alcohol	F15-	Other stimulants
F11-	Opioid	F16-	Hallucinogen
F12-	Cannabis	F17-	Nicotine
F13-	Sedative, hypnotic, or anxiolytic	F18-	Inhalant
F14-	Cocaine	F19-	Other psychoactive substance
		F19-	Polysubstance abuse

ALL
SET
DOC?

Type of use disorder:

'**Dependence**' = daily use

'**Use**' = occasional use

'**Abuse**' = binge or illicit drug use

Diagnosis: '**Nicotine dependence w withdrawal & mood-disorder**'

Addiction continued**Details of this Occurrence:**

Family history (FH) of substance use disorder [Z81-]

Substance blood/urine level, if available

Patient status

'Uncomplicated'

'In remission'

'With intoxication'

'With withdrawal'

Complications: With...**Complications of Addiction**

'Anxiety disorder'	'Perceptual disturbance'
'Delirium'	'Persisting amnestic disorder'
'Delusions'	'Persisting dementia'
'Hallucinations'	'Psychotic disorder'
'Mood-disorder'	'Sexual dysfunction'
'Other Diagnoses'	'Sleep disorder'

Notes SOI of use disorders/complications depend on Type of substance & details of the Occurrence.

13. Adverse drug effect (ADE) /{}

ALL
SET
DOC?

Link to Etiology (drug name determines code)

Type of ADE the patient experienced (hives, anaphylaxis, nausea, respiratory arrest, vomiting, etc.)

Diagnosis: **'ADE w vomiting d/t CPPA morphine, initial'**

Occurrence: CPPA or not and 7th-character encounter (initial, subsequent, sequela)

Notes CPPA: If the drug was correctly-prescribed and properly-administered/taken it was an ADE.

Not CPPA: If the drug was either not-correctly prescribed or not-properly administered/taken. Then the diagnosis is a poisoning, not an ADE. Overdoses (OD), regardless of intent (accidental or deliberate), are poisonings, not ADEs.

14. **AKI:** See renal failure, acute.

15. **Alcohol use disorder (AUD) [F10-]({})**

Etiology: Ethyl, grain, other alcohol; antifreeze

Type of AUD:

'**Use,**' (occasional)

'**Abuse,**' (binge)

'**Dependence**' (daily)

Details of this **Occurrence:**

ALL
SET
DOC?

AUD Occurrence

Z63.72	Alcoholism in family
	Alcohol use complicating pregnancy
O99.311 T1	O99.314 Childbirth
O99.312 T2	O99.315 Puerperium
O99.313 T3	
R78.0	Blood alcohol positive
Y90.-	Blood alcohol level (BAL)
	Y90.0 < 20 Y90.3 60-79 Y90.6 120-199
	Y90.1 20-39 Y90.4 80-99 Y90.7 200-239
	Y90.2 40-59 Y90.5 100-119 Y90.8 >239
Z71.41	Encounter for abuse counseling/surveillance
Z02.83	Encounter for blood-alcohol test
Z71.42	Encounter for counseling of SO/partner/friend
Z81.1	FH: alcohol abuse/dependence
Q86.0	Fetal alcohol syndrome
P04.3	Newborn (suspected) affected by maternal AUD

'Alcoholic' Complications:

Alcohol Related Complications		
(Alcoholic...)		
I42.6	C H	Cardiomyopathy
K70.31	- H	Cirrhosis with ascites
K70.30	- H	Cirrhosis without ascites
G31.2	- H	Degenerative nerve disease
G31.2	- H	Encephalopathy
K86.81	- H	Exocrine pancreatic insufficiency
K70.0	- -	Fatty liver
K29.21	M -	Gastritis with bleeding
K29.20	- -	Gastritis without bleeding
K70.41	M H	Hepatic failure with coma
K70.40	- H	Hepatic failure without coma
K70.9	- H	Liver disease
K70.2	- -	Liver fibrosis/sclerosis
G72.1	- H	Myopathy
		Pancreatitis
K85.22	M -	Acute w infected necrosis
K85.21	M -	Acute w uninfected necrosis
K85.20	M -	Acute wo necrosis or infection
K86.0	C H	Chronic
G62.1	- H	Polyneuropathy
		Etc.

Alcohol use disorder continued

- Notes** See basics above in Addiction
When the patient denies alcohol intake, document '**no alcohol**' or '**alcohol denied**'.
When alcohol is a suspected Etiology of these diseases, document AUD Etiology, Type & Complications:

Conditions Requiring AUD Documentation	
Cerebrovascular disease [I60-I69]	Malignant neoplasm of
Duodenal ulcer [K26]	Larynx [C32]
Esophageal varices [I85]	Lip-oropharynx [C00-C10]
Esophagitis [K20]	Liver/intrahepatic ducts [C22]
Gastric ulcer [K25-]	Pancreas [C25]
Gastritis/duodenitis [K29]	Pharynx-stomach [C14-C16]
Gingivitis/periodontal disease [K05]	Peptic ulcer [K27]
	PHO malignancy [Z85]
	Salivary gland/tongue disease [K11-K14]

16. Alcohol poisoning

Etiology = **Type** of alcohol: Ethanol, methanol, isopropyl, fusel oil, etc.

Occurrence:

7th-character encounter*: '*Initial*,' '*subsequent*,' '*sequela*'

Intent: '*Accidental*,' '*assault*,' '*intentional*/'*self-harm*,' '*undetermined/not yet determined*'

Clinical findings

ALL
SET
DOC?

Alcohol Poisoning / Toxic Effect					
None are MCC, CC, or HCCs					
Ethanol	Methanol	Isopropyl	Fusel oil	Other	Intent
T51.0X1	T51.1X1	T51.2X1	T51.3X1	T51.8X1	' <i>Accidental</i> '
T51.0X2	T51.1X2	T51.2X2	T51.3X2	T51.8X2	' <i>Self-harm</i> '
T51.0X3	T51.1X3	T51.2X3	T51.3X3	T51.8X3	' <i>Assault</i> '
T51.0X4	T51.1X4	T51.2X4	T51.3X4	T51.8X4	' <i>Undetermined</i> '

Isopropyl = 2-Propanol
Fusel oil = amyl/butyl/ propyl alcohol

Comorbid conditions: AUD, intoxication, etc.

Complications: Hepatic failure, respiratory failure, toxic encephalopathy, etc.

17. **Alkalosis [E87.3](CC){}**

ALL
SET
DOC?

Etiology:

Etiology of Alkalosis		
Adrenal disease	High altitude	Pain
Antacids	Hyperventilation	Pulmonary emboli
Anxiety w hyperventilation	Hypokalemia	Renal impairment
Bicarbonate	Hypovolemia	Stroke
Diuretics	Hypoxia	Sweating
Electrolyte loss	Mechanical ventilation	Vomiting
Fever	NG suction	Etc.

Type: Metabolic, mixed, or respiratory

Diagnosis: '*Compensated respiratory alkalosis d/t E*'

Occurrence: Compensated or uncompensated; ABG, imaging, metabolic panel, PFT, UA results

Comorbid Conditions, especially those that could contribute to pH changes.

18.

Complications: Arrhythmias, carpopedal spasms, coma, death, encephalopathy, headache, hypocalcemia, hypokalemia, muscle loss, organ failure, osteoporosis, seizures, shock, syncope, tetany, etc.

Amputations (Detachments in ICD-10-PCS)

ALL
SET
DOC?

Site including **L laterality** and level of surgery

Etiology: Congenital, diabetes, infection, gangrene, PAD, neoplasm, etc.

Type of amputation: congenital, surgical or traumatic

Occurrence: PHO codes [Z89-] indicate absent limbs.

'PHO traumatic amputation 4th distal phalanx R hand'
[Z89.021]

Comorbid Conditions such as diabetes

Complications: AMI, DVT, edema, infection, joint contractures, pain, phantom limb sensation, pneumonia, skin breakdown, slow wound healing

19.

Altered mental status (AMS) [R41.82]{}{}

Think! Is it encephalopathy?

ALL
SET
DOC?

Acuity

Link to Etiology (what caused the AMS?): encephalopathy, traumatic brain injury, poisoning, etc.

Type: Confusion, delusional, dementia, hallucinations; describe the specific findings leading to the conclusion of AMS

Diagnosis: Most diagnoses with a finding of AMS have a high SOI; name the **Diagnosis** in the Diagnosis List to get credit for this sick patient.

Occurrence: Regardless of etiology, always record the three components of the Glasgow Coma/Confusion Scale [R40.2-]{}{/} for accurate SOI and COM; and an objective

	<p>finding to track recovery</p> <p>Comorbid Conditions: Review and document all known current medical conditions; they often provide the clue to the cause of the AMS</p>
	<p>AMS is a sign NOT a <u>Diagnosis</u>. Document the <u>Etiology</u> and a <u>Diagnosis</u> linked to the AMS.</p> <p>Always ask yourself, “Is this an encephalopathy?”</p>

20. **Anemia**

Think! Is it blood loss?

	<p>Anemia is not normal! If you don't treat it explain why.</p>
ALL SET DOC?	<p>Acuity</p> <p>Etiology is sometimes the Type (See following pages), ‘Anemia due to E’ or ‘X (<u>Type of</u>) anemia’</p> <p>Occurrence: H/H, symptoms and signs, transfusion details, etc.</p>

**ALL
SET
DOC?**

Occurrence: Consider all conditions and document :

- What is being managed in this encounter
 - The anemia
 - The underlying etiology (ESRD, malignancy), etc.)
 - Both
- Whether the anemia is:
 - An adverse effect of radiotherapy [Y84.2]
 - An ADE of antineoplastic/ immunosuppressive drugs [T45.1X5-]
 - Or something else
- Treatment provided for the anemia:
 - Medication
 - Supplements
 - Transfusions
 - Etc.
- Treatment provided for the underlying Etiology:
 - Dialysis
 - Chemotherapy
 - Immunotherapy
 - Radiation therapy
 - Etc.

Comorbid conditions: coagulopathies, GI bleed with specifics, malnutrition, traumatic injuries, vitamin deficiencies, etc.

Complications: '*X due to anemia*:

<u>Complications of Anemia</u>	
Arrhythmias	Severe fatigue
Death	Shock
Fever	Type 2 MI (demand ischemia)
Heart failure	Etc.
Pregnancy complications (premature birth)	



Multifactorial anemia , normocytic, microcytic, macrocytic, and anemia of chronic disease have no codes []. Document specifics of chronic diseases, hemolytic diseases, neoplasms, coagulopathies, and ADEs (link the suspected drug to the anemia) for true-SOI.

Anemia continued

Notes There are over 150 ICD-10-CM codes for anemia (see tables that follow). Document at least one Etiology or Type for each anemic patient. When there is more than one suspected cause for the anemia, document all suspected Etiologies/Types individually.

Nutritional, obstetrical, perinatal, and unspecified anemias are so common that they receive little consideration in a problem list. Since they have a low SOI, make sure other Etiologies are documented.

Anemias associated with other diseases or trauma have a higher SOI and COM, are given a higher priority and are usually treated.

Nutritional Anemias		
	SOI	
D52.0	- -	Dietary folate deficiency
D52.1	- -	Drug-induced folate deficiency
D52.8	- -	Folate deficiency, other
D50.8	- -	Iron deficiency, other
D53.1	- -	Megaloblastic, other
D53.8	- -	Nutritional, other
D53.0	- -	Protein deficiency
D53.2	- -	Scorbutic
D50.1	- -	Sideropenic dysphagia
D51.2	- -	Transcobalamin II deficiency
D51.0	- -	Vt B12 d/t intrinsic factor deficiency
D51.1	- -	Vt B12 d/t malabsorption w proteinuria
D51.8	- -	Vt B12 deficiency, other
D51.3	- -	Vt B12 other dietary deficiency, vegan etc

Obstetrical Anemia			
None are MCC, CC, or HCCs			
T1	T2	T3	Pregnancy complicated by...
O36.821	O36.822	O36.823	Fetal anemia
O36.821	O36.822	O36.823	Fetal thrombocytopenia
O99.011	O99.012	O99.013	Anemia
O99.02	Anemia complicating childbirth		
O90.81	Postpartum anemia w none prior to delivery		
O99.03	Postpartum anemia w pre-existing anemia		

Notes

Perinatal Anemia		
	<u>SOI</u>	
P55.1	- -	ABO isoimmunization
P56.99	M -	Alpha thalassemia
P61.2	C -	Anemia of prematurity
P61.4	C -	Congenital
P61.3	C -	Congenital d/t fetal blood loss
P55.8	- -	Other hemolytic disease
P55.0	- -	Rh isoimmunization

Unspecified Anemia		
	<u>SOI</u>	
D64.9	- -	Anemia
D63.8	- -	Anemia in/of a named chronic disease
No code		Anemia in/of chronic disease
D64.81	- -	D/t chemotherapy, reversible effect
D55.0	- H	D/t G6PD deficiency
D63.1	- -	In chronic kidney disease (CKD 1-ESRD)
D63.0	- -	In neoplastic disease
D50.9	- -	Iron deficiency anemia
No code		Multifactorial anemia
D53.9	- -	Nutritional anemia
B20	- -	Pancytopenia d/t HIV
D46.4	- H	Refractory anemia
D51.9	- -	Vt B12 deficiency anemia

Aplastic/Bone Marrow Failure Anemias		
	<u>SOI</u>	
		Pure red cell aplasia
D60.8	M H	Acquired
D60.1	M H	Acquired transient
D60.0	M H	Chronic
D61.810	M H	Chemotherapy pancytopenia
D61.01	C H	Constitutional
D61.2	M H	D/t other external agents
D61.1	M H	Drug-induced
D61.3	M H	Idiopathic
D61.82	C H	Myelophthisis/leukoerythroblastic d/t Malignant breast neoplasm [C50.-] Tuberculosis [A15.-]
D61.89	M H	Other aplastic syndromes
D61.09	C H	Other constitutional
D61.811	M H	Other drug-induced pancytopenia
D61.818	C H	Other pancytopenia

21. **Anemia, blood loss**

Acuity

Blood Loss Anemia

	<u>SOI</u>	
D62	C -	Acute blood loss anemia (ABLA)
D62	C -	Acute posthemorrhagic anemia
D50.0	- -	Chronic blood loss anemia (CBLA)
R71.0	C -	(Precipitous) drop in Hgb/Hct

Link blood loss to a suspected or proven:

Site of bleeding

'ABLA d/t major traumatic laceration of spleen' [D62] + [S36.032]

& **Etiology:**

GI bleed (& Site)

Carotid artery laceration

Ruptured AAA

Ruptured spleen

Etc.

Link ABLA, CBLA, with Etiologies of both types of blood loss for a true SOI:

'ABLA d/t acute bleeding gastric ulcer w anemia of chronic kidney disease d/t dialysis dependent ESRD' [D62] + [K25.0] + [D63.2] + [Z99.2] + [N18.6]

Diagnosis:

'ABLA d/t alcoholic gastritis with bleeding with hypovolemic shock' [D62](C){} + [K29.21](M){}

Complications often increase SOI:

Angina

Death

Heart failure

MI

Hemorrhagic/hypovolemic shock

ALL
SET
DOC?

Notes SOI depends on acuity of blood loss anemia; the Etiology/source of the blood loss (so document each Etiology separately); and Complications.

22. Anemia, hemolytic**ALL
SET
DOC?****Type:**

Hemolytic Anemias		
	SOI	
D59.8	- H	Acquired, other
D59.1	- H	Autoimmune, other
D55.3	- H	D/t nucleotide metabolism disorder
D55.1	- H	D/t other glutathione metabolism disorder
D59.0	C H	Drug-induced autoimmune
D59.2	C H	Drug-induced nonautoimmune
D55.8	- H	Enzyme disorder, other
D69.41	C H	Evans syndrome, rare, autoimmune
D57.01	M H	Hb-SS disease w acute chest syndrome
D57.02	M H	Hb-SS disease w splenic sequestration
D58.2	- H	Hemoglobinopathies, other
R82.3	- {}	Hemoglobinuria
D59.6	- H	d/t named external cause hemolysis
D59.5	- H	paroxysmal nocturnal
D59.3	M H	Hemolytic-uremic syndrome d/t...
		E. coli [B96.2-]
		Pneumococcal pneumonia [J13]
		Shigella dysenteriae [A03.9]
		Hereditary
D58.1	- H	Elliptocytosis
D58.8	C H	Other
D56.4	- H	Persistent fetal hemoglobin [HPFH]
D58.0	- H	Spherocytosis
D59.4	C H	Nonautoimmune, other
		Sickle-cell
D57.211	M H	Hb-C disease w acute chest syndrome
D57.212	M H	Hb-C disease w splenic sequestration
D57.20	- H	Hb-C disease wo crisis
D57.811	M H	Other w crisis w acute chest syndrome
D57.812	M H	Other w splenic sequestration
D57.80	- H	Other wo crisis
D57.3	- H	Trait
D57.1	- H	Without crisis
		Thalassemia
D56.0	- H	(Severe) Alpha (major)
D56.1	- H	Beta
D56.2	- H	Delta-beta
D56.5	- H	Hemoglobin E-beta
D56.3	- -	Minor
D56.8	- H	Other
D57.411	M H	With crisis w acute chest syndrome
D57.412	M H	With splenic sequestration
D57.40	- H	Without crisis

Occurrence: Acute chest syndrome, crisis, organism, splenic sequestration

Complications pain, etc.

23. Anemia, myelodysplastic

ALL
SET
DOC?**Type:****Myelodysplastic Syndromes**SOI

		Refractory Anemia
D46.0	- H	Wo (ring) sideroblasts/excess blasts
D46.1	- H	W (ring) sideroblasts (RARS)
D46.20	- H	W excess blasts (RAEB)
D46.21	- H	W excess blasts1 (RAEB1)
D46.22	C H	W excess blasts2 (RAEB2)
		Refractory cytopenia
D46.A	- H	W multilineage dysplasia
D46.B	- H	w ring sideroblasts (RCMD RS)
		Myelodysplastic syndrome
D46.C	C H	W 5q deletion, 5q minus syndrome
D46.Z	- H	Other myelodysplastic syndrome

24. Anemia, miscellaneous

ALL
SET
DOC?**Type:****Miscellaneous Anemia**SOI

C94.4-	C H	Acute myelofibrosis
D64.4	C -	Congenital dyserythropoietic
D64.0	C H	Hereditary sideroblastic
D47.1	C H	Idiopathic myelofibrosis
D47.4	- H	Myelofibrosis with myeloid metaplasia
D75.81	C H	Myelofibrosis; D+C underlying condition
D64.89	- -	Other
D64.3	- H	Other sideroblastic
C91.4-	C H	Pancytopenia d/t hairy cell leukemia
D64.1	- H	Secondary sideroblastic d/t disease
D64.2	- H	Sideroblastic d/t drugs/toxins

25. **Angina [I20.9](){HCC}**ALL
SET
DOC?**Type:****Type of Angina**

	<u>SOI</u>	
I20.9	- H	Angina
I20.8	- H	Anginal equivalent
I20.1	C H	Angina w documented spasm/Prinzmetal
I23.7	C H	Post-infarctional angina
I20.2	- H	Refractory angina pectoris
I20.8	- H	Stable angina
I20.0	C H	Unstable angina

Link to Comorbid Conditions:

Atherosclerosis of coronary bypass graft(s)
 Atherosclerosis of coronary artery of transplanted heart
 CAD
 Hypertension [I10-I16]
 MI
 Tobacco exposure* (See below)
 Etc.

26. **Anoxia / Anoxemia**ALL
SET
DOC?**Type****Anoxia / Anoxemia**

	<u>SOI</u>	
G95.11	M H	Acute spinal cord infarction
R09.02	- -	Anoxia unspecified
G93.1	C H	Cerebral
T88.59	- -	Complicating (general/local) anesthesia/sedation
G97.81	C -	During a procedure Due to
G97.82	C -	A procedure
T75.1	C -	Drowning
T70.29	- -	High altitude
W94.11	- -	High altitude as cause of anoxia/hypoxia
G95.11	M H	Spinal cord
O74.3	- -	Cerebral anoxia d/t anesthesia during L&D
O89.2	- -	Cerebral anoxia d/t anesthesia in puerperium
O75.4	- -	Delivery (cesarean) (instrumental)
O74.3	- -	In labor and delivery
O29.21-	- -	In pregnancy
O89.2	- -	Postpartum, puerperal
P84	- -	Intrauterine/newborn/neonatal

27. **Antibiogram**

**ALL
SET
DOC?**

Link the infection-diagnosis to the (suspected) organism being treated and the antibiotic(s) ordered

Organisms are the **Etiology** of infections

Type of infection: Abscess, cellulitis, pneumonia, sepsis, UTI, etc.

Notes Annually, hospital microbiology labs publish sensitivity results from their positive cultures. Often gram-positive and gram-negative results are reported in separate tables; inpatient data is reported separately from outpatient data.

Generally, columns are antibiotics, rows are organisms, and cells contain the percentage of organisms sensitive to the specific antibiotic.

BENSEN HOSPITAL Inpatient Antibiogram Gram (-) Isolates 20XX Last Year's data CS Sensitivities	Total #	Aminoglycs	Cephalosporins			Lactams		Penicillins		Others				
		Amikacin	Gentamicin	Cephazolin	Cefepime	Ceftriaxone	Cephtazidime	Aztreonam	Merpopenem	Ampicillin	Amp/Sulbactam	Pip/Tazobactam	Ciprofloxin	
Acinetobacter species	65	55	52	x	43	0	28	R	48	R	75	45	40	46
Citrobacter species	53	98	85	R	100	87	89	92	98	R	R	91	94	87
Enterobacter species	144	99	94	R	87	64	67	64	89	R	R	67	92	91
All Escherichia coli	793	99	84	x	75	73	73	74	99	30	39	90	52	59
ESBL(+) Escherichia coli	198	98	71	x	0	0	0	0	98	0	21	83	9	35
ESBL(-) Escherichia coli	595	100	89	x	100	97	98	99	100	39	46	92	66	67
All Klebsiella	432	95	93	x	73	73	73	73	88	R	60	79	79	74
ESBL(+) Klebsiella	113	87	75	x	0	0	0	0	58	R	3	37	31	14
ESBL(-) Klebsiella	319	99	99	x	99	98	99	98	99	R	80	94	96	95
Morganella morganii	42	100	69	R	93	88	90	98	100	R	R	100	67	52
Proteus mirabilis	163	99	83	x	75	75	76	77	97	68	76	97	65	75
Pseudomonas aeruginosa	306	93	78	x	74	R	66	61	68	R	R	66	72	R
Serratia marcescens	93	100	97	R	86	65	80	80	86	R	R	73	73	97

If you know or suspect a specific organism (E.coli in a UTI), document it and use the antibiogram to determine the best antibiotic based on local sensitivity data

However, when you are uncertain about the organism, until culture results are available, the antibiogram can be used to determine a 'suspected organism' (the **Etiology**) needed for ICD-10-CM infection codes.

When you write an order for an antibiotic using a guideline or protocol use the antibiogram and note what organisms are highly susceptible (90-100%) to the ordered antibiotic(s).

Notes Then document:

- One organism that is highly susceptible to the ordered antibiotic(s) as the ‘suspected’ Etiology. Select the one
 - Most likely to have caused the infection
 - Most susceptible to the antibiotic ordered
- Pertinent patient demographics, risk factors, infection source, environment, and comorbid conditions and Link them to the (suspected) infection Diagnosis;



- Select an organism likely for the Type of infection (cellulitis, pneumonia, UTI, etc.).
- Make sure to use the most current antibiogram.

28. **Antibiotic resistance [Z16-]**

ALL
SET
DOC?

Etiology: Document the organism being treated

Occurrence: Record drug resistance when known

Antimicrobial Drug Resistance		
	<u>SOI</u>	
A49.02	- -	MRSA infection
B95.62	- -	MRSA in diseases classified elsewhere
J15.212	- H	MRSA pneumonia
A41.02	- H	MRSA Sepsis
		<u>Resistant to</u>
Z16.29	C -	Aminoglycosides
Z16.11	C -	Amoxicillin
Z16.11	C -	Ampicillin
Z16.32	C -	Antifungal drug(s)
Z16.341	C -	Antimycobacterial drugs
Z16.31	C -	Antiparasitic drug(s)
Z16.33	C -	Antiviral drug(s)
Z16.10	C -	Beta lactams
Z16.13	C -	Carbapenem
Z16.19	C -	Cephalosporins
Z16.12	C -	Extended spectrum beta lactamase (ESBL)
Z16.29	C -	Macrolides
Z16.24	C -	Multiple antibiotics
Z16.35	C -	Multiple antimicrobial drugs
Z16.342	C -	Multiple antimycobacterial drugs
Z16.29	C -	Other single specified antibiotic
Z16.39	C -	Other specified antimicrobial drug
Z16.19	C -	Other specified beta lactam antibiotics
Z16.11	C -	Penicillins
Z16.31	C -	Quinine & related compounds
Z16.23	C -	Quinolones & fluoroquinolones
Z16.29	C -	Sulfonamides
Z16.29	C -	Tetracyclines
Z16.21	C -	Vancomycin
Z16.22	C -	Vancomycin related antibiotics

Antibiotic resistance continued

Notes For positive cultures, document the causative organism, Etiology, and its drug resistance at least once. If drug resistance is included in the organism's name (MRSA, VRE, MDR-TB, CRE), then the organism alone will suffice.

As noted in the previous list, SOI is increased when drug resistance is documented by the physician. Drug resistance documentation is especially important when changing antibiotics. Resistance and changing treatment increases COMDM.

29. **Appendicitis [K35-, K36, K37](/){}**

ALL
SET
DOC?**Acuity:** Acute, chronic, recurrent**Diagnosis:**

Appendicitis Diagnosis		
	<u>SOI</u>	
K35.80	C -	Acute appendicitis
	-	Acute appendicitis with
K35.219	M -	Generalized peritonitis ? perf w abscess
K35.209	C -	Generalized peritonitis ? perf wo abscess
K35.211	M -	Generalized peritonitis w perf w abscess
K35.201	C -	Generalized peritonitis w perf wo abscess
K35.210	M -	Generalized peritonitis wo perf w abscess
K35.200	C -	Generalized peritonitis wo perf wo abscess
K35.30	C -	Localized peritonitis
K35.31	C -	Localized peritonitis w gangrene
K35.32	M -	Localized peritonitis w perforation
K35.33	M -	Localized peritonitis w perf w abscess
A06.89	C -	Amebic appendicitis
K37	- -	Appendicitis
K38.1	- -	Appendicular concretions
K38.9	- -	Disease of appendix, unspecified
K38.2	- -	Diverticulum of appendix
K38.3	- -	Fistula of appendix
K38.0	- -	Hyperplasia of appendix
K35.890	C -	Other acute appendicitis
K35.891	C -	Other acute appendicitis w gangrene
K36	- -	Other (chronic, recurrent, etc..) appendicitis
K38.8	- -	Other specified diseases of appendix

ALL
SET
DOC?**Link to Complications**, which often increase SOI:

Abscess
 Gangrene
 Generalized peritonitis
 Localized peritonitis
 Perforation
 Rupture
 Sepsis, severe sepsis, septic shock

- Notes** When the pathology report becomes available, add a dated addendum to the chart with the reported findings and reaffirm or amend the original Diagnosis.
- When '**sepsis due to appendicitis**' is documented, sepsis codes will be applied in addition to appendicitis and other complication codes. 'Non-surgical' diagnoses and codes

may significantly increase the SOI of appendicitis patients.

30. **Appendicitis misdiagnosis**

Notes It is acceptable to remove a normal appendix. However, if something other than appendicitis is found at surgery, detail the pre-op signs, symptoms, and test results leading to the original appendicitis Diagnosis. Document the pathology found and the new Diagnosis completely.

If other pathology is found in addition to appendicitis, document both diagnoses comprehensively and link them where appropriate.

31. Arrhythmias /{/}

ALL
SET
DOC?

Laterality & Site: Atrial, bundle branch, ventricular, etc.

Type: Fibrillation, flutter, etc.

Notes Descriptions of arrhythmias cannot be coded, only the specific diagnoses have codes. Life threatening and complex arrhythmias with an increased ROM have higher SOIs, but all documented arrhythmias contribute to complexity of medical-decision-making.

32. **Arthritis** [](){ }{ }

Laterality & Site: Ankle, elbow, foot, hand, hip, knee, shoulder, vertebrae, wrist, multiple sites, etc.

Etiology:

Medications: Drug name + ADE details

Organism, if Infectious

Other diseases

Etiology of Arthritis: Other Diseases**SOI**

E85.-	C H	Amyloidosis
with .61-	/ H	Diabetes E08-E13
L51.-	C H	Erythema multiforme
L52	- -	Erythema nodosum
M36.2-M36	- -	Hematological condition
E83.11-	- H	Hemochromatosis
E21.-	- H	Hyperparathyroidism
M36.4	- -	Hypersensitivity reaction
E00-E03	- /	Hypothyroidism
M36.1	- -	Neoplasms
A52.16	- -	Neurosyphilis
L40.5-	- H	Psoriasis
K50.-	C H	Regional enteritis/Crohn's
D86.86	- -	Sarcoidosis
D57.-	/ /	Sickle-cell disorders
E05.-	- H	Hyperthyroidism
K51.-	C H	Ulcerative colitis
K90.81	C H	Whipple's disease

**ALL
SET
DOC?**

Trauma (recent or distant): describe it

Type

Enteropathic:

Enteropathic arthropathies**SOI**

M07-	- -	Enteropathic arthropathies
K50.-	C H	Regional enteritis/Crohn's
K51.-	C H	Ulcerative colitis
K90.81	C H	Whipple's disease

Type

Infectious: document a suspected organism

ALL
SET
DOC?

Infectious Arthritis

	<u>SOI</u>	
A54.42	C H	Gonococcal arthritis
A69.23	C H	Lyme
A39.83	C H	Meningococcal
B26.85	C H	Mumps
M00.8-	C H	Other bacterial
M00.1-	C H	Pneumococcal
A39.84	C H	Postmeningococcal
M009	C H	Pyogenic, unspecified
B06.82	C H	Rubella arthritis
A02.23	C H	Salmonella
B42.82	- H	Sporotrichosis arthritis
M00.0-	C H	Staphylococcal
M00.2-	C H	Streptococcal, other
A52.77	C -	Syphilis arthritis (late)
A52.16	C -	Charcot's Tabetic arthropathy
A18.02	C -	TB arthritis of other joints
A18.01	C -	TB arthritis of spine
A01.04	C H	Typhoid

Juvenile arthritis:

Juvenile Arthritis

	<u>SOI</u>	
M081	- H	Ankylosing spondylitis
M08.9-	- H	Arthritis
M08.8-	- H	Other
L40.54	- H	Psoriatic arthropathy
		Rheumatoid arthritis
M083	- H	Polyarthritis (seronegative)
M08.2-	- H	With systemic onset
M08.4-	- H	Pauciarticular

Osteoarthritis:

Osteoarthritis

	<u>SOI</u>	
M47-	C -	Of spine/spondylosis
M15-	- -	Primary
M19	- -	Post-traumatic
	- -	Secondary

Arthritis continued**Rheumatoid arthritis:**

Rheumatoid Arthritis		
	SOI	
M45-	- H	Of spine/ankylosing spondylitis
M06.8-	- H	Other specified
M05.8-	- H	Other w rheumatoid factor
M06.9	- H	Unspecified
		With
M05.6-	- H	Other organ/system involvement
C91.Z	C H	Other lymphoid leukemia
M05.9	- H	Rheumatoid factor
M05.3-	- H	Rheumatoid heart disease
M05.1-	- H	Rheumatoid lung disease
M05.4-	C H	Rheumatoid myopathy
M05.-	- H	Rheumatoid polyneuropathy
M05.2-	- H	Rheumatoid vasculitis
M06.0-	- H	Without rheumatoid factor

Other:**ALL
SET
DOC?**

Other Arthritis		
	SOI	
M14.6	- -	Charcot's joint
L51.-	C H	Erythema multiforme
L52	- -	Erythema nodosum
M10-	- -	Gouty arthritis
E83.11-	- -	Hemochromatosis
E21.-	- H	Hyperparathyroidism
E00-E03	- /	Hypothyroidism
E78.81	- H	Lipoid dermatoarthritis
G98.0	- -	Neurogenic arthritis
M04.8	- H	Other autoinflammatory syndrome
M16-19	- -	Post traumatic
L40.52	- H	Psoriatic arthritis mutilans
M02.3-	C -	Reiter's disease, reactive arthritis
D86.86	- -	Sarcoid
D57.-	M /	Sickle-cell disorders
E05.-	- H	Thyrotoxicosis/hyperthyroidism
M12.5-	- -	Traumatic (recent trauma)

Occurrence

Family history of arthritis [Z82.61]

Long-term drug therapy [Z79]

Presence of orthopedic joint implants [Z96.6]

Comorbid Conditions

Complications:ALL
SET
DOC?**Complications of Arthritis**

CAD	Pericarditis
Carpal tunnel syndrome	Pulmonary fibrosis
Fractures	Pulmonary nodules
Infections	Rheumatoid nodules
Lymphoma	Sjogren's syndrome
Osteoporosis	Etc.

Notes Some arthritis codes are HCCs, so documented Site, Etiology, Type, & Complications may improve risk adjusted payments.

Arthritis does not contribute to inpatient SOI, but some diseases that cause arthritis do, so document all Etiologies, Types, and Complications especially when patients are on long-term medication for arthritis inflammation and pain.

33. **Ascites** [R18.8] (){} is a sign with little value that may be increased by linking it to the Etiology/Type.

Etiology:ALL
SET
DOC?**Etiology of Ascites**

	<u>SOI</u>	due to...
K70.31	- H	Alcoholic cirrhosis
K70.11	- -	Alcoholic hepatitis
I82.0	M H	Budd-Chiari syndrome
K71.51	- -	Chronic active hepatitis
I82.0	M H	Hepatic vein thrombosis or obstruction
K71.51	- -	Lupoid hepatitis
B65.2	C -	S. japonicum
A52.74	C -	Syphilis
K71.51	- -	Toxic liver disease with chronic active hepatitis
A18.31	- -	Tuberculosis

Type**Type of Ascites**

	<u>SOI</u>	
R18.8	C -	Ascites (abdominal)
I50.810	- H	Cardiac (right heart failure)
I89.8	- -	Chylous (nonfilarial)
		Infectious (see Etiology)
R18.0	C -	Malignant
R18.8	C -	Pseudochylous

Diagnosis: Infection caused by identified organism

- 34. Asthenia** (See 'Rehab' for additional details)
- DEF: Abnormal physical weakness or lack of energy

ALL
SET
DOC?

Etiology: '*Asthenia d/t septic shock w myopathy of critical illness'*

Type:

<u>Type of Asthenia</u>		
SOI		
R53.1	- -	Asthenia
F44.4	- H	Hysterical
F45.8	- H	Psychogenic cardiac
F48.8	- -	Psychoneurotic
R54	- -	Senile

This Occurrence:

Descriptions of abnormal physical finding (Laterality, Site and Type) with Functional Independent Measurement (FIM)

Comorbid Conditions: All medical/functional conditions.

Complications:

Malnutrition

Traumatic injuries in detail at least once

- Notes** 'Lack of energy' and 'weakness', often cited as the reason for Inpatient Rehab Facility (IRF) care, are not diagnoses and have a low SOI. Document these findings linked to the Etiology, and a Diagnosis to for a more accurate SOI & COM and to better support IRF medical necessity.

- 35. Asthma [J45-] (/){}**

ALL
SET
DOC?

Acuity:

<u>Acuity of Asthma</u>		
/	SOI	
/	C H	Status asthmaticus
J44.9	C H	Exacerbation
	- H	Chronic (obstructive asthma)

Type:

Intermittent

Mild persistent
Moderate persistent
Severe persistent
Other

Diagnosis '**Severe persistent asthma in status w R 32 rapid shallow; decreased BS; quiet expiratory wheezing; tripoding'**

Comorbid conditions: COPD, bronchitis, influenza, pneumonia, etc. + tobacco exposure*.

ALL
SET
DOC?

Complications: Document all details about these conditions that may increase SOI:

Uncomplicated

'**Acute respiratory failure with hypoxia**' [J96.01](M){H}

'**Acute encephalopathy d/t hypoxia w AMS**' [G93.40](M){}

'**Respiratory arrest**' [R09.2](M){H}

Etc.

Notes Rare asthmas, detergent [J69.8], eosinophilic [J82], miner's [J60], and wood [J67.8], should be documented if present.

36. Atherosclerosis/Arteriosclerosis [I25-](/){/}

Laterality + Site:

Site (artery) of Atherosclerosis				
Aorta	Extremity	Leg	Retinal	Etc.
Cerebral	Generalized	Mesenteric	Spinal cord	
Coronary	Kidney	Pulmonic	Vertebral	

Type of vessel:

ALL
SET
DOC?

Native artery

Bypass graft:

Autologous artery

Autologous vein

Non-autologous biological

Other

Although the **Type** of vessel is seldom recorded, it may increase SOI, so, if you know it, write it

Comorbid conditions: Tobacco-exposure* is required

documentation

Complications: Atherosclerosis of extremities also needs documentation of claudication, gangrene, rest pain, and ulceration, some of which increase SOI and COM.

37. **Atherosclerotic heart disease [I25.1-] (/{})**

Site:

- Native artery: CAD
- Bypass graft:
 - Autologous artery
 - Autologous vein
 - Non-autologous biological
 - Other
- Transplanted heart:
 - Native coronary artery
 - Bypass graft

Type of lesion:

- ALL**
SET
DOC
- Atheroembolism [I75.-]
 - Calcified [I25.84]
 - Lipid rich plaque [I25.83]

Comorbid conditions: Tobacco exposure* is required documentation with the Diagnosis of atherosclerosis

Complications:

- Angina pectoris
- Angina pectoris with documented spasm
- Ischemic chest pain
- MI
- Other forms of angina pectoris
- Past MI w/o symptoms diagnosed by ECG/other investigation
- Unstable angina pectoris

Notes For ICD-10-CM, atherosclerotic heart disease is called coronary artery disease (CAD) only when native vessels are involved.

Synonyms:

- Coronary (artery) atheroma
- Coronary (artery) atherosclerosis
- Coronary (artery) disease
- Coronary (artery) sclerosis

-
38. **ATN (acute tubular necrosis):** See Renal failure, acute
39. **Atrial fibrillation (AF) [I48-](/){/}**

ALL
SET
DOC?**Type:**

Type of Atrial Fibrillation		
	<u>SOI</u>	
I48.91	- H	AF > 30 seconds
I48.11	C H	Long-standing persistent AF Uninterrupted AF > 1 year
I48.19	C H	Other persistent AF > 7 days Usually requires treatment
I48.0	- H	Paroxysmal AF Variable frequency, spontaneous or termination w intervention in < 7 days
I48.21	C -	Permanent AF Patient & physician decide to stop trying to restore/maintain sinus rhythm
I48.19	C H	Persistent AF > 7 days

Comorbid Conditions:

Atrial flutter [I48.92](C){H}
 Angina [I20.9]
 Tachycardia [R00.0]

Complications:

Adverse drug effect (hemorrhage from anticoagulant)
 Heart failure
 Stroke
 Etc.

40. **Atrial flutter [I48.92](CC){HCC}**

ALL
SET
DOC?**Type:**

Type I/typical [I48.3](C){H} A flutter is confined to the R atrium
 Type II/atypical [I48.4](C){H} A flutter may originate in the R atrium, but includes a number of abnormal electrical paths

Comorbid Conditions:

Atrial Flutter Comorbid Conditions		
Atrial fibrillation	PHQ cardiac surgery	Thyroid toxicosis
COPD	PHQ atrial ablation	Etc.
Heart failure	Pulmonary embolism	

41. **Bacteremia [R78.81](CC){}**

Think! Is it sepsis?

**ALL
SET
DOC?**

Etiology: Organism identified

Diagnosis: Infection caused by identified organism

Complications: Organ failure, sepsis, severe sepsis, septic shock, etc.

Notes A positive blood culture occurs only if bacteria are captured traveling in the blood stream when the blood is drawn. Bacteremia is a sign, a positive test result, NOT a Diagnosis. It indicates bacteria in the blood stream confirmed on culture. It is not a sign of disease and is usually asymptomatic. Everyone has bacteremia when they brush their teeth.

Symptomatic bacteremia, often a sign of disease, may be accompanied by fever, shaking chills, and an elevated WBC. Document the Diagnosis, the infection, Linked to the bacteremia.

‘Bacteremia’ is NOT ‘sepsis,’ either clinically or in documentation definitions. So, if there is ‘**sepsis**’ in addition to bacteremia, both must be documented.

42. **Behavioral disturbances**

Notes Sleep disturbance, social disinhibition, sexual disinhibition

43. **Blood alcohol: positive test result**

**ALL
SET
DOC?**

Link the test result to a Diagnosis:

‘AUD with Intoxication, BAL 200’ [R78.0]{} + [Y90.6]{}

Occurrence:

An abnormal lab, alcohol present [R78.0]{}

The specific abnormal lab value [Y90.-]{}

Notes A positive blood alcohol finding has two potential codes. The finding of alcohol in the blood [R78.0]{} indicates an abnormal lab result, which will be accompanied by an

External Cause Code [Y90.-], if the blood alcohol level (BAL) is documented.

44. **Blood alcohol level (BAL) [Y90.-]()**

ALL
SET
DOC?

Diagnosis: '*Withdrawal*' may be found in the presence of '*intoxication*'. Both diagnoses increase SOI, especially when treated.

Occurrence: Document the numerical lab result, the amount of alcohol measured in the blood, so it may be coded:

Blood alcohol level (BAL) (mg/100ml)					
	SOI			SOI	
R78.0	- -	Blood alcohol positive			
Y90.0	- -	<20			
Y90.1	- -	20-39	Y90.5	- -	100-119
Y90.2	- -	40-59	Y90.6	- -	120-199
Y90.3	- -	60-79	Y90.7	- -	200-239
Y90.4	- -	80-99	Y90.8	- -	>239

45. **Blood culture (BC)**

ALL
SET
DOC?

Etiology: Organism identified

Link the organism to the **Type** of infection and a **Diagnosis:**

'Sepsis due to E.coli pyelonephritis w +BC'

'Suspected Gram (-) sepsis d/t aspiration pneumonia despite negative BC'

Notes Despite severe infection, BCs are seldom positive (<30%). This may be due to previous antibiotic treatment; poor sample collection or lab techniques; or hard to grow organisms, but it usually has to do with when, in the timeline of the disease, the blood culture was drawn.

Blood cultures are only positive when there are bacteria in the blood stream (bacteremia) at the precise time of culture collection. Bacteria entrenched in an organ are not captured in a blood draw. Labs report their positive-culture statistics in an annual antibiogram.

When BCs are negative in a septic patient, document '**sepsis despite negative BC**,' to prevent a CDI query.

46. **Blood loss anemia:** See anemia, blood loss

47. **Blood sugar (BS) abnormality** /{/}

Link the abnormal BS to a suspected **Etiology:**

Etiology of Abnormal Blood Sugar Test		
	<u>SOI</u>	
O99.81-	- -	Abnormal glucose in pregnancy, not GDM Diabetes Type
E10-	/ H	DM1
E11-	/ H	DM2
E08.-	/ H	DM due to underlying condition
P35.0	C -	Congenital rubella
E24.-	/ H	Cushing's syndrome
E84.-	/ H	Cystic fibrosis
C00-C96	/ H	Malignant neoplasm
E40-E46	/ H	Malnutrition
K85-K86.-	/ -	Pancreatitis/other pancreatic disease
E09.-	/ H	Drug/chemical induced DM (Name the drug/chemical)
O24.4-	- -	GDM (Gestational DM)
P70.2	C -	Neonatal DM
		Other specified DM
E13.-	/ H	Postpancreatectomy DM
E13.-	/ H	Postprocedural DM
R81	- -	Glycosuria...due to X
R73.9	- -	Hyperglycemia...d/t X
E16.2	- -	Hypoglycemia...d/t X
R73.01	- -	Impaired fasting glucose...d/t X
R73.02	- -	Impaired glucose tolerance (oral)...d/t X
R73.09	- -	Other abnormal glucose...due to X

ALL
SET
DOC?

Occurrence (all that apply to convey true SOI):

- Controlled
- Nonketotic
- Using Insulin [Z79.4]
- Using oral antidiabetic/hypoglycemic rx [Z79.84]

Comorbid Conditions: Morbid obesity

Complications:

- Coma
- Diabetic ulcers
- DKA
- Gangrene
- Hyperosmolarity

With hyperglycemic-hyperosmolar coma (NKHHC)

Notes An abnormal BS represents numerous codeable conditions, so link an abnormal test result to the suspected Etiology and include disease details for accurate SOI.

48. **BMI [Z68-](/){/}**

Etiology: underlying disease that caused the malnutrition or obesity

Diagnosis:

‘Severe PCM w cachexia (BMI 17) d/t end stage COPD’

‘Severe malnutrition (BMI 16) d/t X cancer’

‘Morbid obesity (BMI 45) w DM2 w hyperglycemia’

Occurrence: Appetite, details of weight loss/gain, general appearance, height & weight, vomiting, etc.

Comorbid Conditions:

Anemia

Diabetes

Complications:

Falls

Functional disabilities

Muscle wasting

Notes BMI, height, and weight are findings that may be coded when recorded by nursing/dietary staff but only when the physician documents a Diagnosis of obesity or malnutrition.

The CDC defines the BMI as:

Underweight: <18.5

Normal weight: 18.5 to <25

Overweight: 25.0 to <30 [E66.3](){}

Obese: 30.0-40

Class I: 30-35 [E66.09](){}

Class II: 35-40 [E66.09](){}

Class III: >40, severe/morbid obesity [E66.01] (C){H}

Severity of illness varies with BMI value:

BMI<19.9 [Z68.1](C){}

BMI>40 [Z68.41-Z68.45] (C){H}

Linking the BMI increases the SOI of morbid obesity.

49. **Brain injury:** unspecified [S06.9](/){/}

Synonyms: Head injury with loss of consciousness, TBI, traumatic brain injury

Site changes the code set used and SOI

Sites of Traumatic Brain Injury

Diffuse	Internal carotid artery, intracranial portion
Focal	Other specified intracranial site
Cerebrum	Unspecified
Cerebellum	Intracranial
Brainstem	Brain
Epidural	Head
Extradural	
Subdural	
Subarachnoid	

Etiology: For traumatic brain injuries include the mechanism of injury (blunt trauma, crush, penetrating, etc. injury).

ALL
SET
DOC?

Type: For higher SOI, consider terms that follow:

Concussion [S06.0-]

Diffuse traumatic brain injury (TBI) [S06.2-]

Focal traumatic brain injury [S06.3-], contusion, laceration, traumatic hemorrhage

Other specified intracranial injuries [S06.8-]

Traumatic cerebral edema [S06.1X]

Traumatic cerebral/brain compression with herniation [S06.A1]

Traumatic cerebral/brain compression without herniation [S06.A0]

Traumatic epidural/extradural hemorrhage [S06.4-]

Traumatic subarachnoid hemorrhage [S06.6-]

Traumatic subdural hemorrhage [S06.5-]

Unspecified head injury [S09.90].

Diagnosis: “Brain injury” should not be used when there is more information about Laterality, Site, Etiology, Type, and Occurrence.

**ALL
SET
DOC?**

Occurrence:

Death due to brain injury prior to regaining consciousness
GCS evaluations [R40.21- to R40.24-]
Patient surviving
PHO traumatic brain injury [Z87.820]
Screening for traumatic brain injury [Z13.850]
With loss of consciousness duration # min, # hrs, # days
With return to pre-existing conscious level
Without loss of consciousness
Without return to pre-existing conscious level

Comorbid Conditions:

Open wound of head [S01.-]
Skull fracture [S02.-]

Complications:

Dementia
Mental disorders due to known brain injury [F01-F09]
Sequelae of injury
Traumatic cerebral edema [S06.1x-]

Notes “Brain injury” will only be coded as a low SOI unspecified traumatic event with an [S] code. More specific intracranial events have both traumatic [S-T] codes and non-traumatic codes, which require documentation of Type (nontraumatic or traumatic), Laterality, Site, and Etiology

50. **Burns** /{/}

ALL
SET
DOC?

Laterality & Site

Etiology:

Chemical corrosion [T20-T32]
 Sunburn [L55.-]
 Erythema (dermatitis) d/t chronic infrared exposure [L59.0]
 Radiation-related disorders of skin
 Thermal [T20-T32]

Type/degree/depth: 1°, 2°, 3° with size of each depth

Diagnosis:

'Accidental 3° thermal burns over 10% of body, see diagram for locations and sizes'

Occurrence: Document ALL of the following:

Percent (%) of body area
 Size of each burn for each degree at each Site
 Intent:
 Accidental (default)
 Assault
 Intentional self-harm [X71-X83]
 Undetermined (possibly due to coma or head trauma)
 but NOT just undocumented
 7th character encounter: Initial, subsequent, sequala

Comorbid Conditions: Acute respiratory failure, smoke inhalation, traumatic injuries, etc.

Complications: ATN, infection, sepsis, septic shock, etc.

Notes List each burn separately 3 times (in the H&P, in at least one progress note and in the discharge summary). Include Laterality, Site, Type/degree/depth and size of each burn.

51. **Cachexia [R64](CC){HCC}****Link to Etiology:****Etiology of Cachexia****'Severe malnutrition due to...**ALL
SET
DOC?

	<u>SOI</u>	
J44-	/ H	Advanced COPD
B20	C H	AIDS
C00-C96 &	/ /	Cancer (especially lung, pancreas, stomach)
D37-D49		
N18-	/ H	CKD + stage
K50-	C H	Crohn's disease
E84-	/ H	Cystic fibrosis
Multiple	/ /	Heart failure + acuity & type
E05-	- H	Hyperthyroidism/exophthalmic
E23.0	C -	Hypopituitarism
B50-B54	/ H	Malaria/paludal
G35	- H	Multiple sclerosis
F48.8	- -	Nervous cachexia
R54	- -	Old age/senile
M05-M06	/ /	Rheumatoid arthritis
T73.0	- -	Starvation
A15-A19	/ -	Tuberculous
		Etc.

Occurrence: BMI [Z68-]

Link findings (lack of appetite, fatigue, decreased strength, muscle & weight loss); treatment of underlying disease; appetite stimulation medication; nutritional counseling; and supplements to a Diagnosis of (mild, moderate, severe malnutrition).

Diagnosis:

'Severe Malnutrition due to X Etiology with cachexia & dehydration, BMI 15, Tx includes...' [E41](M){H} + [R64](C){H} +[Z68.1](C){}

Comorbid Conditions:

Nutritional anemias [D50-D53](){}

Dehydration [E86.0](){}

Disease/treatment related anemia/pancytopenia



Cachexia has no code []. Cachexia (wasting syndrome), weakness, wasting, and abnormal weight loss [R63.4](){} are signs. They do not code to a Diagnosis of malnutrition.

-
52. **CAD** (Coronary artery disease) [I25.1-] (/{HCC}

**ALL
SET
DOC?**

Type of lesion:

Atheroembolism [I75.-]
Calcified [I25.84]
Lipid rich plaque [I25.83]

Comorbid conditions: CKD, COPD, diabetes, hyperlipidemia, tobacco exposure, etc.

Complications:

Angina pectoris with documented spasm
Angina pectoris without documented spasm
Ischemic chest pain
MI + specifics
Other forms of angina
(Past, PHO, old) MI w/o symptoms
Unstable angina pectoris

-
- Notes** In ICD-10-CM, CAD is atherosclerosis of native, NOT bypass, vessels. (See atherosclerosis above).

-
53. **CAP** (Community acquired pneumonia) [J18.9] (MCC){}
(See pneumonia below for enhanced documentation)

**ALL
SET
DOC?**

Etiology: (Suspected) organism

Diagnosis: ‘*Pneumonia d/t X organism with...*’

Link to:

Comorbid conditions: AIDS, COPD, influenza

Complications: Acute hypoxic respiratory failure, acute renal failure, sepsis, severe sepsis, septic shock etc.

-
- Notes** The (suspected) organism supports medical necessity for antibiotics and complexity of medical-decision-making.
Patients seldom need admission for pneumonia, so make sure to document all Complications.
-

54. **Cerebral edema [/](M){/}**

Link to trauma or **Etiology:** of non-traumatic cerebral edema

Type:

Birth injury [P11.0](M){}

Non-traumatic (cytotoxic, vasogenic) [G93.6](M){H}

Traumatic [S06.1-X](M){H}

Diagnosis:

'Cerebral edema from birth injury, GCS...'

'Non-traumatic cerebral edema due to E, GCS...'

'Traumatic cerebral edema, LOC 40 min, GCS...'

Occurrence:

GCS [R40.21- to R40.24-] is needed on all patients w
cerebral edema

Just for traumatic cerebral edema:

Death due to brain injury prior to regaining
consciousness

Patient surviving

With loss of consciousness duration # min, # hrs, #
days

With return to pre-existing conscious level

Without loss of consciousness

Without return to pre-existing conscious level

ALL
SET
DOC?

Comorbid Conditions:

Conditions associated with the Etiology

Conditions associated with trauma

Concussion [S06.0-]

Diffuse traumatic brain injury (TBI) [S06.2-]

Focal traumatic brain injury [S06.3-], contusion,
laceration, traumatic hemorrhage

Other injuries

Open wound of head [S01.-]

Other specified intracranial injuries [S06.8-]

Skull fracture [S02.-]

Traumatic epidural/extradural hemorrhage [S06.4-]

Traumatic subarachnoid hemorrhage [S06.6-]

ALL
SET
DOC?**Traumatic subdural hemorrhage [S06.5-]****Cerebral edema continued****Complications:**

Dementia/mental disorders due to known brain injury
[F01-F09]

Sequelae of injury

Traumatic cerebral/brain compression with herniation
[S06.A1]

Traumatic cerebral/brain compression without
herniation [S06.A0]



Mass effect, midline shift, & shift to the R/L have no codes [].

55. **Chest pain /{/}**ALL
SET
DOC?

Link chest pain (a symptom) to a suspected-diagnosis for accurate SOI and medical-decision-making complexity

Site:

Anterior wall [R07.89]

Central [R07.9]

Precordial [R07.2]

Type:

Atypical [R07.89]

Ischemic [I20.9]

Musculoskeletal [R07.89]

Non-cardiac [R07.89]

On breathing [R07.1]

Pleurodynia [R07.81]

Precordial [R07.2]

Suspected-diagnosis:

'Costochondritis'

'GERD'

'STEMI'

Notes

Chest pain is a symptom with multiple codes dependent on Site, Etiology, or Type. As with all symptoms, chest

pain should be linked to a suspected-diagnosis for accurate coding

56. **Cholelithiasis [K80-](C){}**

Site: Bile duct or gall bladder

Etiology: Cholesterol-lowering drugs, crash dieting; overweight; rapid weight loss. Link to Comorbid Conditions if they are the suspected cause

Type: Calculus, retained following cholecystectomy, other

Occurrence: Cholesterol-lowering drugs, crash dieting; positive family history, overweight, rapid weight loss

Comorbid Conditions: Diabetes, liver disease, obesity, sickle cell disease

Complications:

Complications of Cholelithiasis

Cholangitis	Obstruction of
Cholecystitis	Bile duct
Acute on chronic	Gallbladder
Acute	Pancreatitis
Chronic	Acute on chronic
Fistula	Acute
Gallstone ileus	Chronic
Gangrene of gallbladder	Perforation of gallbladder
Jaundice	Sepsis
Non-infectious SIRS	Etc.

ALL
SET
DOC?

57. **Chronic (Ch)**

Notes ICD-10-CM guidelines state, “There is no time frame defining when pain becomes chronic pain. The provider’s documentation should be used to guide use of these codes.”

However, the AMA has defined chronic illness in CPT® as having an “Expected duration: one year or until patient death whether or not stage/severity changes

ALL SET DOC? QUICK TIPS

(uncontrolled diabetes & controlled diabetes are a single chronic condition)."

58. **Chronic blood loss anemia (CBLA) [D50]({})**ALL
SET
DOC?**Link to:****Site** of blood loss (GI is most common)**Etiology** of blood loss (anticoagulants, heavy menses, neoplasm, etc.)**Comorbid conditions:** AUD, GI cancer, etc.**Complications:** Angina, death, heart failure, MI, shock, etc.

'...with hypovolemic shock'

'...with hemorrhagic shock'

Notes Chronic blood loss is the most frequent Etiology of iron deficiency anemia [D50]({}), which is the most common Type of anemia. Always consider occult chronic blood loss in anemic patients, even when there is confirmed acute blood loss. Patients tolerate CBLA better than ABLA and much better than ABLA on top of CBLA.

59. **CKD (chronic kidney disease) [N18-]({})**

Chronic renal failure

ALL
SET
DOC?**Etiology:** Diabetes, hypertension, etc.**Type** = stage: 1-5, ESRD w dialysis**Occurrence:** Transplant status**Comorbid conditions:** especially AKI**Link to Complications:** Heart failure, HTN, etc.

Notes Medical and coding definitions are the same:

CKD Details				
SOI	Stage	GFR	Document	
N18.1	- -	1	> 90	Kidney Transplant Status
N18.2	- -	2	60-89	Z76.82 Awaiting kidney
N18.3	- H	3A	45-59	Z94.0 Kidney transplant
N18.3	- H	3B	30-44	Z98.85 Transplant removed
N18.4	C H	4	15-29	Z48.22 Aftercare
N18.5	C H	5	<15	following
N18.6 +	M H	ESRD w dialysis		transplant
Z99.2	- H			

-
60. **Chronic obstructive pulmonary disease (COPD)**[J44-]
]/(){}H}

ALL
SET
DOC?

Acuity:

COPD exacerbation [J44.1](C){H}
COPD [J44.9](){H}

Link to Comorbid conditions:

'COPD exacerbation with acute lower respiratory infection' (acute bronchitis, pneumonia, etc.)
[J44.1](C){H} + [J44.0](C){H}

Complications: Acute hypoxic/hypercarbic respiratory failure, cachexia, etc.

Notes COPD is a common comorbid condition; SOI depends on Acuity.

61. **Coagulopathy** [/(){}/]

ALL
SET
DOC?

Link to... Etiology for more specificity: Due to X

See Etiology list next page

Type: Acquired, hereditary

Diagnosis

'Heparin induced thrombocytopenia (HIT)'

'DIC following incomplete spontaneous abortion.'

Occurrence: Abnormal test results; long term use of anticoagulants

Comorbid conditions: A.fib; DVT; liver disease; pulmonary embolus, etc.

Complications: ABLA, AMI, CVA, death, DVT, hemorrhage, pulmonary embolism, shock, etc.

Coagulopathy continued**Etiology:**

**ALL
SET
DOC?**

Etiology of Coagulopathy = Diagnosis		
SOI		
R79.1	- -	Abnormal coagulation profile test
D68.4	C H	Acquired coagulation factor deficiency
D68.311	C H	Acquired hemophilia
D68.312	C H	Antiphospholipid antibody w hemorrhagic dis.
D68.51	C H	Activated protein C resistance
D68.32	C H	ADE d/t extrinsic circulating anticoagulants
T45.515	- -	Anticoagulant (name)
T45.525	- -	Antithrombotic (name)
Z79.01	- -	Associated long-term use of anticoagulants
D69.0	C H	Allergic purpura
D68.312	C H	Antiphospholipid antibody hemorrhagic dis.
R76.0	- -	Antiphospholipid antibody wo diagnosis
D68.61	C H	Antiphospholipid syndrome
D68.4	C H	Coagulation factor deficiency d/t to liver dis.
D89.1	- H	Cryoglobulinemic purpura
D68.318	C H	D/t intrinsic anticoagulant/antibody/inhibitor
D65	M H	Disseminated intravascular coagulation [DIC]
D68.51	C H	Factor V Leiden mutation
D66	M H	Hemophilia A/Hereditary factor VIII deficiency
D67	M H	Hemophilia B/Hereditary factor IX deficiency
D68.1	C H	Hemophilia C/Hereditary factor XI deficiency
D69.9	- H	Hemorrhagic condition, unspecified
D47.3	- H	Hemorrhagic thrombocytopenia
D75.82	- H	Heparin induced thrombocytopenia (HIT)
D68.2	C H	Hereditary deficiency of other clotting factors
E72.11	C H	Hyperhomocysteinemia
D69.3	C H	Immune thrombocytopenic purpura
Many	/ /	Liver disease
D68.62	C H	Lupus anticoagulant syndrome
D68.6	C H	Other hypercoagulable states
D69.2	- H	Other nonthrombocytopenic purpura
D69.4	C H	Other primary thrombocytopenia
D68.59	C H	Other primary thrombophilia
D69.8	- H	Other specified hemorrhagic conditions
D68.69	C H	Other thrombophilia
Many	/ /	Pancytopenia
D68.5-		Primary thrombophilia
D68.52	C H	Prothrombin gene mutation
D69.1	- H	Qualitative platelet defects
D69.5	- -	Secondary thrombocytopenia
Many	/ /	Thrombocytopenia
Q87.2	C -	Thrombocytopenia w absent radius (TAR)
D69.6	- H	Thrombocytopenia, unspecified
M31.1	- H	Thrombotic thrombocytopenic purpura
E55.9	- -	Vitamin K deficiency
D68.0	C H	Von Willebrand's disease
D82.0	C H	Wiskott-Aldrich syndrome
		Etc.

Notes Abnormal coagulation studies should always be documented as '**evidence of...**' (an inherited or acquired coagulopathy); '**evidence of...**' (intrinsic or extrinsic circulating anticoagulants); or a '**clinically insignificant abnormal coagulation profile**' [R79.1].

Most coagulopathies are a (CC)/(MCC), so document them as a Diagnosis.

When an anticoagulant contributes to bleeding events '**drug-induced hemorrhagic disorder**' should also be documented as a Diagnosis.

Although anticoagulation is usually ordered for conditions that promote the development of thrombosis and embolization (atrial fibrillation), the use of anticoagulants may also be '**evidence of...**' an underlying coagulopathy, which should be documented as a Diagnosis.

Most neonatal and obstetrical coagulopathies are DIC and have a high SOI. None are HCCs.

Coagulopathy in Neonates		
	<u>SOI</u>	
P53	C -	Hemorrhagic disease of newborn
P60	M -	Newborn DIC
P61.0	M -	Transient neonatal thrombocytopenia

Coagulopathy in Obstetrics		
	<u>SOI</u>	
003/4/5/6/7.1	C -	DIC in abortion (document abortion <u>Type</u>)
008.1	C -	DIC in ectopic pregnancy
008.1	C -	DIC in molar pregnancy
045/6.0-	M -	DIC in pregnancy (trimester)
067.0	M -	DIC in childbirth
072.3	- -	DIC in the puerperium

62. **Coma/unconsciousness [R40.20](M){H}****Etiology****Coma Etiology**

**ALL
SET
DOC?**

SOI		
K72.01	M H	Acute/subacute hepatic failure
K70.41	M H	Alcoholic hepatic failure
K72.11	M H	Chronic hepatic failure
E08.01	M H	DM d/t underlying condition w hyperosmolarity
E08.641	M H	DM d/t underlying condition w hypoglycemia
E08.11	M H	DM d/t underlying condition w ketoacidosis
E10.641	M H	DM1 w hypoglycemia
E10.11	M H	DM1 w ketoacidosis
E11.01	M H	DM2 w hyperosmolarity
E11.641	M H	DM2 w hypoglycemia
E11.11	M H	DM2 w ketoacidosis
E09.01	M H	Drug/chemical induced DM w hyperosmolarity
E09.641	M H	Drug/chemical induced DM w hypoglycemia
E09.11	M H	Drug/chemical induced DM w ketoacidosis
K72.91	M H	Hepatic failure
R40.2A	M H	Nontraumatic d/t underlying condition
E13.01	M H	Other specified DM w hyperosmolarity
E13.641	M H	Other specified DM w hypoglycemia
E13.11	M H	Other specified DM w ketoacidosis
K71.11	M H	Toxic liver disease w hepatic necrosis
R40.20	M H	Unspecified

Type: Non-traumatic or traumatic (S06.-)**Occurrence:** GCS**Comorbid conditions:** skull fracture [S02.-] and intracranial injury [S06.-]

Notes A diagnosis of '**coma**' should not be used for a medically induced comas, sedated patients, or persistent vegetative states [R40.3](). Somnolence/drowsiness [R40.0](){} and stupor/catatonic stupor/semin coma [R40.1](){} cannot be coded with coma, so the use of these terms with a coma diagnosis may prompt a CDI query.

The coma scale can be coded from documentation by non-physicians, when the associated detailed diagnosis (acute stroke, TBI, etc.) is documented by the physician.

Also see Glasgow coma scale [R40.21-]

63. Compartment Syndrome /{/}

Laterality**Site:**

Site of Compartment Syndrome				
Ankle	Forearm	Lower leg	Thigh	Etc.
Foot	Hand	Shoulder	Upper arm	

Etiology is often a **Comorbid Condition**

Etiology of Compartment Syndrome	
Anabolic steroids	Prolonged compression due to unconsciousness
Ascites	Procedure (name it) complication
Bleeding	Sepsis
Burns	Surgery to extremity blood vessel
Crush injury	Tight bandage/cast
Edema	Trauma w shock
Extremity embolus/thrombus	Etc.
Fracture	

ALL
SET
DOC?**Type:**

Traumatic [T79.A-](C){H}

Nontraumatic [M79.A-](C){}

Occurrence: Findings like the 5Ps (pain, pallor, paresthesia, pulselessness, paralysis)**Complications:**

Complications of Compartment Syndrome		
/	SOI / /	Complications of original disease/trauma, procedure/treatment, non-compliance
		Death
M62.2-	- -	Nontraumatic ischemia of muscle
/	/ /	Organ failure
M62.82	C -	Rhabdomyolysis
T79.6	- H	Traumatic ischemic muscle infarction
T79.6	- H	Volkmann's ischemic contracture

64. Complications

Notes Although physicians understand relationships between disease, drugs, genetics, patient attributes, procedures, therapies and complications, non-physicians are not well versed in these interactions. Therefore, physicians must document Links between these components to explain apparent complications.

Complications continued

Notes This section discusses how complication documentation is interpreted for coding purposes. It is intended to prevent queries by improving accurate reporting of medical complications and contributing disease/patient/care factors.

DEFINITIONS:

Complication: A problem or difficulty that makes a situation harder to deal with.

Medical complications: Conditions that impede healing or return of function as a direct consequence of a disease, medical care, and/or patient-inherent traits:

Disease-inherent complications: Consequences of a disease/illness/injury (Diagnosis) that impedes healing or functional return. A disease-inherent condition becomes a complication when it exceeds the norm and makes management more challenging. [Example: An abnormal blood sugar is inherent to diabetes; DKA and hypoglycemia are complications.]

Medical care complications: Conditions that develop solely because of medical care, prolong healing, and may require additional treatment. The probability of a complication '**due to**' medical care determines its inclusion in informed consent discussions and documents.

Common medical care complications (high probability of occurrence), like the side effects of drugs (nausea from morphine, bleeding from anticoagulants), are documented as '**expected**'. These conditions should be linked to the medical care responsible [**'Expected nausea d/t MS, treated with Zofran'**].

Unanticipated care complications that occur less frequently should be fully documented and linked to the suspected etiology and treatment [**'Unanticipated GI bleed due to previously undiagnosed gastric ulcer exacerbated by ASA and Plavix for A.fib tx...'**].

ALL SET DOC? QUICK TIPS

Notes CMS uses ICD-10-CM codes, which reflect how a complication is documented, along with mortality measures and payment data, to assess the value of care.

Some severe, rare complications of medical care are considered patient safety events and have automatic reporting requirements. Physician documentation of them should be immediate and in consultation with the facility's on-duty Quality/Patient Safety Officer.

The National Quality Forum's (NQF) Serious Reportable Events (SREs) and the Joint Commission's Sentinel Event (SE) policy contain similar lists of complications considered preventable. Physicians and hospitals are held responsible for implementing and following safety protocols to prevent them.

Patient-inherent complication: Patient specific traits may increase the probability of a disease or medical care complication. Diabetes, severe malnutrition, and morbid obesity are obvious examples of patient-inherent conditions which increase the risk of medical complications. Anatomic anomalies; acquired conditions (extensive adhesions); comorbid conditions (COPD, hypertension); congenital/ genetic disorders; non-compliance; social determinants of health; etc. should always be Linked to the complications they are suspected of generating.

Etiology: What caused the complication?

205. The disease/injury:

'Peritonitis d/t prehospital rupture of appendix'

'Blood loss anemia due to fractured pelvis'

ALL
SET
DOC?

206. Patient characteristics: anatomy (congenital anomaly), acquired conditions (extensive adhesions);

comorbid conditions (COPD, diabetes, malnutrition, morbid obesity); non-compliance; etc.

207. Medical/surgical care: adverse drug effect, radiation proctitis, etc.

208. Accident: (potentially preventable)

ALL
SET
DOC?**Complications continued**

Diagnosis: Document the specific disease/injury that caused the complication

'Sepsis due to rupture of appendix, prior to arrival in ED, w generalized peritonitis'

'Hyperglycemia due to DM2 out of control due to patient non-compliance'

Occurrence: Document the specific disease/injury findings that accompany/helped to diagnose the complication

'Sepsis due to rupture of appendix, prior to arrival in ED, with generalized peritonitis, fever, elevated WBC, septic encephalopathy'

65.

Complication of Medical CareALL
SET
DOC?

Laterality & Site: of complication

Etiology: What medical care caused the complication?

Communication failure

Device (failure)

Diagnostic test

Mechanical ventilation

Medication (ADE, poisoning, under/over dosing)

Negligence

Other treatment/therapy

Procedure

Abortion

Surgical treatment of fractures during healing

Transplant failure/rejection/other

Etc.

Diagnosis:

'Underdose of insulin due to insulin pump failure'

'Non-traumatic intracerebral bleed suspected due to CAPPA Xarelto'

'Pathological fracture of femoral shaft d/t cappa bisphosphonate for osteoporosis'

ALL
SET
DOC?

Occurrence: Details of what occurred

Fetus involved in the complication

Noncompliance [Z91.12-, Z91.13-]

Obstetrical timing of the complication development
(trimester, L&D, postpartum – 6 weeks)

Sequelae of pregnancy/childbirth/puerperium
complication [O94] when the initial complication
develops sequela(e)

Comorbid Conditions: Dementia, encephalopathy,
morbid obesity, osteogenesis imperfecta, etc.

Notes Codes are usually based on documentation of the links between conditions and care/procedure. Not all conditions occurring during or following care/surgery are complications. There must be a cause-and-effect link between care and a condition documented as clinically significant.

It is no longer “necessary for the provider to explicitly document the term “complication”.” If the operative report indicates a condition changes surgery, it is appropriate to report and code a complication. The physician should be queried if the documentation is not clear as to the link between the condition and the care/procedure.

There are codes for failure of insulin pumps [T85.6-], internal/external prosthetic devices/implants/grafts [T38.3X6-], and underdosing of insulin/oral hypoglycemic [antidiabetic] drugs and associated complications that require explicit documentation.

Documentation should explicitly state when treatment is directed at resolving a care/procedure complication.

66. **Complication of Procedure**ALL
SET
DOC?**L laterality & Site:** of complication

Etiology: Why it occurred: Associated conditions that contributed to the complication such as abnormal anatomy; ADE; comorbidity; severe malnutrition, purulent material, uncontrollable bleeding, excessive adhesions obscuring the surgical field; morbid obesity; tumor burden; etc.

Type: Terms to describe procedure related events:

- **'Inherent-to the procedure':** Many adverse effects (bruising, hematomas, incisional weeping, pain, etc.) are inherent-to, not complications-of, procedures.

Examples:

Abdominal surgery with short term ileus

Respiratory procedures with delayed vent liberation

Brain surgery with depressed consciousness

Some anticipated complications are inherent-to even when they require treatment. They are only coded as a complication when specifically documented as a '**complication**' by the physician.

Examples:

Hypotension, even when pressors are used to prevent shock

Acute blood loss anemia, especially in trauma surgery

Hematomas should be documented as a 'complication' only if they are clinically significant, large, and require medication /treatment changes.

- **Expected:** Conditions not inherent-to but occurring frequently during or after a procedure should be documented as '**expected**'.

Examples:

'Expected post CABG atrial fibrillation'

'Expected acute respiratory failure due to X despite (measures taken to prevent the

ALL
SET
DOC?

problem),' which occurs more frequently when respiratory Comorbid Conditions are present. Link adverse events to contributory comorbidities and to any actions taken to prevent the complication.

Type

- **Complication:** Document inherent-to and expected events as complications when the duration or the extent exceeds expected norms (based on the patient's primary and comorbid conditions).

Diagnosis: What occurred:

'Accidental PW to R distal ureter during appendectomy d/t purulent material from ruptured appendix (POA) obscuring the surgical field'

'Intraprocedural hemorrhage d/t accidental puncture of X because extensive adhesions from previous surgery'

Occurrence

Body system: same or different from the system being operated upon

Timing: Intraoperative or following the procedure

Comorbid Conditions: Document pre-existing conditions that maybe considered complications (sepsis) as '**present prior to procedure**' to ensure they are not attributed to the surgery. Risk factors (dirty wounds, ruptured appendix) and conditions that contribution to complications should be included.

Notes Procedural complications do not infer incompetence! There is a difference between a true medical complication and what many Performance Improvement (PI) data analytic programs consider to be a complication.

Physicians no longer have "to explicitly document the term 'complication.' However, the term 'postop/postoperative' can be interpreted differently by physicians and coders. Physicians mean the timeframe following surgery, while coders may interpret "postoperative" as a complication of surgery. Thus,

documentation of ‘postoperative respiratory failure’ may result in the assignment of a complication code.

Complication of Procedure continued

Notes Patients who have elective surgery and later develop sepsis (POA = N) may be included in PSI 13: Postoperative sepsis. Therefore, don't use the term 'postop/postoperative' to describe a diagnosis unless you intent to link the condition to the procedure/surgery

'Postoperative pain d/t painful wire sutures' is a postoperative complication.

'Postprocedural respiratory failure' [J95.82-](M){H} is included in PSI 11 and is defined as when patients unexpectedly take more than 24-48 hrs for vent liberation. Up until 24 hours following surgery when a patient cannot be weaned it is NOT considered "respiratory failure".

'Acute/chronic pulmonary insufficiency following (non)thoracic surgery' [J95.-](M){H}, although not a patient safety indicator, may also trigger PSI 11.

Document the methods used to prevent and treat it.

	Do NOT document something a “complication” or use a heading titled ‘COMPLICATION’ unless you want it called <u>and coded</u> as a complication of care and reported as such.
--	--

67. Complication (Never events, SEs, SREs)

National Quality Forum (NQF) Serious Reportable Events (SREs)	
Procedure Events	
Wrong site	Unintended retention of a foreign object
Wrong patient	Intra/immediate postop death ASA Class 1 pt
Wrong procedure	
Product Or Device Events	
Death or serious injury associated d/t	
Contaminated drugs, devices, or biologics	
Use/function of a device other than as intended	
Intravascular air embolism	
Patient Protection Events	
Discharge/release of patient/resident unable to make decisions, to other than an authorized person	
Death/serious injury associated w pt elopement/disappearance	
Patient suicide/attempted suicide/self-harm w serious injury	
Care Management Events	
Stage 3/4/unstageable pressure ulcers NOT POA	
Artificial insemination with wrong donor sperm/egg	
Death/serious injury associated with:	
A medication error involving:	
Wrong drug	Wrong rate
Wrong dose	Wrong preparation
Wrong patient	Wrong route of administration
Wrong time	Unsafe administration of blood products
Maternal labor/delivery in a low-risk pregnancy	
Neonate labor/delivery in a low-risk pregnancy	
A fall	
Irretrievable loss of irreplaceable biological specimen	
Failure to follow up/communicate lab/path/radiology results	
Environmental Events	
Patient/staff death/serious injury associated with:	
An electric shock during patient care	
A burn from any source during patient care	
Pt death/serious injury associated w physical restraints/bedrails	
Incident where systems designated for patient O2/other gas:	
Contains no gas	
Contains the wrong gas	
Is contaminated by toxic substances	
Radiologic Events	
Pt/staff death/serious injury associated w metal object in MRI	
Potential Criminal Events	
Care ordered/provided by someone impersonating:	
A physician	A pharmacist
A nurse	Another licensed healthcare provider
Abduction of a patient/resident of any age	
Pt/staff sexual abuse/assault in healthcare setting /on grounds	
Death/serious injury of patient/staff from:	
Physical assault (battery) in healthcare setting /on grounds	

68. **Complexity (for medical-decision-making)**

Acuity:

Acute on chronic/exacerbation is the highest SOI and complexity of medical-decision-making (COMDM). It indicates the chronic condition is no longer stable.

Acute (~~new onset~~) may indicate an undiagnosed Diagnosis with high SOI and COMDM.

Chronic problems are stable* if the treatment goals have been reached (per CPT®).

Links from a suspected-diagnosis to the Etiology, Type, details of Occurrence, Comorbid conditions, and Complications increase SOI and support COMDM.

**ALL
SET
DOC?**

Laterality & Site

Etiology generally increases the SOI of ICD-10-CM codes and supports COMDM.

Type may increase SOI and COMDM.

Diagnosis: Signs & symptoms cited as '**Evidence of a (suspected) dx**' support COMDM and a higher SOI than signs & symptoms alone.

Occurrence should include details of the encounter.

Comorbid conditions enhance SOI and COMDM.

Complications, especially those of common diseases like diabetes, will increase SOI and COMDM.

Notes Many elements of CPT®'s E&M complexity of medical-decision-making can be conveyed in the ICD-10-CM code assigned to the encounter. By documenting all components detailed above, physicians can ensure the Diagnosis codes will support their E&M level of service to prevent denials and audits.

69. **Concern (ing) for**

Notes “Concern for” is interpreted as an uncertain diagnosis (coded following the guideline for “uncertain diagnosis” in the inpatient setting per AHA *Coding Clinic* Q1 2018, p. 18). Appropriate in and outpatient uncertain terminology is ‘**evidence for dx includes...**’.

70. **Confusion [R41.0](){}**

ALL
SET
DOC?

Acuity**Link to a Diagnosis**

Etiology: Often the underlying cause of confusion indicates it is a sign of ‘**encephalopathy**,’ which needs to be documented as a Diagnosis.

Occurrence**Comorbid conditions****Complications**

Notes Confusion (unspecified disorientation) is only a sign with a low SOI and COMDM. It should be linked to a suspected-diagnosis.

71. **COPD [J44.9](){H}**

ALL
SET
DOC?

Acuity: COPD w exacerbation [J44.1](C){H}**Occurrence**

Comorbid conditions: Asthma type, bronchiectasis, emphysema without chronic bronchitis, lower respiratory infection, etc.

Complications: Acute/chronic hypoxic/hypercarbic respiratory failure

72. COVID-19 2019 Coronavirus Infection Disease



COVID-19 recognized risk factors; signs and symptoms; treatments; codes and coding guidelines, and therefore documentation requirements and queries, are still changing.

Always indicate whether COVID-19 is active now or was a previous illness (PHO).

Acuity: Acute (now), PHO [Z86.16] (){} (past)

Etiology: Document the Type of covid19 test (antigen, antibody, ELISA, etc.) & indicate results.

Diagnosis:

ALL
SET
DOC?

COVID-19 Diagnosis Documentation		
SOI		
U07.1 +	M -	C19 test (+), confirmed cause of disease
J20.8	M -	Acute bronchitis due to C19
J22	- -	Acute lower respiratory infection d/t C19
J80	M H	ARDS (acute respiratory distress syndrome) d/t C19
J40	- -	Bronchitis due to C19
M35.81	C -	Multi-system inflammatory syndrome (MIS)
M35.89	C -	Other connective tissue involvement
J98.8	- -	Other respiratory infection d/t C19
J12.82	M -	Pneumonia due to C19
U09.9	- -	Post COVID-19 condition
Z03.818	- -	Exposure to C19 <u>ruled out</u> after evaluation
Z20.822	- -	Exposure to someone with confirmed C19
Z11.52	- -	Screening for C19
Z86.16	- -	PHO COVID-19
3/25/20 added to WHO ICD-10 but not USA ICD-10-CM codes		
Z29.0	Isolation	
U07.2	COVID-19 as <u>suspected</u> cause of disease 'Suspected/probable/likely COVID-19' has no ICD-10-CM code, so document if the test (+)	
	[]	

ALL
SET
DOC?

Occurrence: Risk factors, signs, symptoms, test results, SDH, etc.

COVID-19 Occurrence

Risk factors	Symptoms	Treatments
Age >65	Brain fog	Bamlanivimab
CAD	Chest pain	Baricitinib (Olumiant)
Cancer	Chills	Bebtelovimab
Cardiomyopathy	Congestion	C-19 convalescent plasma
Cell transplant	Cough	Casirivimab
Cerebrovascular disease	Cystitis	Etesevimab
Chronic liver diseases	Diarrhea	Evusheld
Chronic lung diseases	Fatigue	Imdevimab
CKD	Fever	Lagevrio (molnupiravir)
Corticosteroids	Headache	Long-acting antibody (LAAB)
Cystic fibrosis	Hemoptysis	Monoclonal antibody (mAb)
Disabilities	Loss of	Paxlovid
DM1, DM2	Smell	Sotrovimab
Heart failure	Taste	Tolcizumab (Actemra)
HIV	MS pain	Veklury (remdesivir)
Immunocompromised	Nausea	Etc.
Immunodeficiencies	Runny nose	
Imunosuppression	Shortness of breath	
Mental health disorders	Sore throat	
Neurolopaty w dementia	Sputum	
Nursing home/LTACH	Stuffy nose	
Obesity (BMI ≥ 30 kg/m ²)	Swollen eyes	
Physical inactivity	Vomiting	
(Recent) pregnancy	Etc.	
Smoking, past/present		
Solid organ transplant		
TB		
Etc.		

Comorbid Conditions

COVID-19 Comorbidities

Asthma moderate/severe	Immune deficiencies
Bone marrow transplant	Morbid obesity
Cancer in treatment	Organ transplant
Chronic liver disease	Prolonged use of
Chronic lung disease	Corticosteroids
CKD	Other immune weakening meds
COPD	Renal failure
Diabetes	Severe obesity BMI ≥ 40
Heart conditions	Sickle cell disease
HIV or AIDS	Etc.
Hypertension	

COVID-19 continued**ALL
SET
DOC?****Complications:****COVID-19 Complications**

Acute cardiac injury	Pneumonia due to C-19
Acute hypoxic respiratory failure	Pneumothorax
Acute kidney injury	Rhabdomyolysis
Acute liver failure	Secondary infection
ARDS	Sepsis
Arrhythmias	Septic shock
ATN	Severe sepsis
Cardiomyopathy	Type 2 MI
Chronic respiratory failure	Etc.
DIC	Death
Encephalopathy	
Hemophagocytic lymphohistiocytosis (HLH)	

Notes

[U07.1] the code for a positive COVID-19 test indicates active disease, rather than a previous illness. This code is disease specific, NOT just any coronavirus infection [B34.2]; not as the cause of another disease [B97.2-]; and not SARS unspecified [J12.81].

A positive COVID-19 test is not needed to prove COVID-19 infection, the provider's documentation that the individual has COVID-19 is sufficient.

If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, code U07.1 will not be used. Instead, the signs and symptoms will be reported.

Additional documentation is needed to identify why the patient was admitted, since COVID is not a reason for admission. Acute hypoxic respiratory failure, pneumonia, septic shock, or other manifestations listed in Complications above should be listed as the admitting Diagnosis .

COVID-19 patients may have acute hypoxic respiratory failure without signs of respiratory distress, referred to as 'silent hypoxia.' When this is the clinical picture, make sure to document, '***Lack of distress probably d/t COVID-19 with silent hypoxia.***'

-
73. **CPPA** (correctly-prescribed & properly-administered/taken)

**ALL
SET
DOC?**

Etiology: Name the drug in question

Type of adverse drug effect (ADE); give details such as anaphylaxis, hives, vomiting, etc.

Diagnosis: '*ADE [symptoms (nausea)/signs (vomiting) /diagnoses (HIT)] suspected due to X drug.*'

Notes For an adverse drug event (ADE) it is crucial to document if the drug was CPPA.

If the drug was not CPPA, regardless of intent, ICD-10-CM considers it a poisoning.

74. **Critical Care for CPT® (99291-99292)**

Notes Critical care can be provided in multiple settings by physicians of any specialty. However, this service is not to be used just because the patient is in an ICU bed. It is only for medical management when impairment of organ system(s) has the acute potential of life-threatening deterioration.

It is a Time and Date of Service (DOS) code set, where duration of service is cumulative for a single date. Always record starting and ending time of the physician's mandatory presence at the bedside and total the time at the end of the date. Critical care can no longer be applied to ED codes, which became medical-decision-making dependent in 2023.

75. **CVA (Cerebral Vascular Accident) or Stroke /{}**

**ALL
SET
DOC?**

Acuity:

New = '**acute**' [I60-I63]

PHO CVA without residual (PRIND) [Z86.73](){}

PHO CVA with sequela (chronic residual) [I98-](/C){}

Laterality: Include all 3:

Hand dominance

Of the abnormal physical exam findings
Of the brain/vessel pathology

CVA continued

Site: Artery by name:

CVA Site (Artery by Name)

Basilar	R/L/B carotid
Other cerebral	R/L/B cerebellar
Other precerebral	R/L/B middle cerebral
Other small artery	R/L/B posterior cerebral
R/L/B anterior cerebral	R/L/B vertebral

Etiology:

- Embolus
- Hemorrhage: (See SAH below)
- Stenosis
- Thrombus

Type: Non-traumatic or traumatic

Diagnosis:

ALL
SET
DOC?

'Non-traumatic cerebral infarction d/t R middle cerebral artery embolus (MRI) suspected d/t A.fib with (list findings), pt. R handed'

'Non-traumatic SAH basilar artery (CT) with (list findings), pt. L handed'

Occurrence:

CVA Details of this Occurrence

Diagnosis determined by:

Imaging (document CT, MRI, etc. for COMDM)

Duration of signs/symptoms

'FH stroke' [Z82.3]

Glasgow Coma Scale (GCS) [R40.20- to R40.24-]

National Institutes of Health Stroke Scale (NIHSS) score [R29.7-]

New physical findings:

Ataxia Motor strength

Dysarthria Neglect

Extraocular movement Sensory loss

Language Visual-field loss

Level of consciousness Etc.

SDH

tPA(rtPA) administered < 24hrs ago in a different facility [Z92.82]

Etc.

ALL
SET
DOC?**Comorbid conditions:****CVA Comorbid Conditions**

- A. fib
- Alcohol use disorder [F10-]
- Diabetes
- Hypertension [I10-I15]
- Hypertensive crisis [I16.9](C){H}
- Hypertensive emergency [I16.1](C){H}
- Hypertensive urgency [I16.0](){H}
- Other medical conditions

'Sequelae of previous CVAs':

- list all in H&P & Diagnosis section of Discharge Summary
- Tobacco exposure [F17-]
- Underlying condition (eclampsia [O15.00-O15.9])

Complications '*X due to current stroke*'; update as changes occur.

Notes Initially, an acute stroke diagnosis [I60-I63], may only be 'suspected'. During this time, it can be documented as:

'Stroke in evolution' [I63.9](M){H} or

'Evidence of acute embolus X artery due to A. fib with...'

NIH stroke scale (NIHSS) codes [R29.7-] are used with acute stroke codes to describe stroke severity and the patient's neurological status.

Additional history & imaging should promote more specific documentation:

'MRI confirmed new embolus L. middle cerebral artery d/t A. fib w R. hemiparesis, R. dominant'

Negative imaging does NOT preclude a CVA, when the presentation is consistent with **'evidence of a stroke'**. If an MRI is contraindicated or a CVA Diagnosis is made despite negative imaging, explain why.

Approximately 90% of strokes are caused by an embolus or thrombus. AIS (~~acute ischemic stroke~~) is a medical subset of CVAs that has no code. It codes to "other CVA" [I63.89](M){H}.

76. **CVA Sequelae****ALL
SET
DOC?****Acuity:** Document clearly which abnormal findings are acute and which are chronic**Laterality:** of sequela and handedness**Site**

Notes Include sequelae of previous CVAs in the Diagnosis List of an acute CVA. Record them as Comorbid Conditions, since they may increase the SOI. Include Laterality and Site.

CVA Sequelae		
	<u>SOI</u>	
I69.320	- -	Aphasia
I69.390	- -	Apraxia
I69.393	- -	Ataxia
I69.322	- -	Dysarthria
I69.391	- -	Dysphagia
I69.321	- -	Dysphasia + <u>Type</u> [R13.1-] (oral, oropharyngeal, pharyngeal, pharyngoesophageal, other phase)
I69.392	- -	Facial weakness
I69.323	- -	Fluency disorder
I69.398	- -	Other
I69.328	- -	Other speech/language deficit
		Monoplegia
I69.332	- H	L arm dominant side
I69.334	- H	L arm non-dominant side
I69.342	- H	L leg dominant side
I69.344	- H	L leg non-dominant side
I69.331	- H	R arm dominant side
I69.333	- H	R arm non-dominant side
I69.341	- H	R leg dominant side
I69.343	- H	R leg non-dominant side
		Hemiplegia/hemiparesis
I69.352	C H	L dominant side
I69.354	C H	L non-dominant side
I69.351	C H	R dominant side
I69.353	C H	R non-dominant side
		Other paralytic syndrome
I69.365	- H	Bilateral
I69.362	- H	L dominant side
I69.364	- H	L non-dominant side
I69.361	- H	R dominant side
I69.363	- H	R non-dominant side
		Other
G83.5	M H	Locked-in state
G82.5-	M H	Quadriplegia

77. **Cystitis []/(){/}/**

Acuity: Acute, chronic (interstitial)

Site: Bladder, prostate, trigone, urethra

Etiology & Type:

Etiology & Type of Cystitis

Infectious: name the suspected organism

Amebic	Gonococcal
Candida	Proteus (mirabilis) (morganii)
Chlamydia	Schistosomiasis [bilharziasis]
Cytomegaloviral	Syphilis
Diphtheritic	Trichomonas
Echinococcus granulosus	Tuberculosis
Echinococcus multilocularis	Etc.

Non-infectious

Allergy
Autoimmune disease
Chemical hypersensitivity: bubble bath, feminine hygiene sprays, spermicidal jellies, etc.
Chronic (interstitial) cystitis: unknown, multifactorial
Complication of: diabetes, HIV/AIDS, kidney stones, prostatic hypertrophy, spinal cord injuries, etc.
Defective bladder epithelium
Drugs: especially chemotherapy drugs cyclophosphamide & ifosfamide, etc.
Foreign-body: indwelling catheter, IUD, self-catheterization,
Heredity
Infection: name the organism
Radiation of the pelvic area
Urinary obstruction
Etc.

Complications

Hematuria
Incontinence
Pyelonephritis
Sepsis, severe sepsis, septic shock
Urethritis

Notes Although cystitis, inflammation of the bladder, is never an MCC and rarely an HCC, over half of the almost 50 codes are CCs. The code, and severity of illness, depends primarily on the etiology of the cystitis.

**ALL
SET
DOC?**

Cystitis continued

Cystitis Severity of Illness		
<u>SQL</u>		
Infectious cystitis		
A06.81	c -	Amebic
O23.1-	c -	Bladder infection in pregnancy
O86.22	c -	Bladder infection following delivery
B37.41	c -	Candidal w urethritis
A56.01	- -	Chlamydial w urethritis
A55	- -	Chlamydial lymphogranuloma (venereum)
A36.85	c -	Diphtheritic
B67.39	c -	Echinococcus granulosus
B67.69	c -	Echinococcus multilocularis
A54.01	c -	Gonococcal w urethritis
B25.8	c H	Other cytomegaloviral diseases
B96.4	- -	Proteus (mirabilis) (morganii)
B65.0	c -	Schistosomiasis [bilharziasis]
A52.76	c -	Syphilitic
A59.03	- -	Trichomonal w urethritis
A18.12	c -	Tuberculosis of bladder
A18.14	c -	Tuberculosis of prostate
N39.0	c -	UTI
Non-infectious cystitis		
N30.01	c -	Acute w hematuria
N30.00	c -	Acute wo hematuria
N21.0	- -	Bladder calculus
N33	- -	Bladder disorder
N30.10	- -	Chronic (interstitial) w hematuria
N30.11	- -	Chronic (interstitial) w hematuria
R39.82	- -	Chronic bladder pain
N30.91	- -	Cystitis w hematuria
N39.49	- -	Cystitis w urinary incontinence
N30.90	- -	Cystitis wo hematuria
R30.0	- -	Dysuria
Following:		
O04.88	c -	(Induced) termination of pregnancy
O03.88	c -	Complete or spontaneous abortion
O08.83	c -	Ectopic or molar pregnancy
O07.38	c -	Failed attempted pregnancy termination
O03.38	c -	Incomplete spontaneous abortion
N30.41	c -	Irradiation w hematuria
N30.40	c -	Irradiation wo hematuria
P00.1	- -	Newborn affected by maternal renal & urinary tract diseases
N30.81	- -	Other w hematuria
N30.80	- -	Other wo hematuria
N30.20	- -	Other chronic w hematuria
N30.21	- -	Other chronic w hematuria
N34.2	- -	Other urethritis
N41.3	- -	Prostatocystitis
M02.3	c H	Reiter's disease
N30.30	- -	Trigonitis w hematuria
N30.31	- -	Trigonitis w hematuria
N34.1	- -	Urethritis

78. **Debility** [⚠] has no code.

(See Asthenia above, Sarcopenia & Rehab below)

79. **Debridement**

**ALL
SET
DOC?**

L laterality & Site

Etiology : Document details of each wound requiring debridement (diabetic, infectious, pressure, trauma, venous stasis, other)

Type of debridement

'Excisional debridement': a surgical-procedure with the removal of **viable tissue** has a higher SOI.

'Non-excisional debridement': a medical-procedure for removal of **non-viable tissue or slough** (trimming with scissors, VersaJet, pulsed lavage, etc.).

Occurrence: Document ALL of the following for each wound:

Instruments used: scalpel, scissors, hydro, etc.

Deepest layer removed: skin, SQ, muscle-fascia, or bone

Total square centimeters of tissue removed per layer

Comorbid Conditions: Gangrene

Notes Document the details of individual wounds and debridement once in a PN and again in the Discharge Summary Diagnosis List to ensure their inclusion in SOI and COMDM.

	<p>The use of 'sharp' instruments does NOT indicate 'excisional' debridement.</p> <p>'Sharp' means a non-surgical, 'non-excisional' code will be applied.</p> <p>Do NOT use the word sharp if you remove any viable tissue; instead, document 'excisional debridement'</p>
---	---

-
80. **Deconditioning** [⚠]: Lack of physical activity causing rapid deterioration of muscles, bones, & mind with functional decline, often documented as ‘weakness’.

ALL
SET
DOC?

Etiology: often Comorbid Conditions, such as cancer, depression, chronic illness, malnutrition, & use disorders

Diagnosis of condition(s) requiring rehab:

'Asthenia with myopathy of critical illness d/t E.coli UTI w septic shock' [G72.81](C){H} + [A41.51]

Complications: falls and functional quadriplegia often result in injuries and other diagnoses (skin ulcers) that increase SOI.

- Notes** ICD-10-CM has no code for “deconditioning”. Several codes cover ‘weakness’ requiring rehabilitation. For rehab include diagnoses explaining why rehab is needed, abuse, neglect, & risk factors. Also see asthenia, sarcopenia, & rehab.

-
81. **Dehydration** [E86.0](), neonatal [P74.1]()

ALL
SET
DOC?

Etiology

ALL
SET
DOC?**Etiology of Dehydration**

Addison's disease
 Adrenal insufficiency [E27.1-E27.9](C){H}
 Biliary vomiting of newborn [P92.01](M){}
 Burns
 Chemotherapy
 Diabetes insipidus [E23.2](C){H}
 Diuretics
 Eating disorders
 Excessive sweating
 Excessive vomiting in pregnancy
 Fever
 Feeding problems in newborn
 Hyperemesis gravidarum [O21.-](){}
 Immunotherapy
 Laxatives
 Malignancy
 Malnutrition [E40-E46](){}
 Nephrogenic diabetes insipidus [N25.1](C){H}
 Postprocedural hypovolemic shock [T81.19](M){}
 Radiation therapy
 Skin tissue damage
 SIADH [E22.2](C){H}
 Traumatic hypovolemic shock [T79.4](M){H}
 Uncontrolled nausea & vomiting
 Etc.

Occurrence**Dehydration this Occurrence**

Anuria	Loss of focus/concentration
Cachexia	Low level of consciousness
Coma	Nutritional deficiencies
Confusion	Oliguria
Concentrated urine	Orthostasis
Dry mouth	Weak pulse
Dry, flaky skin	Etc.
Lethargy	

Complications

Dehydration Complications

Acid-base balance dysfunction [E87.-]({}/{}{})
Acidosis [E87.2-](C){}
AKI w ATN [N17.0](M){}
Arrhythmias
Cerebral edema [G93.6](M){H} [S06.1-](M){H}
Coma
Constipation
Electrolyte disorders /{/}{/}
(potassium/sodium/magnesium/chloride/phosphate)
Headaches
Heat injury/cramps/exhaustion/stroke [T67.-]({}/{}{})
Hyperosmolality & hypernatremia [E87.0](C){}
Hyperosmolality & hyponatremia [E87.1](C){}
Hypovolemia [E86.1]({}){}
Hypovolemic shock [R57.1](M){H}
Loss of consciousness
Muscle weakness/cramps.
Neonatal transitory electrolyte & metabolic disturbances [P74]({}/{}{})
Rhabdomyolysis [M62.82](C){}
Seizures /{/}{/}
Tachycardia
Tiredness/fatigue
Volume depletion [E86.9]({}){}}

Notes Dehydration alone does not have a high SOI. However, the Etiology and Complications of the dehydration, when documented as a Diagnosis, may increase SOI and COMDM.

-
82. **Delirium** [R41.0]{} is a finding; a temporary, usually reversible, fluctuating disturbance in attention, cognition, consciousness level; think encephalopathy

Acuity: Acute (**abrupt, rapid, sudden**)

Link to an Etiology to reflect the true SOI and COMDM.

Etiology: Disorders, drugs, non-disease states (ICU, intoxication, sleep deprivation)

Diagnosis:

ALL
SET
DOC?

'Alcohol dependence with withdrawal delirium...'
[F10.231](C){H}

'Alcoholic encephalopathy with delirium' [G31.2]{}{H}

Occurrence: Confusion, emotional disruption, reduced awareness of surroundings, decrease in attention span, disorientation, hallucinations, altered level of consciousness, delusions, dysphasia, tremors, dysarthria, decrease in short-term memory

83. **Dementia** [/] (/) { / }**Link to Etiology** to increase SOI/ROM/COMDM.

**ALL
SET
DOC?**

Dementia Etiology		
	<u>SOI</u>	
F10.97	C H	Alcoholic
F10.27	C H	Alcoholic with dependence
G30.-	- H	Alzheimer's
F01.50	- H	Arteriosclerosis
E75.4	C H	Cerebral lipidoses
F44.89	- H	Confusional (psychogenic)
A81.0-	C H	Creutzfeldt-Jakob disease/syndrome
F03.90	- H	Degenerative
R41.0	- -	Delirium
A52.17	C -	Dementia paralytica
G40.-	C H	Epilepsy and recurrent seizures
G31.09	- H	Frontal/frontotemporal (lobe)
E83.0-	- H	Hepatolenticular degeneration (Wilson's disease)
B20	C H	HIV disease
G10	C H	Huntington's disease/chorea
E83.52	- -	Hypercalcemia
E03.9	- H	Hypothyroidism, acquired
F18.97	C H	Inhalants
F18.27	C H	Inhalants w dependence
T36-T65	- H	Intoxications
E01.8	- H	Iodine deficiency
A81.0-	C H	Jakob-Creutzfeldt disease
A50.45	C -	Juvenile general paresis/neurosyphilis
G31.83	- H	Lewy body
F03	/ /	Multiple etiologies
G35	- H	Multiple sclerosis
A52.17	C -	Neurosyphilis/paretic/progressive syphilitic
E52	- -	Niacin deficiency
R54	- -	Old age
A81.89	C H	Other atypical CNS virus infections
A50.49	C -	Other juvenile neurosyphilis
G20	C H	Paralysis agitans
A52.17	C -	Paralytic, paralytic (syphilitic)
G31.83	- H	Parkinsonism
E52	- -	Pellagra
G31.01	- H	Pick's
M30.0	C H	Polyarteritis nodosa
A81.9	C H	Prion disease
F19.97	C H	Psychoactive drug
F19.27	C H	Psychoactive drug w dependence
G35	- H	Sclerosis
F13.97	C H	Sedatives/hypnotics/anxiolytics
F13.27	C H	Sedatives/hypnotics/anxiolytics w dependence
M32.-	C H	Systemic lupus erythematosus
S06.-	/ H	Traumatic brain injury
B56.-, B57-	C -	Trypanosomiasis
F03	/ /	Unknown etiology
F01.5-	/ /	Vascular
E53.8	- -	Vitamin B12 deficiency
F18.97	C H	Volatile solvents
F18.27	C H	Volatile solvents w dependence

Dementia continued

**ALL
SET
DOC?**

Type: When ‘mild’, ‘moderate’, or ‘severe’ describes dementia, SOI/ROM/COMDM increases and additional codes are added to the Etiology codes.

Dementia Type		
	SOI	
G31.84	- -	Mild cognitive impairment (MCI): Between normal aging & dementia Losing things Memory/thinking/judgment problems Trouble finding words
F02.A-	C H	Mild dementia: Begins to effect daily life Behavior changes Communication problems Financial management problems Hard to express thoughts/complex ideas Minor care/assistance may be needed More withdrawn Recent memory loss
F02.B-	C H	Moderate dementia: Assistance needed with ADLS Greater memory loss, further into history Personality changes (irritability, suspicion, etc.) Sleep changes (napping, restlessness, sundowning)
F02.C-	C H	Severe dementia: Severe mental decline Severe physical capability decline Loss of bladder/bowel control Walking may not be possible Might struggle with swallowing Full assistance needed with ADLS Infection risk increase (influenza, pneumonia, etc)
F03.90	- H	Degenerative
R41.0	- -	Delirium w dementia
F03-	/ /	Depressed or paranoid type
F84.3	C H	Infantile, infantilis
R41.9	- -	Neurocognitive
F03 -	/ /	Paranoid dementia
F03 -	/ /	Presenile
F03 -	/ /	Senile

Diagnosis: ‘*Moderate dementia d/t EB virus w agitation and wandering*’ [B27.09]{}+[F01.B11](C){H}+[Z91.83]{}

‘Demented’ [Δ] has no code.

OccurrenceALL
SET
DOC?

This Occurrence: Dementia with	
Aberrant motor behavior/agitation:	Behavioral disturbance: Sleep disturbance
Aggression	Social disinhibition
Anger	Sexual disinhibition
Combativeness	Mood disturbance: Anhedonia
Exit-seeking	Apathy
Pacing	Depression
Profanity	No other signs
Restlessness	Psychotic disturbance: Delusional
Rocking	Hallucinations
Shouting	Paranoia
Threatening	Suspiciousness
Violence	Wandering
Acute confusional state	Etc.
Anxiety	

Comorbid conditions: diabetes, dyslipidemia, hypertension, obesity, etc.

Complications: Traumatic injuries with acute blood loss anemia, especially head injuries with traumatic bleeds, due to falls are common in these patients. Be sure to document all of them.

84.

Dependence on machines/devices [Z99-] (/){/}ALL
SET
DOC?

Etiology: Details, if not inherent in the Diagnosis.

Type of device:

Type of Machine/Device Dependency		
SOI		
Z99.0	- -	Aspirator
Z99.2	- H	Dialysis
Z99.89	- -	Other enabling machines/devices
Z99.81	- -	Oxygen for chronic respiratory failure
Z99.11	C H	Ventilator
Z99.12	C H	Encounter during power failure
Z99.3	- -	Wheelchair

Diagnosis: Explain why the patient is dependent on the item:

'Dialysis dependent ESRD ' [N18.6](M){H}+ [Z99.2](){H}

Complications of dialysis, medical care, etc. often increase SOI.

85. **Dependence on (long term use of) medication** [Z79-]{}
 (See Addiction above for substance dependence)

Etiology: Diagnosis requiring ongoing medication.

Type of medication:

Type of Medication Dependency	
<u>SOI</u>	
Z79.2	- - Antibiotics
Z79.01	- - Anticoagulants
Z79.02	- - Antithrombotics/antiplatelets
Z79.811	- - Aromatase inhibitors
Z79.82	- - Aspirin
Z79.83	- - Bisphosphonates
Z79.3	- - Hormonal contraceptives
Z79.890	- - HRT
Z79.51	- - Inhaled steroids
Z79.4	- H Insulin
Z79.891	- - Opiate analgesic
Z79.84	- - Oral hypoglycemic drugs
Z79.899	- - Other drug
Z79.1	- - NSAID
Z79.810	- - SERMs
Z79.52	- - Steroids (inhaled & systemic)

A **Diagnosis** to explain why the patient is Rx dependent.

86. **DM (diabetes mellitus)** [over 300 codes]

Notes

Accurate documentation of diabetes for over 300 codes is hard, but diabetic complications increase SOI and COMDM. ‘Diabetic’ is acceptable to describe diabetes related conditions.

Abnormal BS tests absent diabetes should be explained.

Type:

- ALL SET DOC?
- DM due to underlying condition [E08-]
 - DM1 [E10-]
 - DM2 [E11-]
 - Drug/chemical induced DM [E09-]

GDM (gestational) [O24-]

Other [E13.-]: document Etiology (post pancreatectomy, postprocedural, secondary diabetes mellitus, etc.)ALL
SET
DOC?**Diabetes Basic Documentation**

<u>DM1</u>	<u>DM2</u>	<u>Other DM</u>	<u>Default</u>	<u>Specify</u>	<u>SOI</u>	
E10.9	E11.9	E13.9	-	H		Controlled wo complications
Urgent Complications						
E10.11		E13.11	M	H		DKA w coma
E10.10	E13.10	E13.10	M	H		DKA wo coma
	E11.00	E13.00	M	H		Hyperosmolarity wo coma
	E11.01	E13.01	M	H		NKHHC w coma
E10.65	E11.65	E13.65	-	H		W hyperglycemia
E10.641	E11.641	E13.641	M	H		W hypoglycemia w coma
E10.649	E11.649	E13.649	-	H		W hypoglycemia wo coma

DM due to a Named

<u>Underlying Condition</u>	<u>Drug or Chemical</u>	<u>SOI</u>	
E08.9	E09.9	- H	Controlled wo complications
Urgent Complications			
E08.11	E09.11	M	DKA w coma
E08.10	E09.10	M	DKA wo coma
E08.00	E09.00	M	Hyperosmolarity wo coma
E08.01	E09.01	M	NKHHC w coma
E08.65	E09.65	-	W hyperglycemia
E08.641	E09.641	M	W hypoglycemia w coma
E08.649	E09.649	-	W hypoglycemia wo coma

Diabetes in Obstetrics

SOI: No obstetrical conditions are HCCs

Preexisting DM is a CC in T1/2/3 & after birth & an MCC during L&D
Gestational DM is never a CC/MCC**Pre-existing**

T1	T2	T3	L&D	Puerperium	
O24.011	O24.012	O24.013	O24.02	O24.03	DM1 [E10]
O24.111	O24.112	O24.113	O24.12	O24.13	DM2 [E11]
O24.811	O24.812	O24.813	O24.82	O24.83	Other [E08,E09,E13]

Gestational DM (GDM)

<u>T1/2/3</u>	<u>L&D</u>	<u>Puerperium</u>	
O24.410	O24.420	O24.430	Diet control
O24.414	O24.424	O24.434	Insulin control
O24.415	O24.425	O24.435	Oral antidiabetic
O99.810	O99.814	O99.815	Abnormal GTT

Perinatal Diabetes		
	<u>SOI</u>	
P70.0	- -	Syndrome of infant of mother w GDM
P70.1	- -	Syndrome of infant of diabetic mother
P70.2	C -	Neonatal diabetes
P70.3	- -	Iatrogenic neonatal hypoglycemia
P70.4	- -	Other neonatal hypoglycemia
P70.8	C -	Transitory carbohydrate metabolism disorder

DM (diabetes) continued

ALL
SET
DOC?

Occurrence:

Blood sugar status: '**controlled**,' '**with hyperglycemia**,' or '**with hypoglycemia**'

Use of insulin or oral antidiabetic medication: '**none**,' '**diet controlled**,' '**short term rescue (SSI)**,' '**long-term treatment with insulin/other diabetic meds**'

Urgent **Complications:** Coma, DKA, hyperglycemic-hyperosmolar coma (NKHHC), etc. Document all to increase SOI, support admission, and show COMDM.

Other diabetic **Complications:** CKD, neuropathy, retinopathy, ulcers, etc. List them all with details

Additional Diabetic Documentation to Include		
<u>SOI</u>		
Z79.4	- H	Control w insulin
Z79.84	- -	Control w oral antidiabetic/hypoglycemic
Z79.899	- -	Other current rx
Z96.41	- -	Presence of insulin pump
E23.2	C H	Diabetes insipidus
Encounter for		
Z13.1	- -	Diabetes screening
Z46.81	- -	Insulin pump fit/adjust, training, titration
Z83.3	- -	FH: Diabetes
E16.2	- -	Hypoglycemia, nondiabetic
E16.3	- -	Increased secretion of glucagon
N25.1	C -	Nephrogenic diabetes insipidus
Personal History Of (PHO)		
Z90.411	- -	Acquired partial absence of pancreas
Z90.410	- -	Acquired total absence of pancreas
Z86.32	- -	Gestational diabetes
Z94.0	C H	Kidney transplant
E89.1	C -	Postprocedural hypoinsulinemia
Test results		
R73.09	- -	Abnormal non-fasting GTT
R73.9	- -	Hyperglycemia NOS
R73.01	- -	Impaired fasting glucose
R73.02	- -	Impaired glucose tolerance (oral)
R73.09	- -	Latent diabetes
R73.03	- -	Predabetes
R73.9	- -	Transient postprocedure hyperglycemia
E16.2	- -	Transient postprocedure hypoglycemia

**ALL
SET
DOC?**

Other diabetic **Complications:** CKD, neuropathy, retinopathy, ulcers, etc. List them all with details

Diabetic Ophthalmologic Complications

All codes require documented L laterality (7th character) 1 Right
 SOI depends on documented specificity 2 Left
 None are MCC or CCs, but most are HCCs 3 Bilateral

DM1	DM2	Other DM	
Default	Specify	Nonproliferative Retinopathy	
E10.321	E11.321	E13.321	Mild W macular edema
E10.329	E11.329	E13.329	Mild Wo macular edema
E10.331	E11.331	E13.331	Moderate W macular edema
E10.339	E11.339	E13.339	Moderate Wo macular edema
E10.341	E11.341	E13.341	Severe W macular edema
E10.349	E11.349	E13.349	Severe Wo macular edema
Proliferative Retinopathy			
E10.351	E11.351	E13.351	W macular edema
E10.352	E11.352	E13.352	W macular traction retinal det.
E10.353	E11.353	E13.353	W non-macular traction ret. det.
E10.354	E11.354	E13.354	W combined traction & rhegmatogenous retinal det.
E10.355	E11.355	E13.355	Stable
E10.359	E11.359	E13.359	Wo macular edema
E10.36	E11.36	E13.36	Cataract
E10.39	E11.39	E13.39	Other ophthalmologic complications DM glaucoma [H40-H42], etc.

DM due to a Named

Underlying Condition	Drug or Chemical		Nonproliferative Retinopathy
E08.321	E09.321		Mild W macular edema
E08.329	E09.329		Mild Wo macular edema
E08.331	E09.331		Moderate W macular edema
E08.339	E09.339		Moderate Wo macular edema
E08.341	E09.341		Severe W macular edema
E08.349	E09.349		Severe Wo macular edema
Proliferative Retinopathy			
E08.351	E09.351		W macular edema
E08.352	E09.352		W macular traction retinal det.
E08.353	E09.353		W non-macular traction ret. det.
E08.354	E09.354		W combined traction & rhegmatogenous retinal det.
E08.355	E09.355		Stable
E08.359	E09.359		Wo macular edema
E08.36	E09.36		Cataract
E08.39	E09.39		Other ophthalmologic complications DM glaucoma [H40-H42], etc.

DM (diabetes) continued

**ALL
SET
DOC?**

Diabetic Complications P.1			
SOI depends on documented details of complications Some complications are MCC/CCs, most are HCCs			
DM1	DM2	Other DM	
		Default	Specify
E10.618	E11.618	E13.618	Arthropathy, other
E10.610	E11.610	E13.610	Charcot's neuropathic arthropathy
E10.620	E11.620	E13.620	Dermatitis, necrobiosis lipoidica
E10.628	E11.628	E13.628	Other skin complications
			Nephropathy
E10.21	E11.21	E13.21	Kimmelsteil-Wilson/intercapillary glomerulonephrosis/sclerosis
E10.29	E11.29	E13.29	Other kidney complications
E10.22	E11.22	E13.22	Chronic kidney disease (CKD)
			<u>Also document</u>
Z99.2	On dialysis		N18.1 CKD1 GFR >89
Z94.0	Kidney transplant		N18.2 CKD2 60-89
N17.0	ATN		N18.3 CKD3 30-59
N28.89	Renal tubular degeneration		N18.4 CKD4 15-29
			N18.5 CKD5 <15
			N18.6 ESRD
E10.40	E11.40	E13.40	Neuropathy
E10.41	E11.41	E13.41	Mononeuropathy
E10.42	E11.42	E13.42	Neuralgia, polyneuropathy
E10.43	E11.43	E13.43	Autonomic, gastroparesis
E10.44	E11.44	E13.44	Amyotrophy, myasthenia
E10.49	E11.49	E13.49	Other neuro complications
E10.69	E11.69	E13.69	Osteomyelitis
			Peripheral angiopathy
E10.51	E11.51	E13.51	Without gangrene
E10.52	E11.52	E13.52	With gangrene (MCC) Ulcers, non-pressure
E10.621	E11.621	E13.621	Foot ulcer
			Right Left
		L97.41-	L97.42- Heel / midfoot
		L97.51-	L97.52- Other foot site
E10.622	E11.622	E13.622	Other skin ulcer
			Right Left
		L97.11-	L97.12- Thigh
		L97.21-	L97.22- Calf
1	Skin breakdown	L97.31-	L97.32- Ankle
2	Exposed fat	L97.81-	L97.82- Other LE site
3	Muscle necrosis		L98.41- Buttock
4	Bone necrosis		L98.42- Back
			L98.49- Other site
E10.59	E11.59	E13.59	Other circulatory complication
E10.630	E11.630	E13.630	Periodontal disease
E10.638	E11.638	E13.638	Other oral complications
E10.319	E11.319	E13.319	Retinopathy unspecified

**ALL
SET
DOC?**

Diabetic Complications P.2								
SOI depends on documented details of complications Some complications are MCC/CCs, most are HCCs								
DM due to a Named								
Underlying Condition								
Drug or Chemical								
Arthropathy, other								
E08.618	E09.618	Charcot's neuropathic arthropathy						
E08.610	E09.610	Dermatitis, necrobiosis lipoidica						
E08.620	E09.620	Other skin complications						
E08.628	E09.628	Nephropathy						
E08.21	E09.21	Kimmelsteil-Wilson/intercapillary glomerulonephrosis/sclerosis Other kidney complications						
E08.29	E09.29	Chronic kidney disease (CKD)						
E08.22	E09.22	N18.1	CKD1	GFR >89				
Z99.2	On dialysis	N18.2	CKD2	60-89				
Z94.0	Kidney transplant	N18.3	CKD3	30-59				
N17.0	ATN	N18.4	CKD4	15-29				
N28.89	Renal tubular degeneration	N18.5	CKD5	<15				
		N18.6	ESRD					
E08.40	E09.40	Neuropathy						
E08.41	E09.41	Mononeuropathy						
E08.42	E09.42	Neuralgia, polyneuropathy						
E08.43	E09.43	Autonomic, gastroparesis						
E08.44	E09.44	Amyotrophy, myasthenia						
E08.49	E09.49	Other neuro complications						
E08.69	E09.69	Osteomyelitis						
Peripheral angiopathy								
E08.51	E09.51	Without gangrene						
E08.52	E09.52	With gangrene (MCC)						
E08.621	E09.621	Ulcers, non-pressure Foot ulcer						
		Right	Left					
		L97.41-	L97.42-	Heel / midfoot				
		L97.51-	L97.52-	Other foot site				
E08.622	E09.622	Other skin ulcer						
		Right	Left					
L97 code's 6th character indicates ulcer depth								
1	Skin breakdown	L97.11-	L97.12-	Thigh				
2	Exposed fat	L97.21-	L97.22-	Calf				
3	Muscle necrosis	L97.31-	L97.32-	Ankle				
4	Bone necrosis	L97.81-	L97.82-	Other LE site				
			L98.41-	Buttock				
			L98.42-	Back				
			L98.49-	Other site				
E08.59	E09.59	Other circulatory complication						
E08.630	E09.630	Periodontal disease						
E08.638	E09.638	Other oral complications						
E08.319	E09.319	Retinopathy unspecified						

DM (diabetes) continued**Diabetic Ophthalmologic Complications**

All codes require documented Laterality (7th character) 1 Right
 SOI depends on documented specificity 2 Left
 None are MCC or CCs, but most are HCCs 3 Bilateral

DM1	DM2	Other DM	
Default	Specify	Nonproliferative Retinopathy	
E10.321	E11.321	E13.321	Mild W macular edema
E10.329	E11.329	E13.329	Mild Wo macular edema
E10.331	E11.331	E13.331	Moderate W macular edema
E10.339	E11.339	E13.339	Moderate Wo macular edema
E10.341	E11.341	E13.341	Severe W macular edema
E10.349	E11.349	E13.349	Severe Wo macular edema
Proliferative Retinopathy			
E10.351	E11.351	E13.351	W macular edema
E10.352	E11.352	E13.352	W macular traction retinal det.
E10.353	E11.353	E13.353	W non-macular traction ret. det.
E10.354	E11.354	E13.354	W combined traction & rhegmatogenous retinal det.
E10.355	E11.355	E13.355	Stable
E10.359	E11.359	E13.359	Wo macular edema
E10.36	E11.36	E13.36	Cataract
E10.39	E11.39	E13.39	Other ophthalmologic complications DM glaucoma [H40-H42], etc.

DM due to a Named

Underlying Condition	Drug or Chemical		Nonproliferative Retinopathy
E08.321	E09.321	Mild	W macular edema
E08.329	E09.329	Mild	Wo macular edema
E08.331	E09.331	Moderate	W macular edema
E08.339	E09.339	Moderate	Wo macular edema
E08.341	E09.341	Severe	W macular edema
E08.349	E09.349	Severe	Wo macular edema
Proliferative Retinopathy			
E08.351	E09.351	W macular edema	
E08.352	E09.352	W macular traction retinal det.	
E08.353	E09.353	W non-macular traction ret. det.	
E08.354	E09.354	W combined traction & rhegmatogenous retinal det.	
E08.355	E09.355	Stable	
E08.359	E09.359	Wo macular edema	
E08.36	E09.36	Cataract	
E08.39	E09.39	Other ophthalmologic complications DM glaucoma [H40-H42], etc.	

87. **Diagnosis**

**ALL
SET
DOC?**

Acuity

Link the Diagnosis to Etiology, Occurrence, Comorbid Conditions, and Complications

Uncertainty* is acceptable even in the Discharge Summary (except for COVID-19 and AIDS) if expressed as '**evidence of**', '**suspected**', '**probable**' or '**likely**' Diagnosis

Notes Diagnoses contribute to SOI, ROM, LOS, and COMDM in two ways; the number of codeable diagnoses and the severity of each. The only documentation used for ICD-10-CM coding, is from clinicians trained, licensed and credentialed to synthesize signs, symptoms and test results into a logical, accurate medical Diagnosis.

Document every Diagnosis proven, treated, tested for, monitored, or considered in medical-decision-making.

Write a Diagnosis for each medication, intervention, consultation, and test (especially abnormal results); be as specific as possible.

Link signs, symptoms and test results to a Diagnosis.

Diagnoses should be documented in the DIAGNOSIS/ASSESSMENT section of notes when first suspected and should remain in the notes until documented as 'resolved' or 'ruled out.'

In the discharge summary/final note include every suspected-diagnosis. Indicate if a Diagnosis was PHO, POA, resolved, ruled out, or still only suspected at discharge.

Personal history of (PHO) diagnoses will remain forever in the Diagnosis List because they require life-long monitoring.

88. **Diagnosis List (DL)**

Notes Every note should have a clearly delineated Diagnosis List that includes all active diagnoses, and a Diagnosis for any new abnormal diagnostic finding. Include ‘resolved’ or ‘ruled-out’ for every Diagnosis that has become inactive since the last note. The full list of diagnoses should be found in the H&P and the Discharge Summary.

89. **Discharge Summary (D/S)**

ALL
SET
DOC?

Acuity

Diagnosis: Document each Diagnosis suspected even if resolved, from most to least serious and indicate initial acuity, and if PHO, POA, resolved, ruled out, still just suspected.

Link diagnoses to Site, Etiology, Type, Occurrence (symptoms, signs, test results, other timely details), Comorbid Conditions, and Complications

Uncertainty terminology is OK, if a Diagnosis is still not proven.

Notes The Discharge Summary is the last chance to tell your patient’s story, your way. It should be a coherent, short story about the admission; a story that makes it unnecessary for the ED to call you, when the patient returns, or for you to cringe at in court.

The Discharge Summary is your itemized bill & should contain:

- Appropriate patient identifiers.
- Admission, discharge, and follow up dates.
- Admission diagnoses indicated as POA.
- SUBJECTIVE (S): the original complaint with a brief summary of HPI, risk factors, ROS & PFSH with only pertinent information to support an inpatient admission.

Notes

- OBJECTIVE (O): Hospital course:
 - A brief chronology of relevant events & treatment response.
 - NO exam is required; summarize & date pertinent findings from the entire stay.
 - Analyze relevant/abnormal tests w date when first reported.
 - ASSESSMENT (A) / DISCHARGE DIAGNOSES LIST:
Others look here for diagnostic conclusions.
 - Include a complete Diagnosis List.
 - Document all Diagnoses most to least serious.
 - Include pertinent information recorded 72 hrs prior to admission; ED diagnoses with acuity (even if improved or resolved prior to admission they still count).
 - Indicate POA, on each dx, when appropriate.
 - PLAN (P): Make your hand-off reasoning clear. Explain what should happen next; who will take over the patient's care (where, when, why); what additional testing, treatment, planning is needed; important details of your patient instructions and discharge medications with dose, frequency and duration.
-

90.

Dominance**ALL
SET
DOC?**

Laterality: Righthanded, lefthanded, ambidextrous

Notes

Dominance dictates some neurologic-deficit Diagnosis codes, even when the condition does not include the arms. Document dominance to avoid a query or an unspecified code.

91. **Antibiotic resistance [Z16-]**

ALL

SET

DOC?

Etiology: Document the organism being treated

Occurrence: Record drug resistance when known

Notes For positive cultures, document the causative organism and its drug resistance. If drug resistance is included in the organism's name (MRSA, VRE, MDR-TB, CRE), then the organism alone will suffice.

As noted in the following list, SOI is increased when drug resistance is documented by the physician. Drug resistance documentation is especially important when changing antibiotics. Changing treatment due to drug resistance

increases COMDM.

Antimicrobial Drug Resistance		
	<u>SOI</u>	
A49.02	- -	MRSA infection
B95.62	- -	MRSA in diseases classified elsewhere
J15.212	- H	MRSA pneumonia
A41.02	- H	MRSA Sepsis
		Resistant to
Z16.29	C -	Aminoglycosides
Z16.11	C -	Amoxicillin
Z16.11	C -	Ampicillin
Z16.32	C -	Antifungal drug(s)
Z16.341	C -	Antimycobacterial drugs
Z16.31	C -	Antiparasitic drug(s)
Z16.33	C -	Antiviral drug(s)
Z16.10	C -	Beta lactams
Z16.13	C -	Carbapenem
Z16.19	C -	Cephalosporins
Z16.12	C -	Extended spectrum beta lactamase (ESBL)
Z16.29	C -	Macrolides
Z16.24	C -	Multiple antibiotics
Z16.35	C -	Multiple antimicrobial drugs
Z16.342	C -	Multiple antimycobacterial drugs
Z16.29	C -	Other single specified antibiotic
Z16.39	C -	Other specified antimicrobial drug
Z16.19	C -	Other specified beta lactam antibiotics
Z16.11	C -	Penicillins
Z16.31	C -	Quinine & related compounds
Z16.23	C -	Quinolones & fluoroquinolones
Z16.29	C -	Sulfonamides
Z16.29	C -	Tetracyclines
Z16.21	C -	Vancomycin
Z16.22	C -	Vancomycin related antibiotics

92.

'Due to'**ALL
SET
DOC?**

Link conditions, diagnoses, etiologies, signs, and symptoms together for greater specificity and severity of illness. Use only these terms:

'Due to' (dt, d/t)

'From'

'In'

'With' (w, c)

Notes Use '**without**' or list items separately when potentially related conditions are NOT linked.

93. **E-cigarettes/vaping [F17.29]**

**ALL
SET
DOC?**

Etiology: Details of the substance used

Link use to **Complications** such as '**withdrawal**' (CC), '**acute hypoxic respiratory failure**' (MCC), and other suspected diagnoses.

Notes Although not tobacco per se, alternative methods of delivering nicotine are coded as 'other' nicotine/tobacco products. Document other diseases caused by particulate matter in the inhalant in addition to the nicotine effect.

94. **Electrolytes & other lab results**

**ALL
SET
DOC?**

Link abnormal results to an **Etiology** and a **Diagnosis**

Notes Abnormal test results are signs that should be named, hypER- or hypO-natremia/kalemia, etc., and linked to the **Etiology** and a **Diagnosis**, especially when treated.

Document when a normal test result eliminates a **Diagnosis**.

95. **Elevated troponin**

Troponin leak, Troponinemia, and other slang related to elevated troponins have no codes.

Acuity: Determined by serial measurement rise or fall:

Acute: >99% URL with 50% increase or 20% change

Chronic: >99% URL without rise or fall

Link lab results to a Diagnosis that represents the Etiology of the elevation

Site & Etiology:

ALL
SET
DOC?

Etiology of Elevated Troponin	
Site	
Cardiac	
AMI	Heart failure
Angioplasty	Hypertrophic cardiomyopathy
Aortic dissection	Myocardial damage from
Aortic valve disease	Chemotherapy
Atrial fibrillation	Drugs like cocaine
Bradyarrhythmia	Trauma
Cardiac surgery	Myocardial infarction
Cardiotoxic drugs	Myocardial ischemia
Cardioversion	Myocardial injury
COVID-19 myocarditis	Myocarditis
Demand ischemia d/t:	NSTEMI
Anemia	PCI (Percutaneous coronary intervention)
Arrhythmias	Revascularization procedure
Embolism	Stenting
Heart failure	STEMI
Hypertension	SVT
Hypotension	Tachyarrhythmia
Parox. tachycardia	Tako-tsubo cardiomyopathy
Uncontrolled afib	Traumatic cardiac contusion
Vasospasm	V-tach
Endomyocardial biopsy	Etc.
Heart block	
Noncardiac	
AKI	Renal failure
Amyloidosis	Rhabdomyolysis
Burns	Sarcoidosis
CKD	Sepsis
CVA	Severe critical illness
Extreme exertion	Severe pulmonary hypertension
Hemochromatosis	Stroke
Infiltrative diseases	Subarachnoid hemorrhage
Pulmonary embolism	Etc..

Diagnosis: '*Elevated Troponin not clinically relevant*' or '*Elevated Troponin due to ...*'

ALL
SET
DOC?

Diagnosis for Elevated Troponin		
	SOI	
R79.89	- -	Abnormal test result, clinically insignificant <u>Myocardial injury</u>
I5A	C -	Non-traumatic
S26-	C -	Traumatic
	- -	<u>Ischemic heart disease, NO infarction</u>
I25.9	C H	Chronic
I24.9	C H	Acute
I24.81	C /	Acute coronary microvascular dysfunction
I24.89	M H	Other forms of acute ischemic heart disease <u>AMI due to demand ischemia</u>
I21.A1	M H	Type2 NSTEMI
I21.A1	M H	Type2 STEMI
		<u>AMI due to occlusion ischemia</u>
I21.B	M -	MI with coronary microvascular dysfunction
I21.4	M H	Acute NSTEMI, Type 1
I21.0/1/2/3/4/9	M H	Acute STEMI, Type1
I21.A9	M H	Other including Types 3-5
I21.B	M -	AMI with coronary microvascular dysfunction
I21.9	M H	AMI unspecified
/	/ /	Other cardiac dx See list previous page
/	/ /	Other non-cardiac dx See list previous page

Occurrence: ECG and other evidence of a suspected Etiology

Comorbid conditions: Especially those which might explain the elevated troponin

Notes Elevated troponin [R79.89]{} is a sign, an abnormal blood lab test with a low SOI looking for an Etiology and Diagnosis.

Elevated troponin is associated with increased mortality, especially after surgical procedures, so consider and document possible causes of the elevation. For instance, decreased renal function, alone and in conjunction with other etiologies, is associated with abnormally high troponin levels.

In rhabdomyolysis troponin elevation may be out of proportion to the muscle damage due to the etiology of

the rhabdomyolysis (hypotension, illicit substance use, sepsis, etc.).

Elevated troponin continued

- Notes** If you suspect an Etiology and are going to do additional testing, make sure to document a suspected-diagnoses to justify testing. When testing is complete, write a new note with the post-test suspected-diagnosis.
-

96. **Empirical treatment for...**

- Notes** The term “empirical treatment for...” negates the Diagnosis that follows. Thus, the Diagnosis will not be coded.
-

97. **Encephalopathy [G93.40](M){}**

ALL
SET
DOC?

Acuity

Etiology (may also be a comorbid condition): anoxia, infection, kidney/liver failure, metabolic abnormality, sepsis, trauma, etc.

Type is often based on Acuity or Etiology (see lists)

Link the Diagnosis to evidence found during this Occurrence (AMS, GCS) and to Complications

Comorbid Conditions

- Notes** Altered mental status [R41.82](){}; AMS/altered level of consciousness d/t a named condition [R40.-](){H}; and delirium [R41.0](){} are findings. ‘**Encephalopathy**’ is a Diagnosis. Objective evidence is captured in the GCS.

‘**Encephalopathy**’[disease, damage, or malfunction of the brain manifested by AMS and sometimes accompanied by physical changes] has numerous etiologies with different SOI, ROM, and COMDM.

When patients have AMS, consider encephalopathy, and look for the Etiology.

‘Hepatic encephalopathy’ should always have an additional Diagnosis to indicate the liver dysfunction present

Before you write AMS, consider what Type/Etiology of encephalopathy might be present!

See lists that follow.

**ALL
SET
DOC?**

<u>Type/Etiology of Encephalopathy</u>		
	<u>SOI</u>	
G93.40	C -	Acute
G04.30	M -	Acute necrotizing hemorrhagic
K72.00	M -	Acute/subacute hepatic w/o coma
G31.2	- H	Alcoholic
I67.2-	- H	Arteriosclerotic
I67.3	C H	Binswanger's vascular leukoenceph.
G37.0	C H	Centrolobar progressive (Schilder)
K72.10	M H	Chronic hepatic without coma
G04.02	M -	D/t vaccination
G32.89	- H	Degenerative in specified disease
G37.1	C H	Demyelinating callosal
K76.82	- -	Hepatic encephalopathy due to
K72.90	M H	Hepatic failure without coma
K91.82	C -	Postprocedural hepatic failure
P55-P57		Ikterus of newborn
/	/ /	Viral hepatitis without hepatic coma
I67.4	C H	Hypertensive
E16.2	- -	Hypoglycemic
Numerous	/ /	Infections (influenza)
Numerous	/ /	Intracranial injuries
T56.0-	- /	Lead poisoning
E88.41	C H	MELAS syndrome
G93.41	M -	Metabolic
A81.2	C H	Multifocal leukoencephalopathy
G31.82	C H	Necrotizing, subacute (Leigh)
D49.9, G13.1	- /	Neoplastic disease
G93.49	M -	Other
G04.39	M -	Other acute necrotizing hemorrhagic
G13.1	- -	Paraneoplastic limbic
E52, G32.89	- -	Pellagraous
I67.83	M -	Post. reversible enceph. syndrome (PRES)
F07.81	- -	Post concussional/contusional/traumatic
E16.1, G94	- -	Posthypoglycemic (coma)
G04.32	M -	Postimmunization
G04.31	M -	Postinfectious
G93.89	- -	Postradiation
G93.7	M H	Reye's syndrome
G93.41	M -	Septic
T80.69	C -	Serum reaction
A81.09	C H	Spongiform, subacute (viral)
G40.4	- H	Symptomatic early myoclonic
A50.49	- -	Syphilis, congenital
A52.17	C -	Syphilitic
G92	/ -	Toxic/drug induced ADE/poisoning
A81.1	C H	Van Bogaert sclerosing leukoenceph.
E56.9, G32.89	- -	Vitamin deficiency
E51.2	C -	Wernicke's B1 deficiency

Encephalopathy continued

Notes Perinatal encephalopathy requires additional information depending on the Etiology:

Type/Etiology of Perinatal Encephalopathy		
	<u>SOI</u>	
Q07.9	- -	Congenital
P11.1	- -	Due to birth injury
P57.0	M -	Due to isoimmunization
P55-P57	/ /	Hepatic d/t icterus of newborn
P57.9	M -	Hyperbilirubinemic
P91.60	M -	Hypoxic ischemic (HIE)
P91.61	M -	HIE mild
P91.62	C -	HIE moderate
P91.63	M -	HIE severe
P91.811	- -	In diseases classified elsewhere
P91.819	- -	Neonatal unspecified

98. **Encounter (CPT®)**

Notes To add to documentation confusion, the word ‘encounter’ is used differently in two prominent American coding systems.

CPT® defines ‘encounter’ as “face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility.”

99. **Encounter (ICD-10-CM)**

Notes ICD-10-CM contains codes for those same CPT®-encounters. None are (MCCs); a few transplant related [Z-codes] are (CCs); and a few are {HCCs}. Examples are encounters for:

Administrative examination [Z02-]

Screening [Z13.-]

Immunizations [Z23]

Reproduction [Z30-Z39]

Other specific health care [Z40-Z53]

Trauma/poisoning/medical care complications
7thcharacter:

- **‘Initial’** encounter: Patient receives “active treatment”. *There can be multiple initial encounters.* Many are MCCs.
- **‘Subsequent’** encounter: Patient receives “routine care during healing/recovery phase.”

- '**Sequelae**' encounter: Patient receives care for the sequela or late effects of a traumatic, poisoning, or medical care complications.

100. **Epilepsy** [G40](CC/MCC){HCC}

ALL
SET
DOC?

Acuity:

'**With status epilepticus**' (MCC)

'**Without status**' (CC)

Etiology: trauma, alcohol, drugs, hormonal changes, sleep deprivation, stress, etc.

Type:

<u>Type of Epilepsy</u>		
	<u>SOI</u>	
G40.A-	C H	Absence syndrome
G40.5-	C H	Epileptic seizures due to external causes
G40.82-	C H	Epileptic spasms
	C H	Epileptic syndromes with
G40.2-	C H	Complex partial seizures
G40.0-	C H	Seizures of localized onset
G40.1-	C H	Simple partial seizures
G40.3-	C H	Generalized epileptic syndrome } With status
G40.3-	C H	Generalized idiopathic } = MCC
G40.B-	C H	Juvenile myoclonic
G40.81-	C H	Lennox-Gastaut syndrome
	C H	Localization-related (focal/partial)
G40.0-	C H	Idiopathic
G40.1-	C H	Symptomatic w simple partial seizures
G40.2-	C H	Symptomatic w complex partial seizures
G40.4-	C H	Other named generalized

Occurrence: '*Intractable*' or '*not intractable*'

Complications

Notes SOI and ROM for epilepsy depend on the acuity and intractability of the present **Occurrence**.

101. **ESRD (end-stage renal disease)** [N18.6](MCC){HCC}

ALL
SET
DOC?

Link to an Etiology: DM, drug, HTN, toxin, etc.

Type: of dialysis, hemodialysis or peritoneal.

Occurrence: Dependent on dialysis [Z99.2]; noncompliance with dialysis [Z91.15]; presence of AV dialysis fistula [Z99.2]; etc.

Comorbid Conditions: Fluid overload, heart failure, malnutrition, etc

ESRD continued

Complications of CKD itself

ALL SET DOC? **Complications** of dialysis including cloudy dialysis effluent [R88.0]; intra-dialysis sterility failure [Y62.2]; etc.

Dialysis Occurrence & Complications			
Complications of Dialysis			
E85.3	C H	Amyloidosis	
E71.43	- H	Carnitine deficiency	
I95.3	- -	Intra-dialytic hypotension	
		FB accidentally l: Steal syndrome	
T81.512	- H	Adhesions	
T81.522	- H	Obstruction	
T81.532	H	Perforation	
T81.592	H	Other	
T81.502	- -	Unspecified	
I95.3	- -	Intra-dialytic hypotension	
T82.898	C H	Steal syndrome	
Y84.1	- -	Dialysis Complications not mentioned at dialysis	
Y622	- H	Sterility failure during dialysis	
Peritoneal Hemodialysis			
	<u>SOI</u>	<u>SOI</u>	Complications of dialysis catheter
T85.621	C H	T82.42	C H Displacement, malposition
T85.818	- -	T82.818	C H Embolism
T85.828	- -	T82.828	C H Fibrosis
T85.838	- -	T82.838	C H Hemorrhage
T85.71	C H	T82.7	C H Inflammation/Infection + organism
T85.631	C H	T82.43	C H Leakage
T85.611	C H	T82.41	C H Mechanical malfunction
T85.848	- -	T82.848	C H Pain
T85.691	C H	T82.49	C H Other mechanical (obstruction, perforation, protrusion)
T85.898	- -	T82.898	C H Other specified complications
T85.79	C H	T85.79	C - Sepsis
T85.858	- -	T82.858	C H Stenosis
T85.868	- -	T82.868	C H Thrombosis
T85.9	- -	T82.9	C - Unspecified
Encounters			
Z49.02	- H	Z49.01	- H Dialysis prep, catheter management, equilibration test
Z49.32	- H	Z49.31	- H Assessment of dialysis adequacy

102. **'Evidence of...'**

Notes Use when the Clinical Indicators point toward a Diagnosis you cannot prove, but that, in your clinical opinion, is likely.

103. **External Causes**

Notes External causes are epidemiologic details about injuries, poisonings and complications of medical/surgical care. They must be recorded only once.

Etiology-Diagnosis examples:

Chemical - burn
Cocaine - OD
Confirmed intentional elder abuse - severe malnutrition + the alleged perpetrator
Fentanyl - poisoning
Medical misadventure - Dx + details
MVC - itemized list of injuries
Surgical complication - intestinal perforation + contributing factors
Thermal - burn

Occurrence:

Who [Y92-]: Description of the patient during the event (car driver, bus passenger, pedestrian, etc.)

ALL
SET
DOC?

Patient 'status' [Y99-]: 'Work' during event:

Civilian working [Y99.0]

Military on-duty [Y99.1]

Volunteering [Y99.2]

Other [Y99.8]: anyone not working (hobby recreation, unpaid sport), off-duty military, student, housework, etc.

What: Explain what happened, animal bite, asphyxiation, drowning, fall, etc.

How: Describe each of the following:

- Mechanism of injury: how it happened, what caused it, sequence of events, etc.
- Intent

‘**Unintentional**’ accidental/cataclysmic

‘**Intentional**’ abuse/assault/terrorism

‘**Deliberate self-harm/suicide**’

External Causes continued**Where [Y92-]: Where event occurred, not a complete list.**

**ALL
SET
DOC?**

External Causes [Y92-]: Where or Place of Occurrence		
Residential site + specific area of residence		
Apartment	Barracks	Mess hall
Boarding-house	Bathroom	Patient bath
Children's home/orphanage	Bedroom	Patient room
Hospital	Cafeteria	Swimming pool
Military base	Cell	Other: Give details
Mobile home	Corridor	
Nursing home	Courtyard	
Prison	Dining room	
Reform school	Driveway	
School dormitory	Garage	
Single-family house	Kitchen	
Ambulatory surgery center	Medica office/clinic	
Amusement park	Middle school	
Airplane	Military training ground	
Art Gallery	Mine/pit	
Bank	Movie house/cinema	
Barn	Museum	
Baseball field	Music hall	
Basketball court	Oil rig	
Beach	Opera house	
Bike path	Orchard	
Boat	Parking lot	
Building under construction	Parkway	
Bus	Post office	
Bus station	Public park	
Campsite	Railroad track	
Car	Railway station	
Chicken coop	Religious institution	
City hall	Roller skating rink	
College	Sidewalk	
Courthouse	Slaughter house	
Daycare center	Soccer field	
Desert	Squash court	
Dock/shipyard	State road	
Elementary school	Subway car	
Exit/entrance ramp	Swimming pool private	
Factory	Swimming pool public	
Field	Tennis court	
Football field	Theater (live)	
Forest	Trade school	
Gas station	Train	
High school	Truck	
Highway rest stop	Urgent care center	
Ice skating rink	Zoo (zoologic park)	
Interstate highway	Other: Give details	
Library		
Local residential/business street		

ALL
SET
DOC?**Patient activity [Y93-] at the time of the event:**

Activity Patient Engaged in At Time of Event	
Y93.K	Animal care
Y93.D	Arts/handcrafts
Y93.F	Caregiving
Y93.3	Climbing, rappelling, jumping off
Y93.C	Computer technology/electronic devices
Y93.4	Dancing, other rhythmic movement
Y93.G	Food preparation, cooking, grilling
Y93.2	Ice/snow
Y93.A	Other cardiorespiratory exercise
Y93.B	Other muscle strengthening exercises
Y93.7	Other specified sports, athletics
Y93.5	Other sports, athletics played individually
Y93.6	Other team/group sports, athletics
Y93.8	Other: Give details
Y93.E	Personal, interior property, clothing maintenance
Y93.J	Playing musical instrument
Y93.H	Property/land maintenance, building, construction
Y93.I	Roller coasters, other types of external motion
Y93.0	Walking/running
Y93.1	Water/water craft

104. **Failure to thrive (FTT) /{/}**ALL
SET
DOC?**Etiology:** Abuse, acute/chronic illness, malnutrition, neglect; etc.**Type:**

Type of Failure to Thrive		
	<u>SOI</u>	
P92.6	- -	Newborn
R62.51	- -	Child over 28 days
R62.7	- -	Adult
R62.50	- -	Developmental
E45	C H	Physical retardation due to malnutrition
E64.-	/ /	Sequelae of malnutrition & other nutritional deficiencies
B20	C H	With HIV
R62.59	- -	Other

ALL
SET
DOC?**Failure to thrive continued**

Occurrence: Link signs, symptoms, & test results to support this **Diagnosis**.

Comorbid conditions:

List all associated **Diagnoses**

Complications: See deconditioning* above for a list of “weakness” related **Diagnoses**

Death

Falls

Organ failure

Shock

105. **Fluid overload [E87.70]()**ALL
SET
DOC?**Type:**

Edema/fluid retention [R60.9]

Fluid overload [E87.70]

Other fluid overload [E87.78]

Transfusion associated circulatory overload (TACO)
[E87.71]

Complications: Acute heart failure

Notes When fluid overload is responsible for acute heart failure, it is crucial to document the heart failure in addition to the overload because it increases SOI, ROM, and COMDM.

106. **Fractures**

Notes Fractures require extensive documentation for good fracture care; optimal skin, neurovascular results; and accurate coding. Orthopedics requires years of study to master an enormous database partially reflected in thousands of ICD-10-CM fracture codes each requiring specific terminology.

Fortunately, the ALL SET DOC™ mnemonic has simplified fracture documentation.

Notes Laterality and Site are needed on all fractures, in addition to comorbidities, complications (especially acute blood loss anemia, the natural consequence of pelvic and hip fractures and non-osseous injuries), Type of healing, and the 7th character encounter (initial, subsequent, sequela).

However, fracture documentation is significantly different depending on the Type of fracture, (traumatic or non-traumatic).

Non-traumatic/pathologic fractures are without trauma or from minor trauma (a fall from standing height, a ground level fall (GLF), that would not break normal, healthy bone. They may involve minor trauma, as a consequence, but not the cause, of the fracture.

Sometimes the x-rays clearly indicate a fracture is pathological, showing advanced osteoporosis, a tumor, or a major osseous defect in the form of a lytic lesion. But often, the visual signs of an aging or unhealthy bone are more subtle and will be missed, if not specifically considered. Comorbid Conditions, medications, implants, and as yet undiagnosed signs and symptoms may point to the presence of a non-traumatic fracture.

“If you don’t think of it, you cannot diagnose it.” This axiom is why it is crucial to document the Etiology and Type of fracture as faithfully as the Laterality and Site. Do not let minor trauma or GLF lull you into documenting “fall” as the cause of the fracture. Explore the fracture Etiology and Type completely and document all of its components.

Fractures continued**Non-traumatic/atraumatic/pathologic/fragility fractures****Laterality & Site**

Etiology (of pathology) influences care, code, SOI and COMDM:

Etiology of Non-traumatic Fracture

Drug induced: name it	Osteoporosis
Idiopathic	Age related
Implant related	Drug-induced
Neoplastic: give details	Disuse
Other disease: name it	Idiopathic
Stress	Post-oophorectomy
	Post-traumatic
	Postmenopausal
	Postsurgical malabsorption

Type:**Type of Non-traumatic Fracture**

Atypical femoral fracture	Type:	Healing Type:
Complete oblique		Normal
Complete transverse		Delayed
Incomplete		Non-union
		Mal-union

ALL
SET
DOC?

Occurrence:

Imaging evidence of:

'Major osseous defect'

Other named bone disorders

Long-term medicine use (steroids, etc.)

7th character encounter: (initial, subsequent, or sequelae)

Comorbid conditions:

PHO healed osteoporosis fracture [Z87.310], healed traumatic fracture [Z87.81], hip replacement [Z96.64-], repeated falls [R29.6]

Medical conditions affecting fracture/other care

Complications: Acute blood loss anemia, compartment syndrome, injuries, rhabdomyolysis, etc.

Traumatic fractures

Laterality & Site

Etiology: External causes (MVC, fall, etc.), information to assure proper treatment and to support medical necessity

Type

Type of Traumatic Fracture

Each of these (4) are part of the documented Diagnosis

1 Gustilo (G) Type: Closed (default)
 Open-clean (G1, G2)
 at follow-up, if G type unknown,
 G1 is default, unless fx is infected
 Open-dirty (G3)

2 Displacement Type: Displaced (default)
 Non-displaced

3 Non-vertebral fracture Type:
 Avulsion Named fractures: Segmental
 Bent bone Barton's Spiral
 Comminuted Bennett's Torus, NOT
 Greenstick Colles' buckle or incomplete
 Impacted Galeazzi's Transverse
 Oblique Monteggia's
 Rolando's
 Smith's

4 Healing Type: Normal
 Delayed
 Non-union
 Mal-union

**ALL
SET
DOC?**

Occurrence: 7th character encounter (initial, subsequent, sequelae) + external causes (see above)

Comorbid conditions: list all other organ injuries (lung contusion, major spleen laceration) in detail

Complications: Acute blood loss anemia, acute hypoxic respiratory failure, AKI, ATN, compartment syndrome, neurovascular, other injuries, sepsis, shock, etc.

Fractures continued

**ALL
SET
DOC?**

Traumatic Vertebral Fracture Types:**Type of Traumatic Fractures Cervical Spine**

SOI: Most are CCs/MCCs & HCCs

C1

S12.01	Burst stable	S12.112	Dens type 2
S12.02	Burst unstable	S12.110	Dens type 2 ant
S12.040	Displaced lateral mass	S12.111	Dens type 2 post
S12.030	Displaced post arch		Dens other
S12.041	Nondisplaced lateral mass	S12.120	Displaced
S12.031	Nondisplaced post arch	S12.121	Non-displaced
S12.090	Other displaced	S12.191	Other
S12.091	Other nondisplaced	S12.151	Other traumatic

C2

C3	C4	C5	C6	C7	Displaced
S12.24	S12.34	S12.44	S12.54	S12.64	Type 3 trauma spondylolisthesis
S12.250	S12.350	S12.450	S12.550	S12.650	Other traumatic
S12.290	S12.390	S12.490	S12.590	S12.690	Other
					Nondisplaced
S12.251	S12.351	S12.451	S12.551	S12.651	Other traumatic
S12.291	S12.391	S12.491	S12.591	S12.691	Other
S12.8					Other neck fracture: Give details

Type of Traumatic Fractures Thoracic & Lumbar Spine

SOI: Most are CCs/MCCs & HCCs

'Burst Stable'	'Burst Unstable'	'Wedge Compression'	'Other' : Give details	Site
S22.011	S22.012	S22.010	S22.018	T1
S22.021	S22.022	S22.020	S22.028	T2
S22.031	S22.032	S22.030	S22.038	T3
S22.041	S22.042	S22.040	S22.048	T4
S22.051	S22.052	S22.050	S22.058	T5-T6
S22.061	S22.062	S22.060	S22.068	T7-T8
S22.071	S22.072	S22.070	S22.078	T9-T10
S22.081	S22.082	S22.080	S22.088	T11-T12
S32.011	S32.012	S32.010	S32.018	L1
S32.021	S32.022	S32.020	S32.028	L2
S32.031	S32.032	S32.030	S32.038	L3
S32.041	S32.042	S32.040	S32.048	L4
S32.051	S32.052	S32.050	S32.058	L5

107.

Functional Independent Measurement (FIM)

(See Rehabilitation Admission below)

108. **Functional quadriplegia (FQ) [R53.2](MCC){HCC}**

ALL
SET
DOC?

Diagnosis Linked to an Etiology requiring total care:

‘**Functional quadriplegia due to E**’ (end stage dementia, severe contractures, etc.)

Occurrence: Treatment orders: ‘**ADLS total care**’

Comorbid conditions:

Acute illness/injury causing the FQ

Critical illness:

‘**Myopathy of critical illness**’

‘**Acute necrotizing myopathy**’

‘**Acute quadriplegic myopathy**’

‘**Intensive care (ICU) myopathy**’ [G72.81]

Notes Functional quadriplegia (Complete immobility due to severe physical disability or frailty) was invented by ICD-10-CM and originally defined as the “Lack of ability to use one’s limbs or to ambulate due to extreme debility, NOT associated with neurologic injury or deficit, NOT neurologic quadriplegia.”

Risk factors include chronic dyspnea, cancer, ESRD, palliative care, and hospice.

Functional quadriplegia would NOT be used for frailty [R5], hysterical paralysis [F44.4], immobility syndrome [M62.3, neurologic quadriplegia [G82.5-], quadriplegia [G82.50], or spastic quadriplegic cerebral palsy [G80.0].

109. **GI abscess, perforation & obstruction []**



These conditions are complications of many GI diseases but are not independent diagnoses and have no codes [] apart from the underlying disease.

Document each one as instructed in GI Bleed. Include all relevant components of the ALL SET DOC? mnemonic.

110. **GI Bleed (GIB)** [K92.2](CC){}ALL
SET
DOC?

Acuity: There are separate codes for acute and chronic GI problems with bleeding. When the chronic condition becomes acute, both codes are used, increasing the SOI and COMDM.

Link: GIB to details listed here to reflect accurate SOI

Laterality: '*Left sided colitis with rectal bleeding*'
[K51.511](CC){HCC}

Site: List all suspected GI bleeding sites separately; mouth, esophagus, stomach (gastric/peptic), gastrojejunal, duodenum, small intestine, colon, rectum, anus, etc.

Suspected **Etiology:** Anticoagulation, infection + organism, inflammation, injury, neoplasm, etc.

Type: In cases of known pathology there may be more specific information that should be included, such as malignant neoplasm histology, stage, invasion/metastasis

Diagnosis: "GIB" is a wastebasket phrase, be specific, document a suspected-diagnosis

Occurrence: Duration, estimated amount of bleeding; PHO GI disease or bleeding; hematemesis, abnormal stool; bright red bleeding, coffee ground vomitus, bloody/black/wine colored stool; melena, heme+; etc.

Comorbid conditions: Link all potential related conditions in detail once (alcohol use disorder (AUD), cirrhosis, endoscopy, neoplasm, etc.).

Complications: Acute blood loss anemia, chronic blood loss anemia, heart failure, intestinal abscess/perforation/obstruction, MI, shock, etc.

- Notes** Although GIB has a code, it is an unspecified Diagnosis. Documenting ALL SET DOC details will eliminate queries and decrease denials.
- In ICD-10-CM, bleeding is considered a component complication of a GI Diagnosis. Document a suspected-diagnosis (esophagitis, esophageal cancer, peptic ulcer, stomach cancer, duodenal ulcer, duodenitis, Crohn's disease; diverticulitis, polyps, colon cancer, ulcerative colitis, hemorrhoids) with bleeding.
- Indirect evidence of bleeding (indications reported in the history) are sufficient to diagnose and code bleeding from a GI Diagnosis. Active bleeding or evidence of previous bleeding need not be found during a procedure in order to support the Diagnosis of GI bleeding.
- Bleeding resulting from anticoagulant therapy [D68.32] is an adverse-drug-effect (ADE). A drug code [T45.5-] will be assigned when the drug is documented and Linked to the bleeding.

111. **Glasgow Coma/Confusion Scale (GCS)** [R40.2-](/){/}

ALL SET DOC?	Occurrence:
	E, V, M scores:
	In the field [EMT or ambulance]
	At arrival to emergency department
	At hospital admission
	24 hours or more after hospital admission

- Notes** Originally used to objectively document altered mental status in trauma patients, the GCS is now used to document abnormal mentation in other conditions like encephalopathy, sepsis and stroke. Many physicians routinely include the GCS as part of every patient's vital signs
- Document individual stimulus response (Eye, Verbal, Motor) separately, each counts toward SOI; When the GCS was recorded (7th character); and total GCS in addition to, not instead of the components.

Glasgow Coma/Confusion Scale continued

Glasgow Coma/Confusion Scale			
7th character represents when the GCS was measured			
0	Unspecified time		
1	In the field [EMT or ambulance]		
2	At arrival to ED		
3	At hospital admission		
4	24 hours or more after hospital admission		
<u>SOI</u>			
Eye Opening (E)			
R40.214	- -	4	Spontaneous
R40.213	- -	3	To sound
R40.212	M H	2	To pain
R40.211	M H	1	Never
Verbal Response (V)			
R40.225	- -	5	Alert and Oriented
R40.224	- -	4	Confused but coherent, speech
R40.223	- -	3	Inappropriate words/jumbled phrases
R40.222	M H	2	Sounds, no words
R40.221	M H	1	None
Motor Response (M)			
R40.236	- -	6	Obey commands
R40.235	- -	5	Localizes to noxious stimuli
R40.234	- -	4	Withdraws, normal flexion
R40.233	M H	3	Abnormal flexion, decorticate posturing
R40.232	M H	2	Extensor response, decerebrate posturing
R40.231	M H	1	None
Total GCS			
Lower number = more severe injury/illness, poorer prognosis, more complex MDM.			
R40.4	- -	Transient alteration of awareness	
R40.241	- -	Mild (13-15)	
R40.242	- -	Moderate Disability (9-12): Loss of consciousness (LOC) >30 minutes Potential physical/cognitive impairment resolution Benefits from Rehabilitation	
R40.243	M H	Severe Disability (3-8): Coma w/o meaningful response, no voluntary activity	
R40.244	M H	Vegetative State (Less Than 3): Sleep wake cycles Arousal, no interaction with environment No localized response to pain	
R40.3	C H	Persistent Vegetative State: > 1month	
G93.82	M -	Brain Death: No brain function Specific criteria used to diagnose this	

112. **Hierarchical Condition Category (HCC) V28**

Notes HCC V24 was used to prepare the tables in this book. HCC V28 is not reflected in the tables, as it will be phased in by CMS between 2024 and 2028.

Significant diagnoses of the 2,299 to be eliminated include:

- Acute kidney failure
- Angina pectoris
- Atherosclerosis of the extremities
- Protein calorie malnutrition
- Amputation of toe

Significant diagnoses of the 268 to be added include:

- Anorexia nervosa, bulimia nervosa
- Severe, persistent asthma
- Malignant pleural effusion
- Alcoholic hepatitis with and without ascites
- Toxic liver disease with hepatitis
- Primary sclerosing cholangitis
- Other cholangitis
- Obstruction of the bile duct
- Malignant ascites

113. **Heart failure (HF) /{/}**

Acuity & Type:

ALL
SET
DOC?

Basic Heart Failure <u>Type</u> Documentation				
	Acuity			Type
	A on C	Acute	Chronic	
MCC	MCC	CC		SOI
I50.43	I50.41	I50.42		HCC Combined
I50.33	I50.31	I50.32		HCC Diastolic/preserved EF
I50.23	I50.21	I50.22		HCC Systolic/reduced EF

[⚠]	Valvular heart failure [] has no ICD-10-CM code
-----	--

Heart failure continued**Other Types of Heart Failure**

	SOI	
I50.9	- H	Congestive
Q22.5	M -	Ebstein's anomaly
E87.70	- -	Fluid overload
I43	C H	HF w cardiomyopathy
I50.83	- H	High output
I50.1	C H	Left ventricular
P29.0	- -	Neonatal
I50.89	- H	Other specified
I50.1	C H	Pulmonary edema w HF
J81.0	M H	Pulmonary edema, acute
J81.1	C -	Pulmonary edema, chronic
I50.81-	/ H	Right (ventricular)
Z91.89	- -	Stage A (personal risk factor)
E87.71	- -	Transfusion circulatory overload

Etiology:ALL
SET
DOC?**Etiology of Heart Failure**

AMI	CKD (+) stage	Myocardial ischemia
Amyloidosis	COVID-19	Rheumatic fever
Anemia	Glycogen storage disease	Thyroid storm
Anesthesia	Gout	Thyrotoxicosis
CAD	HTN	Valvular disease
Cardiac prosthesis	HTN & CKD	Etc.
Cardiomyopathy	Myocardial infarction	

Diagnosis:

'Acute on chronic systolic heart failure d/t acute anterior wall STEMI w pulmonary edema'

[I50.23](M){H} + [I21.0-](M){H} + [I50.1](C){H}

Occurrence: Document if postprocedural

Link to Comorbid Conditions: Tobacco exposure*; '***with***' CKD, '***with***' HTN, '***with***' HTN & CKD,

Complications: AMI, pulmonary edema, etc.

Uncertainty: The Etiology of heart failure is often only '***suspected.***' It need NOT be proven.

Physician's Documentation Prescription 2023

Notes “CHF” is NOT adequate documentation for heart failure.

We cannot code from the echocardiogram report or the EF (“EF=X%”) The physician must document ‘**diastolic HF**’/ ‘**HF w preserved EF**’ (HFpEF) or ‘**systolic HF**’/‘**HF w reduced EF**’ (HFrEF).

The most common CDI query is for heart failure specificity (Acuity & Type). Determine Acuity from symptom onset/exacerbation, Hx and home meds. Absent an ECHO, document the ‘suspected’ Type of heart failure from the H&P:

Clinical Indicators in Types of Heart Failure

'Systolic HF' (SHF)

Hx: CAD
Meds: ACE inhibitors, beta/aldosterone blockers, diuretics
Exam: BP normal or low, lower extremity (LE) edema, pulmonary edema
Tests: increased BNP
ECHO: HF w reduced ejection fraction (HFrEF), EF <40%

'Diastolic HF' (DHF): Most frequent Type

Aging
HTN resistant to treatment
Meds: ARBS, other meds in use for DHF
Exam: BP elevated; LE edema, pulmonary edema
Tests: elevated BNP; ECHO: HF w preserved ejection fraction (HFpEF), EF usually ‘normal’

'Combined HF': a combination of findings.

Echo results cannot be coded from a report,
only from a physician documented Diagnosis.

114. **Hematuria [R31-]{}{}**ALL
SET
DOC?**Acuity of cystitis****Etiology:****Link Acuity & Etiology to Hematuria**SOI is variable, depends on Etiology**Hematuria not associated with specified morphologic lesions**

R31.9	- -	Hematuria
R31.29	- -	Other microscopic hematuria
R31.21	- -	Asymptomatic microscopic hematuria
R31.1	- -	Benign essential microscopic hematuria

Cystitis

N30.01	C -	Acute cystitis w hematuria
N30.00	C -	Acute cystitis wo hematuria
N30.81	- -	Other cystitis w hematuria
N30.80	- -	Other cystitis wo hematuria
N30.40	C -	Irradiation cystitis wo hematuria
N30.41	C -	Irradiation cystitis w hematuria
N30.10	- -	Chronic interstitial cystitis wo hematuria
N30.11	- -	Chronic interstitial cystitis w hematuria
N30.20	- -	Other chronic cystitis wo hematuria
N30.21	- -	Other chronic cystitis w hematuria
N30.30	- -	Trigonitis wo hematuria
N30.31	- -	Trigonitis w hematuria

Hematuria with specified morphologic lesions

N02.0	C H	Minor glomerular abnormality
N02.1	C H	Focal/segmental glomerular lesions Glomerulonephritis
N02.2	C H	Diffuse membranous
N02.3	C H	Diffuse mesangial proliferative
N02.4	C H	Diffuse endocapillary proliferative
N02.5	C H	Diffuse mesangiocapillary
N02.7	C H	Diffuse crescentic
N02.A	C H	C3
N02.6	C H	Dense deposit disease
N02.8	C H	Other morphologic changes
N02.9	C H	Unspecified morphologic changes

Notes Hematuria is a sign, not a Diagnosis, and has a low SOI. However, hematuria associated with specified cystitis or morphologic lesions are CCs/HCCs.

115. **Hernia** [K40-K46](/){}

ALL
SET
DOC?

Laterality & Site = Type:

Diaphragmatic
Femoral
Incisional
Inguinal
Other: abdominal, ventral
Parastomal
Umbilical

Occurrence: Recurrent or not

Complications: Gangrene, obstruction

116. **HIV/AIDS** /{/}

Notes “**HIV/AIDS**” is not a Diagnosis; it is a question. Document either a positive test in an asymptomatic patient, ‘**HIV**,’ or symptomatic disease, ‘**AIDS**’.

And/or conditions (HIV/AIDS) will be queried.

Being on medication for HIV is not an indication that the patient has AIDS. If they have never had symptoms or the Diagnosis of AIDS (met the criteria), they are considered not to have the disease until it is documented as ‘**AIDS**’ by a physician.

Once a patient meets AIDS criteria, s/he should always be diagnosed with AIDS [B20] on every subsequent admission/encounter; and it should be documented in every record. CDC AIDS criteria are based on age. Adult criteria are: CD4-T lymphocyte count <200 (<14%, if no count available) and/or an opportunistic infection.

ALL
SET
DOC?

Etiology:

HIV-1: 95%
HIV-2: 5%
Human T-cell lymphotropic virus, type II (HTLV-II)

HIV/AIDS continued**Type****'Type' of HIV/AIDS**SOI**If (+) test but no signs, symptoms, or diagnosis of AIDS ever:**

- Z21 - H Asymptomatic HIV infection status
 Z21 - H "HIV positive"
 Z21 - H "HIV test positive"
 Z21 - H "Known HIV"

If previous signs, symptoms, or diagnosis of AIDS

- (CD4-T lymphocyte count <200 (<14%)/opportunistic infection)
 B20 C H AIDS (acquired immunodeficiency syndrome)
 B20 C H AIDS-related complex (ARC)
 B20 C H HIV (Human immunodeficiency virus) **disease**
 B20 C H Symptomatic HIV-1 infection

As the Etiology of other diseases:

- B97.35 C H Type 2 [HIV 2]
 B97.34 C - HTLV-2 (Human T-cell lymphotropic virus type 2)

Diagnosis: 'HIV' or 'AIDS'.**Occurrence:**ALL
SET
DOC?**This Occurrence of HIV/AIDS**

- | | <u>SOI</u> | During pregnancy |
|---------|------------|---|
| Z21 | - H | Asymptomatic HIV infection status in OB |
| 098.71- | C - | Pregnancy, document trimester |
| 098.72 | C - | Childbirth |
| 098.73 | C - | Puerperium |
| | | AIDS [B20] in OB |
| 098.71- | C - | Pregnancy, document trimester |
| 098.72 | C - | Childbirth |
| 098.73 | C - | Puerperium |
| | | Other |
| Z21 | - H | Asymptomatic HIV infection status |
| Z71.7 | - - | Encounter for HIV counseling |
| Z11.4 | - - | Encounter for screening for HIV |
| Z83.0 | - - | Family history of HIV disease |
| | | High risk behaviors: document all present |
| Z72.53 | - - | Bisexual |
| Z72.51 | - - | Heterosexual |
| Z72.52 | - - | Homosexual |
| Z91.89 | - - | IV drug use |
| Z72.89 | - - | Other |
| F19.9- | / - | Other psychoactive substance abuse |
| Z20.6 | - - | Contact with/exposure to HIV |
| Z57.8 | - - | Occupational exposure to HIV |
| R75 | - - | Inconclusive laboratory evidence of HIV |

Complications: Identify all HIV related findings/diagnoses.

ALL
SET
DOC?

Complications of HIV/AIDS		
	<u>SOI</u>	
I33.-	M -	Acute/subacute endocarditis
B37.-	/ H	Candidal infections + Site
B37.7	M H	Candidal sepsis
B45-	C H	Cryptococcal infections + Site
F03.91	C H	Dementia with behavioral disturbance
F03.90	- H	Dementia without behavioral disturbance
B007	M H	Disseminated herpesviral disease
G05.3	M -	Encephalitis/encephalomyelitis
D59.31	M H	Hemolytic-uremic syndrome
A60.-	- -	Herpesviral infections
J09.X1	M -	Influenza A virus w pneumonia
C46 -	C H	Kaposi's sarcoma + Site
J18.-	M H	Lobar/other pneumonia
C84.-	C H	Mature T/NK-cell lymphoma + Site
J15.-	M H	Named bacterial pneumonia
C83.-	C H	Non-follicular lymphoma + Site
G93.9	C -	Other brain disorder
F02.81	C H	Other dementia with behavioral disturbance
F02.80	- H	Other dementia wo behavioral disturbance
G93.4-	C -	Other encephalopathy
A41.-	M H	Other sepsis
J12.-	M -	Other viral pneumonia
C85.-	C H	Other/unspecified non-Hodgkin lymphoma
B59	M H	Pneumocystosis
A40.0	M H	Strep sepsis
A15-A19	C -	Tuberculosis

117.

HPI (History of present illness)

ALL
SET
DOC?

Acuity: Duration of problem

Laterality & Site: Location of the problem

Link the complaint to associated signs and symptoms

Occurrence: Context, quality, severity, timing, modifying factors (what helps, what makes it worse) and who is providing the history.

Comorbid conditions

Notes

Document who provides the history, parent, spouse, friend, other, it contributes to COMDM. Detail conditions preventing the patient from providing a history.

118. **Hypercarbia/hypercapnia [R06.89]{} / [P84]{}{}**

Think! Is this respiratory failure?

**ALL
SET
DOC?**

Etiology: What is causing the elevated CO₂?

Diagnosis: What are you treating? What diagnosis does it represent?

This **Occurrence:** paCO₂, respiratory rate, signs of respiratory distress, and mental status.

Notes

Hypercapnia is a finding with a low SOI. However, it is an essential component/ clinical indicator of acidosis and respiratory failure.

If it is '**respiratory failure**', is the O₂ also low and is it acute, chronic, or both?

Does it represent '**acidosis**'? Is it respiratory, metabolic, both? Compensated or uncompensated?

Make sure this crucial lab value is fully accounted for in the documentation to show the complexity of medical-decision-making for patients with a high SOI/ROM..

119. **Hypernatremia [E87.0.](CC){}**

**ALL
SET
DOC?**

Etiology: What caused an abnormal test? Is it significant? Dehydration, delirium, dementia, diabetes mellitus, diabetes insipidus, diuretics, heat injuries, hyperemesis gravidarum, insensible water loss, kidney disease, fever, nephrogenic diabetes insipidus, severe diarrhea, vomiting, ect?

Diagnosis: What are you treating?

Comorbid conditions/complications: Dehydration [E86.0]{}; hyperosmolality; hypokalemia; metabolic encephalopathy; mild [E44.1](CC){HCC}, moderate [E44.0](CC){HCC}, or severe [E43](CC){HCC} malnutrition; other disorders of fluid, electrolyte and acid-base balance, etc.

Notes An elevated sodium is a CC only when documented as 'hypernatremia'!

120. **HTN (hypertension) [/(){}]**

Link Type, Etiology, Comorbid conditions, Complications

Link Hypertensive...

Document type of HF and stage of CKD

[I50.-]

[N18.1-N18.4, N18.9]

I11.0	- H	Heart disease with heart failure
I11.9	- H	Heart disease without HF
I12.0	C H	CKD5/ESRD
I12.9	- H	CKD1-4
I13.0	C H	Heart + CKD 1-4 with heart failure
I13.10	- H	Heart disease + CKD1-4 without HF
I13.11	C H	Heart disease + CKD5/ESRD without HF
I13.2	C H	Heart disease + CKD5/ESRD with heart failure

Laterality & Site: If brain or eye involved

Etiology: Document all etiologies

ALL
SET
DOC?

Etiology of Hypertension

	<u>SOI</u>	
		Due to underlying condition:
I15.2	- H	Endocrine disorder
I15.1	- H	Named renal disorder
I15.8	- H	Other named etiology
I15.0	- H	Renovascular
		Pregnancy induced (document when it started, trimester/childbirth/puerperium)
O15-	M -	Eclampsia
O13-	- -	Gestational HTN
O12-	C -	Gestational edema & proteinuria without hypertension
O13-	- -	Gestational HTN wo significant proteinuria
O14.2	M -	HELLP syndrome
O14-	C -	Pre-eclampsia
O10-	C -	Pre-existing HTN
O11-	- -	Pre-existing HTN with eclampsia
O13-	- -	Transient HTN of pregnancy

Type:

Type of Hypertension		
	<u>SOI</u>	
I10	- H	Arterial
I10	- H	Essential/benign/primary/systemic
I60-I69	/ H	Hypertension involving vessels of brain
H35.0-	/ H	Hypertension involving vessels of eye
I10	- H	Malignant
I97.3	- -	Postprocedural

Hypertension continued

Diagnosis: '*Hypertension d/t DM2 and ESRD w hypertensive emergency and, hypertensive encephalopathy, BP 210/130, AMS w GCS 12'*

This **Occurrence:**

Hypertensive “crisis” may be added to any hypertension:

Hypertensive "Crisis"

'**Hypertensive crisis'** [I16.9](C){H}

Severe increase in BP may lead to a stroke

SBP >180 or DBP >120

CVA, MI, HF, AKI

'**Hypertensive emergency'** [I16.1](C){H}

Elevated BP with organ damage

SBP >180 or DBP >120

Chest pain, headache, altered mentation

Signs of organ damage:

AKI, encephalopathy, papilledema, retinal hemorrhages, etc.

'**Hypertensive urgency'** [I16.0](I){H}

SBP >180 or DBP >120

Without organ damage

No symptoms or only a headache

Blood pressure usually brought under control in hours to days

ALL
SET
DOC?

Obstetrical timing: trimester/childbirth/puerperium

'POA': Since patients can develop HTN in the hospital/physician's office, note if it was present on admission

Comorbid Conditions: Tobacco exposure

Complications: '**Hypertensive**' (document all that apply)

AKI

AMI

CKD (stage) d/t HTN

Hypertensive encephalopathy (NOT AMS) with GCS
 Hypertensive heart disease
 Hypertensive heart failure (Acuity (+) Type)
 Other named hypertensive organ damage

Notes ICD-10-CM hypertension codes often combine multiple diseases into a single combination code, so link all conditions related to the hypertension.

121. **Hypoglycemia** /{/}

Link to type of DM and coma

Hypoglycemia

	<u>SOI</u>	
E11.641	M H	DM2 with hypoglycemia with coma
E11.649	- H	DM2 with hypoglycemia without coma
E09.649	- H	Drug/chemical induced DM w hypog wo coma
E08.649	- H	DM d/t underlying condition w hypog wo coma
E13.649	- H	Hypoglycemia
E10.641	M H	DM1 with hypoglycemia with coma
E10.649	- H	DM1 with hypoglycemia without coma
E16.2	- -	Hypoglycemia
E13.641	- H	Other specified DM w hypoglycemia with coma
E16.0	- -	Drug-induced hypoglycemia wo coma
E16.1	- -	Other hypoglycemia
P70.4	- -	Other neonatal hypoglycemia
P70.3	- -	Iatrogenic neonatal hypoglycemia
E15	C H	Nondiabetic hypoglycemic coma
E09.641	M H	Drug/chemical induced DM w hypog w coma
E08.641	M H	DM d/t underlying condition w hypog w coma

122. **Hyponatremia** [E87.1](CC){/}

Etiology: What is causing the abnormal test result? Is it significant? Is it Addison's disease, bronchial tumor, syndrome of inappropriate secretion of antidiuretic hormone, water intoxication psychosis, etc.?

ALL
SET
DOC?

Diagnosis: What are you treating?

Occurrence: Confusion, disorientation, diuresis, fluid restriction, hypertonic saline, isotonic saline. nausea, vomiting, mental status changes, psychotic symptoms.

Comorbid conditions: Dehydration [E86.0](); mild [E44.1](CC){HCC}, moderate[E44.0](CC){HCC}, or severe [E43](CC){HCC} malnutrition.

Complications: Hypo-osmolarity, seizures, coma, death.

Notes Low sodium is a CC, if documented in Greek (hyponatremia)!

123. **Hypotension /{/}****Think! Is it shock?****Acuity****Etiology/Type:****ALL
SET
DOC?****Hypotension without Shock****SOI**

I95.89	- -	Chronic
I95.3	- -	D/t hemodialysis, intra-dialytic
I95.2	- -	Drug-induced, name the drug [T36-T50]
I95.9	- -	Hypotension
I95.89	- -	Iatrogenic
I95.0	- -	Idiopathic (permanent)
R03.1	- -	Incidental BP reading wo hypotension
G97.2	- -	Intracranial, post ventricular shunting
O26.5-	- -	Maternal/supine hypotensive syndrome
F45.8	- H	Neurocirculatory asthenia
R03.1	- -	Nonspecific low BP reading
G90.3	c H	Orthostatic, neurogenic, Shy-Drager
I95.1	- -	Orthostatic, vasogenic
I95.89	- -	Other: Give details
I95.81	- -	Postprocedural cardiac

Occurrence: Signs & symptoms, especially those which confirm that shock is not present (appearance, mental status, vitals).

Notes Abnormally low BP is a sign, a number on a BP monitor, SBP<90 DBP<60. 'Hypotension' does NOT code to shock.

There are multiple codes for hypotension, so be specific when documenting it and specify when the patient is not in shock.

When shock is present the patient is significantly sicker than indicated by the term 'hypotension.' Shock increases SOI and COMDM and should be captured in the ICD-10-CM codes. Document the Type of shock as well as other details. (See shock below.)

124. Hypoxia/hypoxemia [R09.02]()

Think! Is this respiratory failure?

ALL
SET
DOC?

Type: In addition to the laboratory and clinical findings of '**hypoxia**', ICD-10-CM also has codes for two types of procedure related hypoxia:

'**Cerebral hypoxia during a procedure**' [G97.81](C){}

'**Postprocedural hypoxia**' [G97.82](C){}

'**Sleep related hypoxemia in...dX**'[G47.36]()

'**Hypoxia/hypoxemia of newborn**' [P84]()

This **Occurrence:** Always document the paO2 or O2 sat, the dose/route of O2 being delivered at the time of the reading, and signs' of respiratory distress.

Indicate when '**silent hypoxia**' (hypoxia without the usual signs of distress) is present and if it is due to COVID-19.

Notes Hypoxia is a finding with a low SOI. However, it should always be documented since it is an essential component and clinical indicator of respiratory failure.

125. Imaging requisition

ALL
SET
DOC?

Acuity

Laterality & Site

Diagnosis

Occurrence:

Summarize the complaint, symptoms, and exam findings and Link to a suspected-diagnosis. This lets the radiologist see images through your eyes, so they can report the most relevant findings to assist you in evaluating the patient.

Comorbid Conditions provide context, vital clues, which may increase the awareness of or explain abnormalities on images.

Imaging requisition continued

Notes Radiologists are your consultant, maximize the consultation, give them “clinical correlation” on the requisition, so they can find and report findings relevant to the current problem.

126. **Imaging reports**

**ALL
SET
DOC?**

Diagnosis: A Diagnosis stated on an image report is only coded when the Diagnosis is also stated in the attending physician's Diagnosis List.
Once the attending acknowledges the Diagnosis, details Linked to the Diagnosis in the imaging report may then also be coded.

127. **Independent historian**

**ALL
SET
DOC?**

Occurrence: CPT® complexity of medical-decision-making is increased by documenting the use of a non-patient, independent historian (not a translation service), in person or off site, because the patient is unable to provide a complete or reliable history.

128. **Infection**

Think! Is the patient septic?

**ALL
SET
DOC?**

Laterality & Site

Type of infection (abscess, cellulitis, central line, pneumonia, puncture wound, UTI, UTI d/t cath etc.).

Etiology: The suspected or treated organism

Occurrence: For positive cultures document drug resistance (See above).

Clinical indicators and ABCD infection-maskers to support the Diagnosis.

Comorbid conditions: Cancer, diabetes, immunosuppression d/t

ALL
SET
DOC?

Complications: Organ failure, sepsis, severe sepsis, septic shock, etc.

Uncertainty: ‘*Evidence of,*’ ‘*likely,*’ ‘*probable,*’ or ‘*suspected,*’ organism/infection/complication

- Notes**
- Physicians seldom know for sure what organism is causing an infection; less than 1/3 of cultures are positive.
 - However, we treat infections using available information:
 - Patient demographics: age, gender, lifestyle, immune status
 - EBM guidelines
 - Epidemiology: ‘things going around’
 - Using the current antibiogram*, name one organism most likely to be sensitive to the antibiotic(s) prescribed.

129. **Influenza**ALL
SET
DOC?

Etiology: Name the organism when tests are positive

Comorbid Conditions & Complications: ‘with’

Comorbid Conditions & Complications of Influenza

Acute hypoxic/hypercapnic respiratory failure	
ARDS	Otitis media
COVID-19	Perforated tympanic membrane
Encephalopathy	Pharyngitis
Gastroenteritis	Pleural effusion
Hemoptysis	Pneumonia
Laryngitis	Sepsis, severe sepsis, septic shock
Lower respiratory symptoms	Sinusitis
Lung abscess	Upper respiratory symptoms
Myocarditis	

130. **Initial (CPT®)**

- Notes**
- CPT® uses the term ‘**initial**’ defined as ‘the first one,’ as in ‘**initial hospital visit**’ (the first, single, date-of-service of an inpatient admission).

131. **Initial (ICD-10-CM)**



In ICD-10-CM the word ‘initial’ has been redefined for injuries, burns, poisonings, and complications of medical care. These are conditions for which 7th character encounter documentation is required.

In ICD-10-CM, ‘initial’ is when the patient is receiving ‘active treatment,’ thus the patient can have multiple ‘initial’ encounters.

Since there is no medical definition of when ‘active treatment’ ends, the treating physician gets to determine when the transition from ‘active treatment’ to ‘care for routine healing’ occurs.

132. **Injury**

Notes ‘Injury’ implies trauma. However, ICD-10-CM includes the term ‘injury’ to describe non-traumatic insults to brain, kidney, and now myocardial tissue (an elevated Troponin with no other explanation). Thus, for documentation purposes, it is crucial to state non-traumatic or traumatic when using the term injury.

One might think that it will be obvious when an injury is traumatic, but often a non-traumatic brain injury will cause trauma. Take a patient on anticoagulants who is admitted after a car crash with a SAH; was the SAH the cause of the accident or the result of the accident?

For non-traumatic brain injuries, document underlying diseases, injuries, and insults that caused the cerebral dysfunction. Primary etiologies affect the brain directly and selectively. Secondary etiologies, such as systemic diseases/disorders, attack the brain as one of multiple organs or body systems involved.

133. **In remission**

Notes Substance dependence: ‘**in remission**’ (any (mild/moderate/severe) early or sustained remission.

Neoplasms: ‘**not having achieved remission**’.

134. **Intent** (ICD-10-CM)

**ALL
SET
DOC?**

Occurrence link to the Diagnosis

‘Accidental’

‘Assault’

‘**Intentional self-harm**’ {HCC}

‘**Undetermined**’: not-yet-determined rather than NOT-documented

Notes For ICD-10-CM, injuries, burns, poisonings, and complications of medical care require documentation of ‘intent’ of the circumstances surrounding the event.

135. **Intent** (ICD-10-PCS)

**ALL
SET
DOC?**

Occurrence: Link the intended procedure to the Diagnosis

Notes For ICD-10-PCS, all inpatient procedure documentation requires procedure ‘intent’ (what procedure the physician planned to do before the procedure started).

When the intended procedure is not done, document the reason why it was not done/completed (why another procedure was substituted) and what procedure was actually done.

136. **Intensity of Service (IOS)**

Notes The cost of a category of service due to the level of medical care provided. IOS is audited for its direct relationship to SOI, which is controlled by physician documentation of diagnoses.

137. **Intestinal obstruction [/]{}{}****Site:** Give details**Etiology:**ALL
SET
DOC?

Etiology of Intestinal Obstruction		
	<u>SOI</u>	
K56.5-	C -	Adhesions (intestinal) (peritoneal)/bands Congenital:
Q42-	C -	Large bowel
Q43.1	C -	Hirschsprung's disease/megacolon
Q41-	C -	Small bowel
K59.0-	- -	Constipation
K56.41	- -	Fecal impaction
K56.3	C -	Gall stone ileus
K40-K46	/ -	Hernia*
K56.7	C H	Ileus/adynamic/neurogenic/reflex
R15.0	- -	Incomplete defecation
K56.1	C H	Intussusception
E84.11	C H	Meconium ileus (cystic fibrosis/mucoviscidosis) Neonatal:
P76.8	- -	Fecaliths
P76.2	- -	Inspissated milk
P76.0	- -	Meconium (plug)
P76.8	- -	Other
	/ /	Neoplasm: give details <u>Site, Type</u>
K56.9-	C -	Other named cause (enterostenosis, occlusion, stenosis, stricture)
K56.49	C H	Other impaction
K56.0	C -	Paralytic ileus
K91.3-	C -	Postoperative
K31.1	C -	Pyloric stenosis
K56.2	C H	Volvulus
K31.5	C -	Volvulus of duodenum

Type: Complete, incomplete/partial, newborn, transitory
newborn ileus [P76.1()C){}**Diagnosis:***'Complete postprocedural intestinal obstruction d/t X w
nausea & vomiting'***Occurrence:** Link to signs & symptoms

138. **Intractable**ALL
SET
DOC?**Diagnosis:** '*Intractable [epilepsy, headache, migraine, neuralgia, pain, sneezing, vomiting]*'**Occurrence:**'*Intractable...*''*Not intractable/tractable/controlled...*'

Notes ICD-10-CM defines intractable as “medically refractory, pharmacologically resistant, pharmacoresistant, treatment resistant, or poorly controlled.”

139. **Ischemic heart disease** [I20.-](/){/} not anginaALL
SET
DOC?**Acuity** (affects SOI)**Site:**

Site of Ischemic Heart Disease	
Native coronary artery	Transplanted heart
Coronary artery bypass graft	Native coronary artery
Autologous artery	Coronary artery bypass graft
Autologous vein	
Non-autologous biological graft	
Other coronary artery bypass graft	

Type:

Type of Ischemic Heart Disease		
	<u>SOI</u>	
I24.0	C H	Acute coronary embolus, thrombosis or occlusion without AMI
I24.9	C H	Acute ischemic heart disease
I25.1-	/ /	Atherosclerotic heart disease
I25.9	- H	Chronic ischemic heart disease
I25.82	- H	Chronic total occlusion of coronary artery
		Coronary atherosclerosis d/t:
I25.84	- H	Calcified coronary lesion
I25.83	- H	Lipid rich plaque
I24.1	C H	Dressler's syndrome
I21.A1	- -	AMI Type2 (d/t demand ischemia)
P29.4	- -	Newborn transient myocardial ischemia
I24.8	C H	Other acute ischemic heart disease
I24.1	C H	Post infarction syndrome
I23.7	C H	Post infarction angina

Ischemic heart disease continued

ALL
SET
DOC?

Occurrence: Link to signs & symptoms,

Comorbid Conditions may increase SOI

Complications often increase SOI

140. **Laterality:**

Notes Right, left, bilateral; ALWAYS document it. If unsure, confirm it with the patient. CMS is considering payment denial if it is missing.

Neurologic deficits: include dominance (R/L handed or ambidextrous) even when only a leg is involved.

Be specific. ~~Right-sided weakness~~ is NOT adequate, since it could mean, just the arm, just the leg, or both the right arm and leg; and what about the face?

Example: A patient with '**complete right hemiparesis right side dominant**' requires different physical therapy than a deficit on the left, non-dominant side.



141. **Long term use of medication [Z79.-]{}{}/**

Notes ICD-10-CM has [Z-codes] for long-term use of many medications. Documentation should include the reason, the Diagnosis, for the continued use of medications, especially those generally only used for short term therapy (antibiotics, steroids, etc.).

ALL
SET
DOC?**Type:**

Type of Medication Long Term Use		
	<u>SOI</u>	
Z79.2	- -	Antibiotics
Z79.01	- -	Anticoagulants
Z79.02	- -	Antithrombotics/antiplatelets
Z79.811	- -	Aromatase inhibitors
Z79.82	- -	Aspirin
Z79.83	- -	Bisphosphonates
Z79.3	- -	Hormonal contraceptives
Z79.890	- -	HRT
Z79.4	- H	Insulin
F11.9-	C H	Methadone
F11.2-	C H	Methadone to tx heroin addiction
Z79.1	- -	NSAID
Z79.891	- -	Opiate analgesic
Z79.84	- -	Oral hypoglycemic drugs
Z79.818	- -	Other estrogen receptor/level agents
Z79.899	- -	Other named drug
Z79.810	- -	SERMs
Z79.51	- -	Steroids inhaled
Z79.52	- -	Steroids systemic

Link the drug to the **Diagnosis** for which it is prescribed.

142.

Malnutrition**Think! Is it severe?**ALL
SET
DOC?**Acuity:**

Acuity of Malnutrition		
Acute:		
<3 months		
Acute disease: unable to eat for >5 days		
Disease or injury-related		
Chronic:		
Starvation without inflammation:		Disease-related:
Abuse		Organ failure
Anorexia nervosa		Pancreatic cancer
Bulimia		Rheumatoid arthritis
Etc.		Sarcopenic obesity
		Etc.

Site of muscle wasting, SQ fat loss, weakness

Malnutrition continued

Etiology:

Etiology of Malnutrition

Abuse	Chemotherapy	Injury
Age	Dieting	Named chronic disease
Alcohol	Drug induced	Poverty
Bariatric surgery	Eating disorder	Vomiting
Cancer	Infirmity	Etc.

Type:

Type of Protein-Calorie Malnutrition (PCM)

Extract from Dietitian notes:

Severe' [E43](M){H} 2 of these:

Obvious significant muscle/SQ fat loss
Nutrition <½ recommended x 2 weeks
Bedridden/significantly reduced functional capacity
Weight loss >2%/1 week, 5%/1 month, 7.5%/3 months

Moderate' [E44.0](C){H} 2 of these:

Some muscle wasting/SQ fat loss
Nutrition <½ recommended x 1 week (dietitian assessed)
Reduced functional capacity
Weight loss >1-2%/1 week, 5%/1 month, 7.5%/3 months

Mild' [E44.1](C){H} Both of these:

Food intake <½ normal in preceding week
Weight loss

ALL
SET
DOC?

Diagnosis:

'Mild/moderate/severe PCM w vitamin X deficiency'

Occurrence (indicators of malnutrition):

This Occurrence of Malnutrition

Extract from Dietitian notes:

BMI
Duration/amount of decreased food intake
Functional status relative to when last in good health
Social determinants of Health (SDoH)
Weight lost over what duration

Symptoms:

Nausea	Poor appetite	Vomiting	Etc.
Pain	SOB	Weakness	

Findings:

Cachexia, not eaeheetie	Muscle wasting	Weakness
General appearance	Scant SQ fat	Etc.
Other evidence of malnutrition see Complications below		
Stable (at tx goal)	Not stable (not at tx goal)	

ALL
SET
DOC?**Complications:**

<u>Complications of Malnutrition</u>	
Apathy	Inactivity
Anemia	Infant mortality
Blood clots	Introversion
Chemotherapy intolerance	Low WBC
Chest infections	Over-hydration
Decreased mobility	Pain
Dehydration	Poor temperature control
Delayed illness recovery	Poor wound healing
Delayed sexual development	Post-operative complications
Depression	Pneumonia
Difficulty breathing	Pressure ulcers
Depression	Reduced
Electrolyte imbalances	Ability to cough
Fractures	ADLs
Infections	Muscle mass
Infertility	Social interactions
Injuries	Respiratory failure
Falls	Rickets
Growth failure	Self-neglect
Heart disease	Stunted growth
Heart failure	Tiredness
Hypothermia	Vision loss: Cataracts
Immunocompromised	Glucoma
Impaired: Coordination	Macular degeneration
Intellect	Vitamin deficiency diseases
Memory	Weakness
Speech	Etc.



Some malnutrition is generally found only in third world countries during famines. US patients rarely meet the definition of:

- Kwashiorkor, “severe malnutrition with nutritional edema and dyspigmentation of skin and hair” [E40]
- Severe malnutrition with marasmus [E41]
- Marasmic kwashiorkor [E42]



The Academy of Nutrition & Dietetics, American Society for Parenteral & Enteral Nutrition (ASPEN) and CDC provide criteria to determine stages of malnutrition. Unfortunately, these do not always match i10 codes.

Malnutrition continued

Notes Malnutrition is an often missed Diagnosis that significantly increases SOI, ROM, LOS, and healing time. Don't miss it!

Registered dietitians/nutritionists can determine the Type (severity) of malnutrition. To be coded, dietary assessments require the BMI and physician documentation of findings (cachexia, muscle weakness/wasting, functional loss) and the term 'malnutrition' or 'PCM'. Order and summarize dietary consults on your sick patients.

A BMI <19 indicates malnutrition; however, acute malnutrition may occur even in morbidly obese patients nutritionally depleted by alcohol, bariatric procedures, prolonged illness, and weird diets. Document nutritional/functional circumstances to explain why a patient with malnutrition has a normal or high BMI.

Additional malnutrition related documentation can support the Diagnosis of malnutrition.

Malnutrition Related Documentation		
	<u>SOI</u>	
R63.4	- -	Abnormal weight loss
R63.0	- -	Anorexia
R64	C H	Cachexia
R62.7	- -	Failure to thrive (FTT), adult (See failure to
R62.51	- -	Failure to thrive, child thrive above)
P92.6	- -	Failure to thrive, newborn
E74.39	- -	Intestinal absorption malnutrition
E40	M H	Kwashiorkor/malignant malnutrition
K91.2	C H	Malnutrition following GI surgery
E41	M H	Nutritional marasmus/emaciation Protein-calorie Malnutrition (PCM)
E44.1	C H	Mild
E44.0	C H	Moderate
E43	M H	Severe
E42	M H	Severe intermediate/ marasmic Kwashiorkor
E46	C H	Protein-calorie/energy (imbalance)
E45	C H	Retarded development following PCM
E64.0	C H	Sequelae of PCM
E43	C H	Starvation edema
T730XXA	- -	Starvation, initial encounter
R63.6, Z68.1	C -	Underweight, $BMI \leq 19$

143. Masked-clinical-indicator ABCDs

Notes Since vital signs, WBCs, and other clinical findings are used to evaluate just how sick patients are, things that alter these findings will increase complexity of medical-decision-making and should be taken into consideration when making a Diagnosis.

When sick septic patients do not look appropriately ill, consider masked-sepsis and document what conditions might be masking the usual signs of critical illness or injury. Document ALL conditions contributing to the enigma, including the ABCDs, Age, Beta blockers, Comorbidities, and Drugs.

Advanced age: ‘Well-elderly’ often look sick when at baseline; dementia and stroke sequelae can mimic, and thus mask, changes in mental state and well-being; and aging organs can prevent expected changes in vital signs.

Beta blockers alter normal bodily functions and prevent expected vital sign changes in sepsis, shock, trauma, etc.

Comorbid conditions deplete body resources and the ability to manifest clinical indicators. Sepsis may be misdiagnosed as a chronic comorbid condition or masked by medications for chronic comorbid conditions.

Duration of extremis: The longer a patient is sick, the less reserves they have, and the less the body can launch the expected systemic response to infection, organ failure, trauma, etc.



If these ABCDs are masking sepsis, shock, or other critical conditions in which appearance and vital signs are used to evaluate the clinical condition, document them linked to the Diagnosis.

144. **Mass/lump/cyst/tumor**

**ALL
SET
DOC?**

Laterality & Site

Suspected **Etiology**

Suspected-diagnosis

Notes ‘Neoplasm,’ the term used in ICD-10-CM for diagnosed masses, includes unspecified codes for use before a diagnosis is made.

Physicians usually document ‘mass’ or “lump” for as-yet undiagnosed palpated/visualized growths. ICD-10-CM only has a few codes for the terms ‘mass’ and ‘lump’, none of which have an increased SOI.

ICD-10-CM 'Mass' or 'Lump' Codes

SOI: None of these codes are CCs, MCCs or HCCs

R19.00	Abdominal	H93.8-	Ear <u>Laterality & Site</u>
R19.06	Epigastric	R22.4-	Lower limb <u>Laterality & Site</u>
R19.07	Generalized	R22.3-	Upper limb <u>Laterality & Site</u>
R19.04	LLQ	R22.0	Head
R19.02	LUQ	N28.89	Kidney
R19.05	Perumbilical	R16.0	Liver
R19.03	RLQ	R22.9	Localized (skin)
R19.01	RUQ	R22.1	Neck
R19.09	Other	R22.2	Trunk
N63.0-	Breast quadrant	R91.8	Lung
R22.2	Chest	R16.1	Splenic
		R22.9	Superficial

Cysts have their own codes. Documentation requirements vary depending on Site.

There are numerous ‘tumor’ codes, all of which require the Site and Etiology or Type (often a person’s name) of tumor.

145.

Mass effect and Midline shiftALL
SET
DOC?

Link these abnormal imaging findings to:

An **Etiology**:

- Birth trauma [P11.0](M){}
- Cerebral edema [G93.6](M){H}
- Trauma [S06.1-](M){H}

A **Diagnosis**: ‘non-traumatic SAH with midline shift and brain compression’

Complications:

- Brain compression [G93.5](M){H}
- Brain stem herniation [G93.5](M){H}



Mass effect and **midline shift** have no codes []; link them to cerebral edema, brain compression, and brain stem herniation.

Notes

Findings cannot be coded from the radiologist’s report without documentation of the associated **Diagnosis** in the attending’s Diagnosis List and the Discharge Summary.

146.

MEAT Criteria for chronic diseases

Link specifics of the following four items to a chronic condition to support a **Diagnosis** with an HCC code:

M = Monitor: order or reference test/monitor results

E = Evaluate: targeted parts of the physical examination specific to the condition

A = Assess: current status, progression or severity of the diagnosis

T = Treat: counseling, lifestyle modification, medication, monitoring, procedure, lifestyle modification, referrals, therapy, etc.

147. **Migraine** [G43-](/){HCC}**Acuity:**

'With status migrainosus' [G43-](/){H}

Chronic [G43.7-](){H}

Type:ALL
SET
DOC?**Type of Migraine**

	<u>SOI</u>	
G43.D-	- -	Abdominal
G43.1-	C H	Classical (with aura)
G43.0-	- -	Common (without aura)
G43.4-	- -	Hemiplegic
G43.82/3-	- -	Menstrual
G43.B-	- -	Ophthalmoplegic
G43.6-	C H	Persistent aura w cerebral infarction
G43.5-	- -	Persistent aura wo cerebral infarction
G43.8-	- -	Other
G43.A-	- -	With cyclical vomiting

Occurrence: Is it intractable or NOT?**Complications** Visual disturbance, vomiting w dehydration148. **Mood disturbance** [F02.81]

Anhedonia (inability to feel pleasure), apathy, depression

149. **Morbid/severe obesity:** See Obesity below150. **Myocardial Infarction (MI)** [I/](/){/}ALL
SET
DOC?**Acuity:****Acuity of Myocardial Infarction**

	<u>SOI</u>	
I21-	M H	Acute MI: <4 weeks
I25.2	- H	Old MI: >4weeks
		Subsequent MI: within 4 weeks of last MI
I22.0/1/8/9	M H	STEMI + wall
I22.2	M H	NSTEMI

ALL
SET
DOC?**L laterality & Site:****L laterality & Site of Myocardial Infarction**L laterality & Site of coronary artery involved:

L anterior descending R main

L circumflex Other

L main

Site of wall infarcted: Anterior, inferior, other

Etiology:**Etiology of MI**

	SOI	
N17.-	M H	Acute kidney failure
I40.-	M -	Acute myocarditis
D50.0-D64.9	/ /	Anemia
/	/ /	Arrhythmias
I25.-	/ /	Atherosclerotic heart disease
I42.-	C H	Cardiomyopathy
N18.-	/ H	Chronic kidney disease (CKD)
T82.218-	C -	Coronary bypass graft occlusion
J44.-	/ H	COPD
I50-	/ H	Heart failure
I10-I16	/ H	Hypertension
I16.1/9	C H	Hypertensive emergency/crisis
I35.-	- -	Nonrheumatic aortic valve disorders
I47.0-I47.9	C H	Paroxysmal tachycardia
I26.-	M H	Pulmonary embolism
I27.0, I27.2	- H	Pulmonary hypertension
N17.0-N19	/ H	Renal failure
A41-	M H	Sepsis + organism
R57.0-R57.9	/ H	Shock + type
T82.897-	C -	Stent occlusion
T82.855-	C -	Stent stenosis
T82.867-	C -	Stent thrombosis
I51.81	C -	Takotsubo syndrome
		Etc.

Myocardial Infarction continued**Type:**

**ALL
SET
DOC?**

Type of Myocardial InfarctionSOI

Coronary thrombosis d/t plaque rupture/ulceration/erosion/dissection

I21.4 M H NSTEMI: <100% occlusion

No new depressed ST

No new inverted T wave

No new Q wave

Partial obstruction of a coronary artery

121.- M H Type 1 (T1MI) (STEMI): 100% occlusion

1x troponin >99percentile

+(1) of these:

Symptoms of acute myocardial ischemia

New ischemic ECG changes

Development of pathological Q waves

Imaging: new loss of viable myocardium/
abn. wall motion consistent w ischemia

Coronary thrombus by imaging'autopsy

Demand ischemia NOT due to coronary thrombosis

121.A1 M H Type 2 (T2MI)

1x troponin >99percentile

+(1) of these:

Symptoms of acute myocardial ischemia

New ischemic ECG changes

Development of pathological Q waves

Imaging: new loss of viable myocardium/
abn. wall motion consistent w ischemia

I21.A9 M H Type 3: MI at autopsy

I21.A9 M H Type 4a: MI \leq 48 hours of PCI

I21.A9 M H Type 4b: MI d/t stent thrombosis after PCI

I21.A9 M H Type 4c: MI d/t restenosis after PCI

I21.A9 M H Type 5: MI \leq 48 hours of CABG

121.B M - MI w coronary microvascular dysfunction/disease

121.B M - MI w non-obstructive coronary arteries (MINOCA)

4th Universal Definition of MI Expert Consensus Document

ALL
SET
DOC?**Occurrence:****This Occurrence of Myocardial Infarction**

	SOI	
I97.89	C -	AMI complicating PCI
I97.790	C -	AMI during cardiac surgery
I97.791	/ /	AMI during non-cardiac surgery
I97.190	C -	AMI following cardiac surgery
I97.191	/ /	AMI following non-cardiac surgery
R79.89		Elevated troponin
Z92.82		TPA (rtPA): document where & when

Signs & symptoms of AMI:

Chest pain	Other pain:	SOB
Diaphoresis	Arm Neck	Vomiting
Nausea	Back Shoulder	Etc.

ECG changes:

- Pathological Q waves
- New depressed ST
- New inverted T wave

Imaging:

- New loss of viable myocardium
- (Partial) obstruction of a coronary artery
- Abnormal wall motion consistent w ischemia

Comorbid Conditions:**DM (Type & Complications)**

Morbid obesity

Exposure to environmental tobacco smoke [Z77.22]

History of tobacco dependence [Z87.891]

Occupational exposure to environmental tobacco smoke [Z57.31]

Tobacco dependence [F17.-]

Tobacco use [Z72.0]

Myocardial Infarction continued**ALL
SET
DOC?****Complications:**

<u>Complications of Myocardial Infarction</u>		
	SOI	
I23.1	C -	Atrial septal defect
I46.2	M H	Cardiac arrest
I97.89	C -	Complication of PCI
I23.0	C -	Hemopericardium
I50	/ /	Heart failure
T82.218-	C -	Occlusion coronary bypass graft
I23.8	C -	Other current complication
I23.7	C -	Post-infarction angina
		Rupture of:
I23.3	C -	Cardiac wall wo hemopericardium
I23.4	M -	Chordae tendineae
I23.5	M -	Papillary muscle
I97.89	C -	Stent occlusion [T82.897-]
I97.790	C -	Stent stenosis w(T82.855-)x
I97.190	C -	Stent thrombosis (T82.867-)
I23.6	C -	Thrombosis of atrium/ventricle
I23.2	C -	Ventricular septal defect

Notes Myocardial infarction: Non-traumatic myocardial injury **with** clinical evidence of acute ischemia.

A Type 1 MI is due to coronary thrombosis with plaque changes. It has separate codes for STEMI and NSTEMI. Type 2 MI is not associated with coronary thrombosis, but due to oxygen supply-demand mismatch. Type 2 has only one code for either STEMI or NSTEMI. Distinction between type 1 and type 2 MI is important because the treatment is different (restoring myocardial blood flow vs correcting the underlying cause of the mismatch).

	<p>Mandatory CDI query: Although a Type 2 MI could be either a NSTEMI or a STEMI, depending on the amount of damage to the myocardium, coding terminology only includes the terms NSTEMI and STEMI in the type 1 MI descriptors. Therefore, if you write “<u>type-2-NSTEMI</u>” or “<u>type-2-STEMI</u>”, the CDI Department is required to query to determine if it was a NSTEMI/STEMI (type 1) or a type 2 MI.</p>
---	--

151. **Myocardial Injury** (without infarction)

ALL
SET
DOC?

Type:

Non-traumatic [I5A](CC){}

Traumatic [S26-](CC){}

Notes I5A is code applied to non-traumatic, **non-ischemic** myocardial **injury without infarction** that results in an elevated troponin ($cTn > 99^{\text{th}} \text{ percentile upper reference limit (URL)}$). It is not for acute T1 or T2 myocardial infarction.

DO NOT use the abbreviation 'AMI' which could mean either myocardial infarction or injury.

Myocardial injury is considered acute if the troponin rises or falls.

152. **Neonatal fever** [P81.9](){}



Both neonatal fever and fever of the newborn will generate a query to determine if sepsis was present. To avoid a query, document:

'Neonatal fever without sepsis' [P81.9](){}

'Neonatal environmental hyperthermia' [P81.0](){}

'Environmental hyperthermia of newborn' [P81.0](){}

'Other newborn (named) disturbances of temperature regulation' P81.8](){}

153. **Neonatal sepsis** [P36-](MCC){HCC}

ALL
SET
DOC?

Etiology: Anaerobes; E. coli; Group B strep, other strep; other named bacteria; staph aureus, other staph

Complications: Organ failure, shock

154. **Neoplasm**ALL
SET
DOC?**Laterality & Site****Type** of behavior:

Type of Neoplasm Behavior	
Benign	Malignant secondary (metastases)
Cured (PHO)	From-where?
Functional activity	To where?
In remission	Other details
In situ	Morphology
Malignant primary	No current evidence of disease
Contiguous	Uncertain: histologic confirmation of
Noncontiguous	malignancy cannot be made

Occurrence: (document all that apply)**'This inpatient admission is for treatment of ...'**

- A named comorbid condition
- A named complication
- Pain
- The neoplasm

Other patient information may increase SOI:

- Family history (FH) of neoplasm
- Genetic information

Comorbid Conditions / Complications155. **NSTEMI:** See myocardial infarction.156. **O2 Sat** (O2% saturation)ALL
SET
DOC?**Type**

Type of O2 Delivery Device			
BIPAP	Mask	Vent	
CPAP	Nasal cannula	Venturi mask	
High flow nasal cannula	Non-rebreather mask	Etc.	

Diagnosis requiring O2**Occurrence:****Dose of O2** during measurement of the O2 sat (RA/%)

Vent parameters

Etc.

157. **Obesity [E66-] (/){/}****Think! Is it morbid/severe obesity?****Etiology:****Etiology of Obesity**

	<u>SOI</u>	
E27.8	- H	Adrenal
E31.0	- H	Autoimmune polyglandular failure
E66.1	- -	Drug-induced: name the drug
E66.8	- -	Endocrine/endogenous/familiar/other Excess calories/exogenous/nutritional
E66.01	- H	Morbid obesity
E66.09	- -	Other obesity
E88.2	- -	Lipomatosis
O26.0-	- -	Obstetrical: Excessive weight gain + trimester
E23.6	- H	Pituitary/Adiposogenital dystrophy
Q87.11	C -	Prader-Willi syndrome

Type is based on BMI:**Type of Obesity**ALL
SET
DOC?

	<u>SOI</u>	
E66.3	- -	Overweight: BMI 25.0 to <30
E66.09	- -	Obese: BMI 30.0-40
E66.01	C H	Severe/morbid obesity: BMI >40

Diagnosis: Physician must document obesity as a separate problem in the Assessment or Diagnosis List:

'Obesity due to... with...'

'Morbid obesity due to...with...'

This **Occurrence:****This Occurrence (all that apply) Linked to Obesity**

	<u>SOI</u>	
Z68.30-45	C H	BMI (>30)
K95.8-	- -	Bariatric surgery complication
O99.84-	- -	Bariatric surgery status in pregnancy
Z71.3	- -	Dietary counseling/surveillance Excess healthy muscle mass Fat distribution: Waist & above or lower body
Z90.3	- -	Gastrectomy (complete) (partial)
Z98.84	- -	Gastric banding, bypass, other Etc.

ALL
SET
DOC?**Obesity continued**

Comorbid conditions unrelated to obesity **Complications** due to obesity:

Complications of Obesity	
SOI	
Multiple give details	Diabetes
Multiple give details	Heart disease
Multiple give details	Hypertension
Multiple give details	Musculoskeletal problems
E66.2 C H	Obesity hypoventilation syndrome (OHS)
E66.2 C H	Pickwickian syndrome
O99.21- - -	Pregnancy, childbirth, puerperium
G47.3- - -	Sleep apnea
	Etc.

Multiple give details	Diabetes
Multiple give details	Heart disease
Multiple give details	Hypertension
Multiple give details	Musculoskeletal problems
E66.2 C H	Obesity hypoventilation syndrome (OHS)
E66.2 C H	Pickwickian syndrome
O99.21- - -	Pregnancy, childbirth, puerperium
G47.3- - -	Sleep apnea
	Etc.

Notes BMI may be recorded by others, but the physician must document a Diagnosis, supporting evidence, and summary of any dietary consult; adjust the diet; and order counseling, just as for malnutrition.

Obesity and morbid obesity are ALWAYS clinically relevant to SOI.

Describe how the obesity affected patient care:

'Two nurses needed to get patient to bathroom.'

158. **Opportunistic Infections**

Link these infections to a Diagnosis explaining the immunocompromised condition of the patient

Etiology:

Etiology of Opportunistic Infections	
<i>Candida</i>	JC virus
<i>Coccidioides</i>	Kaposi's sarcoma herpesvirus (KSHV)
<i>Cryptococcus neoformans</i>	<i>Pneumocystis jirovecii</i>
<i>Cryptosporidium</i>	<i>Salmonella</i>
<i>Cystoisospora belli</i>	<i>Streptococcus pneumoniae</i>
<i>Cytomegalovirus (CMV)</i>	<i>Toxoplasma gondii</i>
Herpes simplex virus (HSV)	<i>Tuberculosis (TB)</i>
<i>Histoplasma</i>	Etc.
Human herpesvirus 8 (HHV-8)	

ALL
SET
DOC?

Type:

Types of Opportunistic Infections	
Candidiasis	Pneumocystis pneumonia (PCP)
Coccidioidomycosis	Pneumonia
Cryptococcosis	Mycobacterium avium complex (MAC)
Cryptosporidiosis (Crypto)	Progressive multifocal leukoencephalopathy
Cystoisosporiasis	<i>Salmonella</i> sepsis
Encephalopathy	<i>Salmonella</i> septicemia
Herpes simplex virus (HSV)	Toxoplasmosis
Histoplasmosis	Tuberculosis (TB)
Invasive cervical cancer	Wasting syndrome
Kaposi's sarcoma (KS)	Etc.
Lymphoma	

Notes Opportunistic infections almost always increase SOI. These infections should prompt documentation of all immunocompromising diseases, medications, and conditions.

Always consider whether or not an opportunistic infections is present when documenting a Diagnosis indicating an immunocompromised state.

The CDC maintains a list of these infections on their website.

159. **Organ ‘dysfunction’ or ‘insufficiency’**ALL
SET
DOC?**Acuity****Etiology****Type****Diagnosis:** Is it ‘**failure**’?**Occurrence:** Signs, symptoms, test results; is it failure?**Comorbid Conditions****Complications**

‘Dysfunction’ and ‘Insufficiency’ generally code to ‘unspecified’ disease of an organ, often with a low SOI. Make sure to document ‘**failure**’ when failure is present.

Postprocedural pulmonary insufficiency, a real clinical entity between normal and respiratory failure should be documented when failure criteria are not met.

160. **‘Organ failure’**ALL
SET
DOC?**Acuity****Etiology****Type****Diagnosis****Occurrence:** Link to signs, symptoms, & test results**Comorbid Conditions****Complications**

Organ ‘**failure**’ is reversible; it does NOT always lead to death. It does NOT reflect negatively on the physicians or medical care. And, it usually increases severity of illness.

Notes

Heart and liver failure are common diagnoses, not so renal and respiratory failure. Chronic renal failure (CKD) is accepted but appropriate documentation of acute renal failure is rarer. Physicians should become more comfortable documenting organ ‘**failure**.’

The sooner organ failure is diagnosed, the more likely treatment will succeed.

161. **Pain****Acuity****Laterality & Site****Laterality & Site of Pain**

Abdominal	Finger	Pelvic
Epigastric	Foot	Perineal
Generalized	Hand	Precordial pain
Lower abdominal	Intercostal	Scrotal
Lower quadrant	Jaw	Testicular
Perumbilical	Joint (name)	Thoracic spine
Upper abdominal	Limb upper/lower	Throat
Upper quadrant	Low back	Toe
Bladder	Ocular	Etc.
Chest	Other chest	

Etiology:**Etiology of Pain**ALL
SET
DOC?

Atherosclerosis of extremities		Infection
Native arteries		Neoplasm
Nonbiological bypass graft(s)		Phantom limb synd.
Central pain syndrome		Post-thoracotomy
Chronic pain syndrome		Postprocedural
Complex regional pain syndrome I (CRPS I)		Psychological factors
Due to prosthetic devices/implants/grafts		Trauma
Cardiac	Other	Trigeminal nerve
Genitourinary	Vascular	Varicosities
Orthopedic		Etc.
Gas		

This Occurrence:**This Occurrence Linked to Pain**

Intractable or not	Reason for the inpatient admission?
Psychological factors	The pain
When	The etiology of the pain
At rest	Both
With:	Different problem (<u>Comorbid Condition</u>)
Breathing	
Micturition	

Notes There are hundreds of codes for pain. Most depend on Laterality and Site.

 162. **Palliative medicine/hospice**

**ALL
SET
DOC?**

Acuity: Acute, chronic, accelerated

Type:

- Stable transition
- Active dying

Diagnosis: Use the life-altering-diagnosis

Occurrence:

- Family conferences
- Health care power of attorney (HCPOA) /advanced directives/living wills
- Non-HCPOA decision influencers
- Pertinent religious, spiritual, cultural factors
- Progression of medication, oral, SQ, PCA, sedation

Comorbid conditions:

- Present being treated
- Present but no longer being treated
- Requiring care decisions: ventricular assist devices, hemodialysis, ICDs, etc.

Complications:

Common Complications Seen in Palliative Medicine

Anxiety	Malnutrition
Aphagia (inability to swallow)	Metastases
Aspiration	Multisystem failure
Constipation	Nausea
Dehydration	Pain
Depression	Secretions
Dyspnea	Terminal agitation
Failure to eat	Vomiting
Fever	Weight loss
Kennedy terminal ulcers (KTU)	Etc.
Level of consciousness changes	

Notes Document terminal problems & diagnoses with ALL-SET-DOC specificity to justify continuing care (proof of SOI, ROM, medical necessity, and continued complexity of medical-decision-making). Document '**comfort care only**' & '**palliative medicine services**' to support an 'expected' death & positively impact quality scores.

Include details of 'feeding the soul' & additional issues inherent in palliation, pain management, and anxiety / respiratory comfort at vent discontinuation.

Per CMS: If hospice is ordered in the ED, the patient cannot be an inpatient but only in observation.

163.

Pancreatitis

Acuity

Acute/subacute [K85-](MCC){}

Chronic [K86-](CC){HCC}

Etiology

ALL
SET
DOC?

Etiology of Pancreatitis			
	<u>SOI</u>	<u>'Acute'</u>	<u>Other acute</u>
K85.2-	M -	Alcohol	Autoimmune
K85.1-	M -	Billiary (gallstones)	Genetic
K85.3-	M -	Drugs	Metabolic disorders
K85.0-	M -	Idiopathic	Surgery
K85.8	M -	Infectious, organism	Trauma
K85.8	M -	Other acute	Unknown (~15%)
		<u>'Chronic'</u>	<u>Other chronic</u>
K86.0	C H	Alcohol	Etc.
K86.1	C H	Infectious, organism	Cystic fibrosis
K86.1	C H	Other chronic	Drugs/medications
		Infectious	FH pancreas dis.
B25.2	M H	Cytomegaloviral	Gallstones
B20	C H	HIV	Hypercalcemia
B26.3	C -	Mumps	Hyperlipidemia
A52.74	C -	Syphilitic	Smoking
			Unknown 20-30%
			Etc.

Pancreatitis continued**Type:**

<u>Type of Pancreatitis</u>		
	<u>SOI</u>	
K85.9-	M -	Acute
K86.1	C H	Chronic
K86.1	C H	Cystic
K86.1	C H	Fibrous
		Fitz's syndrome (acute hemorrhagic p.)
K85.80	M -	Acute
K86.1	C H	Chronic
K86.1	C H	Interstitial
K85.8-	M -	Other acute
K85.9-	M -	Pancreatitis
K86.1	C H	Recurrent chronic
K86.1	C H	Relapsing chronic

This Occurrence:ALL
SET
DOC?

<u>This Occurrence of Pancreatitis</u>		
ADE	Signs	With
Drug abuse	Symptoms	Infection
Drug dependence	Tests	Infected necrosis
Hemiparetic	Etc.	Necrosis

Complications

<u>Complications of Pancreatitis</u>		
Acute lung injury		Malnutrition
ARDS		Pancreatic calcification
Chronic pain		Pancreatic cancer
Diabetes [E08]		Pancreatic necrosis
Exocrine pancreatic insufficiency [K86.81]		
Gallstones		Pleural effusion
Gas gangrene [A48.0]		Pseudocysts
Infected pancreatic necrosis		Pulmonary edema
Infection		Sepsis
Inflammation		SIRS d/t non-Infectious process
Kidney failure		Etc.

Notes Regardless of Type or Etiology '**acute**' pancreatitis has a higher SOI for inpatients and '**chronic**' pancreatitis is an HCC.

Pancreatitis can cause sepsis. However, SIRS may be present without infection and should be documented as

'non-infectious SIRS' when it accompanies pancreatitis to provide an accurate SOI.

164. **Pancytopenia** /{/}

ALL
SET
DOC?

Etiology

Etiology of Pancytopenia

SOI
D61.810 M H Antineoplastic chemotherapy
D61.82 C H Bone marrow infiltration
D61.01 C H Congenital (pure) red cell aplasia
D61.09 C H Fanconi's (congenital pancytopenia)
C91.4- C H Hairy cell leukemia
B20 C H Human immunodeficiency virus disease
D61.82 C H Leukoerythroblastic anemia
D46.- / H Myelodysplastic syndromes
C92- / H Myeloid leukemia
D47.1 C H Myeloproliferative disease
D61.811 M H Other drugs
D61.818 C H Other pancytopenia
D61.818 C H Pancytopenia

Comorbid Conditions: Cancer, bone marrow disorders, lupus, etc

Occurrence: Abnormal bleeding, dizziness, easy bruising, fatigue, fever, pallor, purpura, rash, SIRS, tachycardia, trouble breathing, weakness, etc.

Notes Although pancytopenia is a deficiency of all three blood cell lines, documentation of anemia, neutropenia, and thrombocytopenia cannot be coded as 'pancytopenia' unless the term 'pancytopenia' is documented.

The SOI and COMDM of pancytopenia is determined by the Etiology of the blood cell scarcity. Documentation of infectious, autoimmune, genetic, nutritional, and/or malignant Comorbid Conditions ensures accurate representation of how sick the patient is.

165. . **PCM (protein calorie malnutrition):** (See malnutrition above.)

166. **Peritonitis****Acuity**

Link: to both the Diagnosis and/or organism

Site: Generalized, localized; abdominal, pelvic, retroperitoneal; section of intestine or organ involved

Etiology/ Type:

Infectious

ALL
SET
DOC?

Etiology of Infectious Peritonitis**SOI**

A56.11	- -	Chlamydial pelviperitonitis (female)
A74.81	- -	Chlamydial peritonitis
A36.89	C -	Diphtheria peritonitis
A54.24	C -	Gonococcal pelviperitonitis (female)
A54.85	C H	Gonococcal peritonitis
B95-B97	/ /	Identify infectious agent
K67	M H	Other infectious diseases
K65.2	M H	Spontaneous bacterial peritonitis
A50.08	C -	Syphilis (early)/congenital peritonitis
A52.74	C -	Syphilis (late) peritonitis
A18.31	M -	Tuberculosis ascites
A18.31	M -	Tuberculosis peritonitis
A18.17	C -	Tuberculous pelvic (female) peritonitis

ALL
SET
DOC?**Etiology/ Type**

Intestinal

Intestinal Etiology of Peritonitis		
SOI		
		Acute appendicitis
K35.20	C -	With generalized peritonitis wo abscess
K35.21	M -	With generalized peritonitis w abscess
		With localized peritonitis
K35.30	C -	Without perforation, wo gangrene
K35.31	C -	Without perforation, with gangrene
K35.32	M -	With perforation, wo abscess
K35.33	M -	With perforation, with abscess
K35.32	M -	With perforation
K35.33	M -	With peritoneal abscess
Q43.8	C -	Congenital diverticulum of intestine Diverticulitis: w peritonitis = w perforation & abscess
		Small intestine
K57.00	C -	Without bleeding
K57.01	M -	With bleeding
		Large intestine/colon
K57.20	C -	Without bleeding
K57.21	M -	With bleeding
		Small & large intestine
K57.40	C -	Without bleeding
K57.41	M -	With bleeding
		Intestine
K57.80	C -	Without bleeding
K57.81	M -	With bleeding
Q43.0	- -	Meckel's diverticulum
K35.32	M -	Perforated appendix
K35.32	M -	Ruptured appendix

Obstetrical

Obstetrical Peritonitis		
SOI		
		Pelvic peritonitis following
003.5	C -	Complete spontaneous abortion
008.0	C -	Ectopic pregnancy
007.0	C -	Failed attempted termination of pregnancy
003.0	C -	Incomplete spontaneous abortion
004.5	C -	(Induced) termination of pregnancy
008.0	C -	Molar pregnancy
085	- -	Puerperal peritonitis

Peritonitis continued**Etiology/ Type:**

Perinatal

Perinatal Peritonitis

	<u>SOI</u>	
P78.0	- -	Meconium peritonitis
P78.1	- -	Neonatal peritonitis
P78.1	- -	Other neonatal peritonitis
P78.0	- -	Perinatal intestinal perforation

Types of PeritonitisALL
SET
DOC?

	<u>SOI</u>	
K65.1	M H	Abdominal/pelvic abscess (any site)
T81.61	C -	Aseptic P. d/t talc/other foreign substance
T81.61	C -	Aseptic peritonitis d/t FB
K65.9	M H	Bacterial peritonitis
E85.0	C H	Benign paroxysmal peritonitis
T81.61	C -	Chemical peritonitis
K65.3	M H	Choleperitonitis
K65.8	M H	Chronic proliferative peritonitis
K65.0	M H	Diaphragmatic peritonitis
K65.4	C H	Fat necrosis of peritoneum
K65.0	M H	Generalized (acute) peritonitis
K65.4	C H	(Idiopathic) sclerosing mesenteric fibrosis
K65.8	M H	Localized (acute) peritonitis
K65.4	C H	Mesenteric lipodystrophy
K65.4	C H	Mesenteric panniculitis
K65.8	M H	Other peritonitis
		Pelvic peritonitis, female
N73.3	M -	Acute
N73.4	C -	Chronic
N73.5	- -	Unspecified
N73.6	- -	With adhesions
K65.0	M H	Pelvic peritonitis (acute), male
E85.0	C H	Periodic familial peritonitis
K65.9	M H	Peritonitis
		Peritonitis due to
K65.3	M H	Bile
T81.599	C -	Object accidentally left during procedure instrument/sponge/swab
K65.8	M H	Urine
K65.8	M H	Peritonitis, eosinophilic
K65.4	C H	Retractile mesenteritis
K65.4	C H	Sclerosing mesenteritis
K65.2	M H	Spontaneous bacterial peritonitis
K65.0	M H	Subphrenic peritonitis (acute)

ALL
SET
DOC?**Diagnosis:**

'Acute ruptured appendicitis with localized peritonitis'
 [K35.30]

Occurrence:

Pertinent history
 How the patient looks sick
 Abdominal exam findings with site
 Lab & imaging test results
 Procedural findings
 Path report (add an addendum, if necessary)

Comorbid conditions: Crohn's, diverticulitis, IBS, etc.,
 see conditions in Etiology above.

Complications: Abscess, bleeding, gangrene;
 perforation; portal vein phlebitis [K75.1]; rupture;
 sepsis, severe sepsis, septic shock; etc.

Notes Peritonitis is inflammation or infection of the peritoneum lining the abdominal/pelvic cavity and covering the organs. Every abdominal/pelvic organ can cause peritonitis, but the peritoneum may also be infected by blood borne organisms, affected by inflammatory diseases, or inflamed/contaminated by surgery, trauma, and substances without primary organ involvement.

A long list of signs and symptoms indicate peritonitis, including abdominal tenderness/guarding/rebound.

Since peritonitis is neither a treatable disease, nor an independent Diagnosis, physicians often do not document it, even when it is obvious, literally from across the room, as in PID. Although the presence of peritonitis indicates a more severe form of disease and increases the complexity of medical-decision-making, only the condition causing the peritonitis finds its way into the record; it can be treated and then, the peritonitis will clear up.

Peritonitis continued

Notes However, '**peritonitis**' has a very high SOI. All seven independent codes for peritonitis [K65-] are {HCCs}, six are (MCCs) and one is a (CC). In addition, when the term '**with peritonitis**' is added to a GI or pelvic Diagnosis and the ICD-10-CM code changes, the new code often has a higher SOI. Thus, it is crucial to specifically document '**with peritonitis**' when it is present, or suspected due to other findings, such as rebound or an intestinal perforation.

Medically, "rebound" and "pus in the abdominal/pelvic cavity" indicate peritonitis. However, to receive credit for this increased SOI, '**peritonitis**' or the terms noted in these tables must be documented.

ICD-10-CM is inconsistent in the requirement to identify perforations and abscesses as inherent-to or separate-from peritonitis. When perforation/rupture of the viscus or an abscess is present, specifically document it, and always document '**with peritonitis**' when you suspect it.

167. **PHO (personal history of)**ALL
SET
DOC?**Diagnosis: 'PHO...'****PHO Diagnoses**

Anaphylactic shock	Nephrotic syndrome
Benign carcinoid tumors	Nervous system disease
Blood/blood-forming organ disease	Nontraumatic fracture
Cardiovascular disease	Peptic ulcer
Childbirth complications	Poliomyelitis
Childhood abuse/neglect	Pre-term labor
Colonic polyps	Psychological trauma
Combat/operational stress reaction	Recurrent pneumonia
Congenital malformation repaired	Retained foreign bodies fully removed
Contraception use	Self-harm
Diabetic foot ulcers	Sense organ disease
Encephalitis	Sudden cardiac arrest
Gestational diabetes	TIA
GU dysplasia	Tobacco dependence
Immune diseases	Tuberculosis
Infectious/ parasitic diseases (physical/ psychological/sexual)	Urinary calculi
Malaria	UTIs
Meningitis	Venous thrombi/emboli
Mental/behavioral disorders	TBI
MRSA	Traumatic fracture
Neoplasm	Trauma
Benign	Sexual reassignment
In-situ	Etc..
Malignant	

Notes **'Personal History of'** (PHO) justifies seeing a patient who lacks a Diagnosis. PHO conditions are over, but not gone, they still need monitoring. PHO explains why medication is still prescribed:

'PHO PE/DVT (2019) taking X anticoagulant to prevent recurrence'

Include the date of the original Diagnosis as a reference for colleagues.

PHO conditions are NOT PMH (over and gone, no longer considered in medical-decision-making). PHOs influence medical-decision-making and therapy.

168. **Pleural effusion [J90](CC){}****L laterality****Etiology:****Etiology of Pleural Effusion**

	SOI	
B74.0-B74.9	C -	Filarisis
I50.-	/ /	Heart failure
J09.X2,	M -	Influenza
J10.1, J11.1		
J91.0	C -	Malignant (give details of the malignancy)
J91.8	C -	Other diseases (give diagnosis)
M32.13	- H	Systemic lupus (SLE)
Multiple	/ /	Trauma (give details)
A15.6	C -	Tuberculous

Type:ALL
SET
DOC?**Type of Pleural Effusion**

	SOI	
J94.0	C -	Chylous
J94.1	- -	Fibrothorax
J94.8	C -	Hydrothorax
J94.2	C -	Non-traumatic hemothorax
J94.8	C -	Other
R09.1	C -	Pleurisy
J86-	M -	Pyothorax
S27.1	M -	Traumatic hemothorax

Diagnosis:

'Right traumatic hemothorax d/t 30' fall off a roof with 12 broken ribs...chest tube inserted R side'

'Bilateral pleural effusion d/t COVID-19 pneumonia with acute hypoxic respiratory failure'

Occurrence: Link to treatment, especially procedures.

169. **Pneumonia****Think! Is there sepsis?**

(Suspected) **Etiology:** See lists below

What are you treating?

An organism

An aspirated/inhaled irritant

An underlying disease

Type:**Type of Pneumonia**

Aspiration	Irritant	Viral
Bacterial	Other	
Lobar	Other infectious	

ALL
SET
DOC?

Comorbid conditions: (especially chronic conditions with exacerbation that need treatment and increase SOI. Document all that are present):

Complications: Usually the real reason for admission.

Complications of Pneumonia

	SOI	
J96.0-	M H	Acute respiratory failure
J80	M H	ARDS (acute respiratory distress syndrome)
[/]	/ /	Encephalopathy, see above
R04.2	C -	Hemoptysis
R79.81	- -	Hypercapnia / Hypoxia
J85.1	M H	Lung abscess
I40.0, J09.X9,	/ /	Myocarditis
J91.8	C -	Pleural effusion
J81-	/ /	Pulmonary edema
[/]	/ /	Sepsis, severe sepsis, septic shock
		Other, especially life-threatening conditions

Pneumonia continued

Notes There are over a hundred ICD-10-CM codes for pneumonia, most based on the suspected organism, many of which have a high SOI (MCCs/HCCs, see lists). Non-specific “pneumonia” [J18.9](M){} is an MCC but not an HCC

What are you treating? Show your complex MDM:

Name the organism based on epidemiology, antibiogram, drug choice, or culture results;

An irritant aspirated, inhaled, or exposed to lung tissue; or

An underlying disease



There is no code for “~~community acquired pneumonia~~” (~~CAP~~) or “~~healthcare acquired pneumonia~~” (~~HAP/HCAP~~). They code to ‘other pneumonia’ [J18.8](M){}, which is NOT an HCC.

	Patients seldom get admitted for simple pneumonia. Document <u>Complications</u> , generally the real reason for admission, to get full credit for a sick patient. Simple pneumonia is easy, complex pneumonia and complications have increased SOI, ROM, and complex MDM.
--	--

170. **Pneumonia, aspiration**

ALL
SET
DOC?

Link aspiration to the Etiology:

Etiology of Aspiration Pneumonia

SOI		
	-	Anesthesia
J95.4	C -	Not OB related
J69.0	M H	Food or vomit
J69.1	M H	Lipids, oils, essences
	- -	Obstetrical [O29.01-/O74.0/O89.0]
J69.8	M H	Other solid/liquid
J69.9	- -	Unspecified
		Perinatal
P24.11	M -	Amniotic fluid/mucus
P24.21	M -	Blood
P24.01	M -	Meconium
P24.31	M -	Milk/regurgitate
P24.81	M -	Other

Diagnosis:

'Pneumonia due to aspiration of food from stomach contents d/t advanced age'

Occurrence: Link the **Diagnosis** to risk factors

Aspiration Pneumonia Risk Factors

ALL
SET
DOC?

Age	Neurologic disorders
Altered/reduced consciousness	Dementia
Alcoholism	Multiple sclerosis
Drug overdose	Myasthenia gravis
General anesthesia	Parkinson disease
Head trauma	Pseudobulbar palsy
Seizures	Other
Stroke/TIA	Bronchoscopy
Debility	Critical illness
Esophageal conditions	Endotracheal intubation
Diverticula	Feeding tubes
Dysphagia	General deconditioning/debility
GERD	Nasogastric tube
Neoplasm	Periodontal disease
Strictures	PPIs/H2-receptor antagonist (risk 1.63x)
Tracheoesophageal fistula	Prolonged recumbency
	Protracted vomiting
	Tracheostomy
	Upper GI endoscopy

Complications:

Acute hypoxic/hypercarbic respiratory failure

[J96.-] (/){H}

Sepsis, severe sepsis, septic shock [R65-] (/){H}

Etc.

Physician's Documentation Prescription 2023

Notes Aspiration is common, especially with ageing. A barium swallow is NOT necessary to prove it.

171. **Pneumonia, bacterial**(Suspected) **Etiology:** What are you treating?ALL
SET
DOC?

Etiology (Organism) of Bacterial Pneumonia		
	<u>SOI</u>	
Gram (-) Bacteria		
J15.61	M -	Acinetobacter baumannii
A37.11	M -	Bordetella parapertussis
A37.01	M -	Bordetella pertussis
A37.81	M -	Bordetella, other species
A37.91	M -	Bordetella, unspec
J16.0	M -	Chlamydia
J15.5	M H	Escherichia coli
J85.0	M H	Gangrene
A54.84	C H	Gonorrhea
J15.6	M H	Gram (-)
J14	M H	Hemophilus influenzae
J15.0	M H	Klebsiellae
A48.1	M H	Legionnaires
A70	C -	Ornithosis, psittacosis
J15.69	M -	Other Gram-negative bacteria
A24.1	C -	Pseudomallei
J15.1	M H	Pseudomonas
A78	C -	Q fever
A02.22	M H	Salmonella
A21.2	C H	Tularemia
A01.03	C H	Typhoid fever
A20.2	M H	Y. pestis, pneumonia plague
Gram (+) Bacteria		
J67.1	- H	Actinomycetes: Bagassosis
A42.0	C H	Actinomycosis
A22.1	M H	Anthrax
J15.9	M -	Gm(+) bacteria
J15.212	M H	MRSA
J15.211	M H	MSSA
A43.0	C H	Nocardiosis
J15.29	M H	Staph, other
J15.20	M H	Staph, unspecified
J13	M H	Strep
J15.3	M H	Strep group B
J15.4	M H	Strep, other

Occurrence: POA; '**failed outpatient antibiotic therapy**'; etc.

Sepsis, severe sepsis, septic shock [R65-](/){H} (see more complete list above In Pneumonia).

Complications: Usually the real reason for admission.

Acute hypoxic/hypercarbic respiratory failure [J96.-]](/){H}
--

Notes An organism need NOT be proven to treat pneumonia; therefore, documentation should include a 'suspected' organism susceptible to the antibiotic selected. Use the antibiogram* to assist in the selection of an organism.

172. **Pneumonia, fungal**

ALL
SET
DOC?

Acuity

Etiology:

Etiology of Fungal Pneumonia		
SOI		
		Aspergillosis
B44.0	M H	Invasive pulmonary
B44.1	C H	Other pulmonary
B44.9	C H	Unspecified
J67.4	- H	Clavatus/fumigatus, maltworker lung
B37.1	M H	Candidiasis
		Coccidioidomycosis
B38.0	C H	Acute pulmonary
B38.1	C H	Chronic pulmonary
B38.2	C H	Unspecified pulmonary
		Histoplasmosis
B39.0	M H	Acute
B39.1	M H	Chronic
B39.2	M H	Unspecified
J67.3	- H	Penicillium glabrum, suberosis, corkhandler
B59	M H	Pneumocystis carinii, jiroveci, plasma cell

Notes When both chronic and acute pneumonia are documented, SOI is higher and both will be coded.

173. **Pneumonia, interstitial**

ALL
SET
DOC?

Acuity

Type:

Type of Interstitial Pneumonia

	<u>SOI</u>	
J84.114	C H	Acute
J84.117	C H	Desquamative
J84.113	- H	Idiopathic non-specific
J84.111	- H	Idiopathic NOS
J84.17	C H	In other/collagen vascular disease
J84.2	C H	Lymphoid
J84.9	C H	Unspecified

174. Pneumonia, obstetrical d/t anesthesia**Link to the pregnancy****Etiology: 'Due to anesthesia'****Occurrence:****ALL
SET
DOC?****Occurrence of Obstetrical Pneumonia**

	<u>SOI</u>	
		Aspiration d/t anesthesia
O29.011	- -	Trimester 1
O29.012	- -	Trimester 2
O29.013	- -	Trimester 3
O74.0	- -	During L&D
O89.01	- -	During puerperium

175. Pneumonia, other**ALL
SET
DOC?****Etiology may be the Type:**

Other Types of Pneumonia

SOI		
J67.2	- H	Bird fancier's lung
J84.89	- H	BOOP, cholesterol, organizing
J18.0	M -	Bronchopneumonia
J84.116	C H	Cryptogenic organizing
J67.7	C H	Due to air-conditioner
J67.9	C H	Due to allergy
J68.0	C H	Due to fumes or vapors
J67.0	- H	Farmer's lung
J18.2	C -	Hypostatic, passive
J84.112	- H	Idiopathic pulmonary fibrosis
J84.17	- H	In other diseases
J69.1	M H	Lipid, lipoid
J18.1	M H	Lobar
J67.6	- H	Maple bark-stripper's lung
J67.5	- H	Mushroom worker's lung
J67.8	C H	Organic dust NEC
J17	M -	Postinfectious, in other diseases
J95.89	C -	Postprocedural
J82	C H	Pulmonary eosinophilia, Löffler's
J70.0	C H	Radiation
I00	- -	Rheumatic
T79.8xxS	- H	Traumatic
J95.851	C H	Ventilator

176. Pneumonia, other organisms

ALL
SET
DOC?**Etiology:**

Etiology of Pneumonia: Other Organisms		
	<u>SOI</u>	
B77.81	M -	Ascariasis (round worm)
J15.7	M -	Mycoplasma
B65.9	C -	Schistosomiasis (worm)
A69.8	- -	Spirochete
A50.04	C -	Syphilis spirochet, early congenital
B58.3	M H	Toxoplasmosis, parasite

177. Pneumonia, perinatal

ALL
SET
DOC?**Type/Etiology:**

Etiology & Type of Perinatal Pneumonia		
	<u>SOI</u>	
		d/t Aspiration of...
P24.11	M -	Amniotic fluid/mucus
P24.21	M -	Blood
P24.01	M -	Meconium
P24.31	M -	Milk/regurgitated
P24.81	M -	Other
		Neonatal Gram (-)
P23.1	M -	Chlamydia
P23.4	M -	E.coli
P23.6	M -	H.flu
P23.6	M -	Klebsiella
P23.5	M -	Pseudomonas
		Neonatal Gram (+)
P23.2	M -	Staph
P23.3	M -	Strep group B
P23.6	M -	Strep not group B
		Other Neonatal Pneumonia
P23.9	M -	Congenital
P23.6	M -	Mycoplasma
P23.6	M -	Other bacteria
P23.8	M -	Other organism
P23.0	M -	Viral

178. **Pneumonia, viral****ALL
SET
DOC?****Etiology:****Etiology of Viral Pneumonia**

	<u>SOI</u>	
J12.0	M -	Adenovirus
J12.81	M -	Coronavirus, SARS-associated
U07.1	M -	COVID-19
B25.0	M H	Cytomegalovirus
J12.3	M -	Human metapneumovirus
B05.2	M -	Measles
J12.89	M -	Other virus
J12.2	M -	Parainfluenza virus
J12.1	M -	Respiratory syncytial virus (RSV)
B06.81	C -	Rubella
B01.2	M -	Varicella, chickenpox
J12.9	M -	Viral pneumonia

179. **Pneumonia with systemic influenza**

Notes Patients with influenza may not have the same organism causing their pneumonia. When possible, the specific strain of flu and the organism causing the pneumonia should be identified.

**ALL
SET
DOC?****Etiology of flu & pneumonia****Pneumonia in Patients With Systemic Influenza**

Document organisms for both the Flu and the Pneumonia

	<u>SOI</u>	<u>Flu Virus</u>	<u>Pneumonia Organism</u>
J09.X1	M -	Novel influenza A	Novel influenza A
J09.X1+pneumonia code			Other (name it)
J10.08	M -	Other (name it)	Other (name it)
J10.01	M -	Other (name it)	Same virus
J10.00	M -	Other (name it)	Unspecified
J11.08	M -	Unidentified	Other
J11.00	M -	Unidentified	Unspecified

180.

Post-OP

	<p>When used with a <u>Diagnosis</u>, the term <u>post-op/postoperative</u> will generate a CDI query because it has two interpretations, ‘following’ surgery and ‘due to’ surgery. To avoid queries, clearly document when a condition is due to surgery/ procedure by stating, ‘following X’ when describing a temporal sequence.</p> <p>‘Postoperative respiratory failure’ results in a complication code because new coding guidelines no longer require physicians “to explicitly document the term ‘complication.’” Therefore, some conditions that develop after surgery, may be coded as a complication of care. Do not use the term “postoperative” unless you want to link the condition, as a complication, to the procedure/surgery.</p> <p>For example: Patients who have elective surgery and later develop sepsis (POA = N) may be included in PSI 13: Postoperative sepsis.</p>
---	--

181.

Postprocedural

- Notes** There are a number of conditions which have a separate code when documentation indicates **‘X condition following Y procedure’**. Unlike the term ‘post-op’, ‘postprocedural’ may not be automatically linked to a complication.

182.

POA (present on admission)

- Notes** Present on admission (POA): Indicates conditions present at the time of the admission order. Diagnoses/conditions documented in the ED chart or date of admission H&P are POA. H&Ps should contain all current acute and chronic conditions, the ED diagnoses, a diagnosis for each medication (home and ordered), and early signs of developing problems, such as stasis ulcers, UTIs from catheters, sepsis, and early organ failure. If not recorded as POA, physicians may be given credit for having caused these conditions or letting it develop through negligence

183. **Precipitous drop in hematocrit/hemoglobin (PDH)**
[R71.0](C){}

Notes ≥ 20% drop, PDH is alternative terminology used by some physicians to indicate '**acute blood loss anemia (ABLA)**' [D62](C){}. (See anemia)

184. **Psychotic disturbance:** Hallucinations, delusional state, paranoia, suspiciousness, etc.

185. **Pulmonary edema**

Acuity

Pulmonary Edema

ALL
SET
DOC?

SOI		
J81.0	M H	Acute pulmonary edema
J81.1	C -	Chronic pulmonary edema
J81.1	C -	Pulmonary edema
J68.1	M H	Pul edema d/t chemicals/gases/fumes/vapors
J60-J70	/ /	Pulmonary edema due to external agents
O75.4	- -	Pul edema following ob surgery/procedures
I50.1	C H	Pulmonary edema with heart disease
I50.1	C H	Pulmonary edema with heart failure

Occurrence: Tobacco exposure

186. **Pulmonary effusion** []

[⚠] Pulmonary effusion has no ICD-10-CM code []. Document '**pleural effusion**' instead. (See above.)

187. **Pulmonary embolism (PE)** /{/}

ALL
SET
DOC?

Acuity:

Acute [I26.99](M){H}

Chronic [I27.82](C){H}

Healed or old: '**PHO PE**' [Z86.711]{}{}

Site: Artery or vein

Etiology: suspected due to

Suspected Etiology of Pulmonary Embolism

Air	Crystals	Plaque	Tumor part
Amniotic fluid	Fat	Septic thrombus	
Cholesterol	Foreign body	Thrombosis	

**ALL
SET
DOC?**

Type

Type of Pulmonary Embolism			
	SOI		
T80.0xxA	M -	Air embolism following infusion/transfusion/ therapeutic injection Obstetrical (T1,2,3; L&D; puerperium)	
O88.0-	M -	Air [O88.0-](M){}	
O88.1-	M -	Amniotic fluid [O88.1-](M){}	
O88.8-	M -	Other [O88.8-](M){}	
O88.3-	M -	Pyemic/septic [O88.3-](M){}	
O88.2-	M -	Thromboembolism [O88.2-](M){}	
003-O08	M -	PE following (<u>Type of</u>) abortion	
T81.718A	C -	PE following a procedure	
T82.817A	C -	PE d/t cardiac device/implant/graft	
T82.818A	C H	PE d/t vascular device/implant/graft	
000-007,	M -	PE with (<u>Type of</u>) ectopic/molar pregnancy	
O08.2			
T79.0xxA	M H	Traumatic air PE	
T79.1xxA	M H	Traumatic fat PE With acute cor pulmonale	
I26.09	M H	Other	
I26.02	M H	Saddle	
I26.01	M H	Septic	
		Without acute cor pulmonale	
I26.94	M -	Multiple subsegmental	
I126.99	M H	Other	
I26.92	M H	Saddle	
I26.90	M H	Septic	
I26.93	M -	Single subsegmental	

Occurrence:

Long-term use of anticoagulants [Z79.01]{}
Obstetric timing: pregnancy, childbirth, puerperium

Complications:

Acute cor pulmonale

Notes Cor pulmonale:

Acute R ventricular overload due to acute pulmonary hypertension is usually from a PE

Chronic R ventricular dilation, hypertrophy and failure due to primary, but not congenital, lung disease

188. **Pulmonary insufficiency** [j95.1-.3](M){}

**ALL
SET
DOC?**

Acuity

Type: Following thoracic/nonthoracic surgery

189. **Pyelonephritis** /{/}ALL
SET
DOC?**Acuity & Etiology****Pyelonephritis**SOI**Acuity**

N10	C -	Ac pyelo/pyelitis/infectious interstitial nephritis
N11.8	C -	Chr nonobstructive pyelonephritis
N11.0	- -	Chr nonobstructive reflux-associated pyelo
N11.1	C -	Chronic obstructive pyelonephritis
N11.9	C -	Chronic pyelonephritis NOS
O86.21	C -	Following delivery

Etiology

N20.9	- -	Calculus pyelonephritis
B37.49	C H	Candidal
E72.04	C H	Cystinosis
E08-E13 w .29	- H	Diabetes
A36.84	C -	Diphtheria
A52.76	C -	Late syphilis
M32.15	- H	Lupus
N12	C -	Pyelonephritis
N16	- -	Pyelonephritis in diseases classified elsewhere
A02.25	C -	Salmonella
D86.84	- -	Sarcoid
M35.04	- H	Sjogren syndrome
A18.11	C -	TB
B58.83	C -	Toxoplasmosis

Complications significantly impact the SOI and COMDM

- Acute renal failure
- Emphysematous pyelonephritis (EPN)
- Papillary necrosis,
- Renal vein thrombosis
- Renal/perinephric abscess
- Sepsis

190. **qSOFA (Quick Sepsis Organ Failure Assessment)**ALL
SET
DOC?**Etiology:** Suspected organism**Type:** Suspected source of infection**Diagnosis:** Sepsis, severe sepsis, septic shock

ALL
SET
DOC?**Occurrence:****Occurrence (qSOFA Score)****2 of 3 Criteria = Sepsis**

Altered mentation:

Describe the abnormalities

Document the GCS'

Include a diagnosis of '**septic encephalopathy**'Respiratory rate \geq 22 / minSystolic blood pressure \leq 100mmHg

POA

Etc.

Complications: Details of organ failure

- Notes** Rapid identification of sepsis in patients with suspected infection requires 2 of 3 clinical

191. Quadriplegia [G82.5-](MCC){HCC}ALL
SET
DOC?**Site:** C1-4 or C5-7**Type:**

Complete

Incomplete

Comorbid Conditions**Complications:****Complications of Quadriplegia**

Cardiovascular	Pain
Autonomic dysreflexia	Muscle spasm pain
Cardiac atrophy	Neuropathic pain
Orthostatic hypotension	Nociceptive pain
Reflex bradycardia	Visceral pain
Thromboembolism	Respiratory
GI	Atelectasis
Bowel distension	Hemothorax
Hemorrhoids	Obstructive sleep apnea
Anal fissures	Pleural effusion
Fecal impaction	Pneumonia
Neurogenic bowel	Pneumothorax
MS	Respiratory failure
Fractures	Urologic
Muscle spasm	Bladder distension
Osteoporosis	Neurogenic bladder
Spasticity	Urinary catheter blockage
Other	Urinary retention
Obesity	UTI
Skin ulcers	UTI d/t catheter(ization)
Smoking	Etc.

192. **Rehabilitation admission**

Rehab **Etiologic Diagnosis** (RED): Etiology/ problem that caused impairment needing rehab
'Recent stroke' (include details)

This Occurrence: include details

Impairment Group Code (IGC): Primary reason patient is being admitted to the rehab program; directly related to the care plan goals

Include objective descriptions of each abnormal finding to support IRF medical necessity

Functional Independence Measurement (FIM): Uniform Data Set for Medical Rehabilitation (UDSMR), 18 items rated on a 7-level scale from independent (7) to complete dependence (1)

1. Eating (39A)
2. Grooming (39B)
3. Bathing (39C)
4. Dressing – Upper (39D)
5. Dressing – Lower (39E)
6. Toileting (39F)
7. Bladder (39G)
8. Bowel (39H)
9. Transfers: Bed, Chair, Wheelchair (39I)
10. Transfers: Toilet (39J)
11. Transfers: Tub, Shower (39K)
12. Walk/Wheelchair (39L)
13. Stairs (39M)
14. Comprehension (39N)
15. Expression (39O)
16. Social Interaction (39P)
17. Problem Solving (39Q)
18. Memory (39R)

Comorbidities: All medical/functional conditions

ALL
SET
DOC?

Notes **Debility***: Loss of strength and energy; weakness; or **deconditioning**, is often the reason why a patient is referred to IRF. Document the Diagnosis that caused the impairments needing rehab, to support medical necessity.

AIR (Acute Inpatient Rehabilitation)

ARF (Acute Rehabilitation Facility)

IRF (Inpatient Rehabilitation Facility)

To avoid AIR/ARF/IRF denials the CMS Patient Assessment Instrument (PAI) is usually completed.

The physician must document the following:

Why the patient requires:

- Active, ongoing Physical Therapy (PT) or Occupational Therapy (OT) and Speech-Language Pathology (SLP) and/or prosthetics/ orthotics;
- 3 hours of therapy/day \geq 5 days per week (15 hours in each 7-consecutive day period);
- Face-to-face visits \geq 3 days/ wk by a rehab physician for medical and functional assessment to modify the course of treatment;
- An acute level of RN nursing care and assessment round the clock; and
- An intensive, coordinated interdisciplinary team approach to rehab care.

And how the patient is expected to:

- Actively participate in therapy (condition/ functional status evaluation - a comatose patient cannot actively participate);
 - Benefit from the therapy (anticipated improvement in the next month due to unique IRF therapy); and
 - Derive practical value from the improvements.
-

193. **Renal/kidney failure****ALL
SET
DOC?****Acuity:** Document both AKI and CKD if both are present**Site:** Cortical, medullary, tubular**Etiology**

Do NOT use the term renal **insufficiency** or **dysfunction** when the kidneys are failing.

Notes See ESRD above for details on end stage renal disease.

194. **Renal failure, acute [N17.-](CC){HCC}**

Notes Synonym: '**AKI**' (acute non-traumatic kidney injury)

AKI is present in ~15% of hospitalized patients. Do NOT use the terms **insufficiency** or **dysfunction** when acute failure criteria are met.

Criteria for Acute Renal Failure / AKI

<u>(1) criteria needed</u>		<u>Timeframe</u>
≥150% (1.5x) sCr increase over 3 mo baseline		< 7 days
or ≥ 0.3 mg/dL sCr increase over 3 mo baseline		≤ 48 hours
or Equivalent sCr decrease		In hospital
or Urine output <0.5 ml/kg/h		> 6 hours
or Kidney rescue therapy (KRT)		Acute

Acuity

Link to suspected **Site** of necrosis: No tests are required to prove the suspected site.

**ALL
SET
DOC?****Site of Acute Renal Failure / AKI**

<u>SOI</u>		
N17.0	M H	Tubular necrosis most common (>50%)
N17.1	M H	Cortical necrosis ~2%
N17.2	M H	Medullary necrosis mostly middle aged females

**ALL
SET
DOC?**

Etiology by Site of necrosis/dysfunction:

By Site	Etiology of Acute Renal Failure
Tubular:	
Acute tubular necrosis (ATN) is the most common (>50%), due to:	
Anaphylaxis	Fluid sequestration
Arrhythmias	Heart failure
Burns	Hemorrhage
Dehydration	Hepatobiliary disease
Diarrhea	Hypercalcemia
DIC	Hypotension >30 mins
Drugs:	Hypovolemia
Aminoglycosides	Injury
Amphotericin B	Major surgery
Angiotensin receptor blockers (ARBs)	Massive hemolysis
Angiotensin-converting enzyme (ACE) inhibitors	Multiple myeloma
Chemotherapy drugs	Nephrotoxins
Cisplatin	Pancreatitis
Colistimethate for Pseudomonas aeruginosa, Klebsiella pneumoniae, Acinetobacter	Pericardial tamponade
COX inhibitors	Radiocontrast
Cyclosporine	Renal ischemia
Epinephrine	Rhabdomyolysis
Immunosuppressives	Sepsis
NSAIDs	Serious burns
Norepinephrine	Shock
Systemic calcineurin inhibitors:	Toxins
Cyclosporine	Tumor lysis
Tacrolimus	Vomiting
Vancomycin	Etc.
Cortical: Rare (~ 2%), due to cortical ischemia due to vascular spasm, microvascular injury, or intravascular coagulation	
Medullary: Etiology obscure, ischemic infarct absent major blood vessel obstruction; mainly in middle-aged females. Pregnancies increase risk	

Diagnosis: 'AKI (sCr increase x2 in 1 month) d/t ATN d/t septic shock'

Renal failure, acute continued

Occurrence: Link to the criteria and clinical indicators present:

ALL
SET
DOC?

Clinical Indicators of Acute Renal Failure / AKI

Risk	New biomarkers that improve early detection of AKI
AKI history	Cystatin C
CKD	Insulin-like growth factor binding protein 7 (IGFBP7)
DM	Interleukin-18 (IL-18)
HTN	Kidney injury molecule-1 (KIM-1)
Major surgery	Liver-type fatty acid-binding protein (L-FABP)
Nephrotoxins	N-acetyl-β-glucosaminidase (NAG)
Biomarkers	Neutrophil gelatinase-associated lipocalin (NGAL)
GFR	Tissue inhibitor of metalloproteinases 2 (TIMP-2)
sCR	
Urine output	
Other	
Acute KRT	
Exposure alert	
Monitor biomarkers	
Rx adjustment	
Warn patient/team	

195. **Renal failure, chronic**
CKD (chronic kidney disease) [N18-] (/){/}

ALL
SET
DOC?

Etiology: Diabetes, hypertension, etc.

Type = stage: 1-5, ESRD w dialysis

Link to Complications: Heart failure, HTN, etc.

Notes Medical and coding definitions are the same:

CKD Details				
	<u>SOI</u>	<u>Stage</u>	<u>GFR</u>	<u>Document</u>
N18.1	- -	1	>90	Kidney Transplant Status
N18.2	- -	2	60-89	Z76.82 Awaiting kidney
N18.3	- H	3A	45-59	Z94.0 Kidney transplant
N18.3	- H	3B	30-44	Z98.85 Transplant removed
N18.4	C H	4	15-29	Z48.22 Aftercare
N18.5	C H	5	<15	following
N18.6 +	M H	ESRD w		transplant
Z99.2	- H	dialysis		

196. **Respiratory distress:** Only a sign, NEVER a Diagnosis.

Think! Is it respiratory failure?

Respiratory Distress Indicators		
Accessory muscle use	Orthopnea	Etc.
Altered mentation	"Paradoxical" respirations	
Brief, fragmented speech	Retractions	
Cyanosis/dusky skin	Tachypnea (R >20)	
Diaphoresis	Tripodism	
Inability to complete a full sentence without taking a breath		

197. **Respiratory failure**

Acuity

Acuity of Respiratory Failure		
SOI		
J96.2-	M H	Acute on chronic
J96.0-	M H	Acute
J96.1-	C H	Chronic

Etiology: Link to the Diagnosis that caused the failure:

Etiology of Respiratory Failure		
ARDS	Medications	Radiation injury
ALS	MS	Sepsis
Asthma	OD	Shock
Bronchiolitis	OSA	Trauma
CVA	Pancreatitis	Transfusion-related acute
Epiglottitis	Pleural effusion	lung injury (TRALI)
Guillain-Barre	Pneumonia	Vocal cord paralysis
Heart failure	Pulmonary edema	Etc.

ALL
SET
DOC?

Type: Hypoxic, hypercapnic, both

Diagnosis:

- 'Acute hypoxic respiratory failure d/t E.coli sepsis'
- 'Chronic hypoxic respiratory failure , home O2'

Occurrence:

This Occurrence of Respiratory Failure		
AMS (metabolic encephalopathy)	PaCO ₂ - 'hypercarbic'	
Due to procedure	PaO ₂ - 'hypoxia'	
During procedure	pH - 'acidosis' / 'alkalosis'	
Following procedure	Postprocedural [J95.82-](CC){}	
O ₂ sat on RA or baseline	Respiratory distress'	
O ₂ sat + O ₂ dose	R	
P	Etc.	

Respiratory failure continued

ALL
SET
DOC?

Comorbid conditions:

Comorbid Conditions of Respiratory Failure

Chronic respiratory failure	Obesity w/wo hypoventilation synd.
COPD	Obstructive sleep apnea (OSA)
COVID	Pneumonia
Heart failure	Sepsis
Hypertension	Etc.

Complications:

Complications of Respiratory Failure

Acidosis	Death
Acute encephalopathy	MI
Arrhythmias	Renal failure
ARDS [J80](MCC){HCC}	Etc.
Cardio/respiratory failure [R09.2](MCC){HCC}	

Notes ‘**Respiratory failure**’ requires respiratory support but NOT intubation or a ventilator. It is usually NOT fatal.

‘**Postprocedural respiratory failure**’ does NOT imply or get coded as a surgical complication.



Do NOT document respiratory distress, dysfunction, or insufficiency when clinical indicators of ‘failure’ are present.

198. **Respiratory failure, acute** [J96.2-](MCC){HCC}

<u>Criteria for Acute Respiratory Failure</u>	
(2) criteria needed	Respiratory distress
1. $pO_2 < 60\text{mmHg}$ or $O_2 \text{ sat} \leq 88\% \text{ RA}$	Abnormal VS esp R>20 Accessory muscle use AMS
2. $pCO_2 > 50\text{mmHg}$ and $\text{pH} < 7.35$	Anxiety Cyanosis/dusky skin Diaphoresis Dyspnea/orthopnea Fragmented sentences
3. Documented respiratory distress ->	Labored respirations Paradoxical breathing Respiratory distress Retractions Tripoding Etc.
NEVER document:	
Lungs CTA	
Lungs +	
NAD	
NI breathing	

Acuity

Etiology: Link to the Diagnosis that caused the failure:

<u>Etiology of Acute Respiratory Failure</u>		
ARDS	Heart failure	Pulmonary embolism
ALS	Medication	Radiation injury
Asthma	MS	Sepsis
Bronchiolitis	OD	Shock
COPD exacerb.	OSA	Trauma
COVID	Pancreatitis	Transfusion-related acute
CVA	Pleural effusion	lung injury (TRALI)
Epiglottitis	Pneumonia	Vocal cord paralysis
Guillain-Barre	Pulmonary edema	Etc.

ALL
SET
DOC?

Type: Hypoxic, hypercapnic, both; if '***postprocedural***' [J95.82-](CC){} what system the procedure involved.

Diagnosis:

***'Acute hypoxic respiratory failure (R24, O₂sat 70% RA)
d/t E.coli sepsis w metabolic encephalopathy'***

Occurrence: Criteria & CIs of respiratory distress (see above); especially RR; general appearance re breathing; O₂ sat on RA or baseline; O₂sat + O₂ dose + delivery system (O₂ NC (4L); HHFNC (6L); nonrebreather; HHFNC (15L); BIPAP; intubation; proning); PaCO₂; pH.

Comorbid Conditions: See Etiology; chronic respiratory failure; CKD; DM; morbid obesity

Complications: AKI; AMI; arrhythmias; cardiac arrest; death; metabolic encephalopathy; respiratory arrest.

199.

Respiratory failure, chronic [J96.1-](CC){HCC}**Acuity & Etiology****Type:** Hypoxic, hypercapnic, both**Diagnosis:**

'Chronic respiratory failure d/t COPD d/t cigarette smoking on continuous home O2 4L NC'

Occurrence: Include findings, ABG, dose of O₂, signs of respiratory failure, VS, etc.**Comorbid Conditions & Complications**

Notes Patients on **continuous** home O₂ are in '**chronic respiratory failure**' by definition and CMS criteria (room air (RA) PaO₂ ≥ 60mmHg / carbon dioxide PaCO₂ ≤ 45mmHg.).

200.

Respiratory insufficiency [R06.89]{}{}**Respiratory insufficiency of newborn [P28.5](M){}**

Notes When respiratory status is not normal and does not meet the criteria for acute or chronic respiratory failure, it is appropriate to use the term respiratory insufficiency. It is a sign, not a diagnosis and has a low SOI except in the neonatal period.

201. **Rhabdomyolysis****Etiology & Type** (non-traumatic or traumatic)**Etiology of Rhabdomyolysis**

Non-traumatic [M62.82]{CC}{}{}	Traumatic [T79.6](){HCC}{}{}
Alcohol abuse	Crush injury
Antipsychotics	Electrical shock
Bacterial infections	Heat
Congenital muscle enzyme deficiency	Lightning strike
Delirium tremens (DTS)	Long-duration muscle compression
DKA	Snake or insect venom
Duchenne's muscular dystrophy	Stroke
Electrolyte abnormalities	Third-degree burn
Hyperthermia	Etc.
Illicit drugs	
Immobility	
Medications	
Muscle diseases	
Muscle exertion	
Muscle strain	
Neuroleptic malignant syndrome (NMS)	
Seizures	
Sepsis	
Statins	
Viral infections (flu, HIV, herpes simplex, etc.)	
Etc.	

ALL
SET
DOC?**Complications:****Complications of Rhabdomyolysis**

SOI		
E87.2	C -	Acidosis
N17.0	M H	Acute kidney injury (AKI) d/t ATN
[/]	/ /	Arrhythmias
I46.8	M H	Cardiac arrest
[/]	/ /	Compartment syndrome
D65	M H	Disseminated intravascular coagulation (DIC)
E86.1	- -	Hypovolemia
R57.1	M H	Hypovolemic shock
[/]	/ /	Neuromuscular damage (give details)
E86.9	- -	Volume depletion

202. **Sarcopenia****ALL
SET
DOC?****Etiology:****Etiology of Sarcopenia**

	<u>SOI</u>	
M62.84	- -	Age
G73.-	/ H	Myoneural junction/diseases
G72.-	/ H	Myopathies
G71.-	/ H	Primary disorders of muscles
/	/ /	Etc.

Notes Sarcopenia is a syndrome of progressive, generalized loss of skeletal muscle mass and strength correlated with physical disability, and poor quality of life.

Risk factors include age, gender and level of physical activity. Despite normal weight patients with malignancy, rheumatoid arthritis, and aging, lose lean body mass. Fat mass (sarcopenic obesity) may even increase as marked weakness develops.

Sarcopenia has a high ROM, although treatment with exercise and nutritional interventions improves survival rates.



Deconditioning [] has no ICD-10-CM code but can be documented as '**sarcopenia with muscle weakness due to E**' [M62.84]().{ }.

203. **Seizures****Etiology:**

Epilepsy + Type:

Type of Epilepsy		
	<u>SOI</u>	
G40.A-	C H	Absence syndrome
G40.5-	C H	Epileptic seizures due to external causes
G40.82-	C H	Epileptic spasms
	C H	Epileptic syndromes with
G40.2-	C H	Complex partial seizures
G40.0-	C H	Seizures of localized onset
G40.1-	C H	Simple partial seizures
G40.3-	C H	Generalized epileptic syndrome }
G40.3-	C H	Generalized idiopathic }
G40.B-	C H	Juvenile myoclonic
G40.81-	C H	Lennox-Gastaut syndrome
	C H	Localization-related (focal/partial)
G40.0-	C H	Idiopathic
G40.1-	C H	Symptomatic w simple partial seizures
G40.2-	C H	Symptomatic w complex partial seizures
G40.4-	C H	Other named generalized

ALL
SET
DOC?

Cerebral contusion
 Fever
 Hypoxia
 Meningitis
 Poisoning
 Traumatic brain injury
 Etc.

Type of seizure:

Complex partial
 Grand mal on awakening
 Myoclonic absences
 Myoclonic-astatic
 Simple partial

Occurrence: Intractable or not**Complications:** Especially injuries

204. **Sepsis:** Take full credit for a sick patient by recording all components of sepsis.

Link: Patient general appearance; abnormal vital signs and WBC; and treatment to the sepsis Diagnosis

Site: of infection (dirty open fracture of femur, MRSA pneumonia, UTI, etc.)

Etiology: Name a suspected organism

ALL
SET
DOC?

Etiology (Organism) of Sepsis		
	<u>SOI</u>	
A42.7	M H	Actinomycosis
A41.4	M H	Anaerobes
A22.7	M H	Anthrax
B37.7	M H	Candida
A41.51	M H	E.coli
A41.81	M H	Enterococcus
A26.7	M H	Erysipelothrix
A48.0	M H	Gangrene
A54.86	M H	Gonococcus
A41.50	M H	Gram-negative
A41.59	M H	Gram-negative, other
A41.3	M H	H.influenzae
B00.7	M H	Herpes virus
A32.7	M H	Listeria
A31.2	C H	Mycobacterium avium-intracellulare complex (MAC)
A24.1	C -	Meliodosis
A39.2-A39.4	M H	Meningococcal
A41.02	M H	MRSA
A41.01	M H	MSSA
A41.89	M H	Other organism causing sepsis (2 codes apply)
U07.1	M -	COVID
[/]	/ /	Virus
A20.7	M H	Plague
A41.52	M H	Pseudomonas
A02.1	M H	Salmonella
A41.53	M H	Serratia
A41.2	M H	Staph
A41.1	M H	Staph, other
A40.9	M H	Strep
A41.81	M H	Strep group D
A40.0	M H	Strep, group A
A40.1	M H	Strep, group B
A40.8	M H	Strep, other
A40.3	M H	Strep, pneumoniae
A21.7	C -	Tularemia
A41.9	M H	Unspecified
A28.2	C -	Yersinia

ALL SET
DOC?**Etiology (Organism) of Perinatal Sepsis**

SOI		
P36.5	M H	Anaerobes
P36.8	M H	Bacteria, other
P36.9	M H	Bacteria, unspecified
P36.4	M H	Escherichia coli
P36.39	M H	Staphylococci, other
P36.19	M H	Streptococci, other
P36.2	M H	Staphylococcus aureus
P36.0	M H	Streptococcus, group B
P36.30	M H	Staphylococci unspecified
P36.10	M H	Streptococci unspecified

Type:**Type of Sepsis**

SOI		
		Postprocedural Sepsis
T80.2-	C -	Post infusion/transfusion/therapeutic injection
T88.0	C -	Postimmunization
T81.4-	C /	Postprocedural
		Post Abortion Sepsis
004.87	C -	(Induced) termination of pregnancy
003.87	C -	Complete or unspec spontaneous abortion
007.37	C -	Failed attempted termination of pregnancy
003.37	C -	Incomplete spontaneous abortion
008.82	C -	Ectopic/molar pregnancy
		Obstetrical Sepsis
075.3	M -	During labor
085	M -	Puerperal

Diagnosis:

Write '**sepsis**', NOT bacteremia, septicemia, SIRS, or **urosepsis** []; they do NOT code to 'sepsis' and may generate a query:

'E. coli sepsis d/t UTI w T 103.6, P 120, R 22 (POA)'

'Despite (-) BC, suspected Gram-negative sepsis from aspiration pneumonia w tachycardia (120), fever (102)'

'Puerperal sepsis, suspected Strep'

Sepsis continued**Occurrence:**

Abnormal VS; GCS; mSOFA, qSOFA or SOFA score;

Link how the patient looks sick to the Diagnosis

Note, if applicable:

'Failed outpatient antibiotic treatment'

'Sepsis despite negative BC'* to avoid a query

POA

Comorbid Conditions, especially those which increase SOI, cancer, HIV, injuries

Complications: Link to vital signs and therapy.

**ALL SET
DOC?**

<u>Complications of Sepsis</u>		
	<u>SOI</u>	
E87.2	C -	Acidosis
N17.0	M H	Acute kidney injury (AKI) d/t ATN
I21.-	M H	Acute myocardial infarction
I50.23	M H	Acute on chronic systolic heart failure
J96.0-	M H	Acute respiratory failure
I50.21	M H	Acute systolic heart failure
[/]	/ /	Arrhythmias
I46.8	M H	Cardiac arrest
G72.81	C H	Critical illness myopathy
D65	M H	Disseminated intravascular coagulation (DIC)
K72.0-	M /	Hepatic failure
R57.1	M H	Hypovolemic shock
I43	C H	Septic cardiomyopathy
G93.41	M -	Septic encephalopathy
M62.82	C -	Septic rhabdomyolysis
R65.21	M H	Septic shock

Notes Do NOT document “no acute distress”.

Describe exactly how the patient looks sick.

If the patient looks well, then explain how they can be septic & not look sick, masked-sepsis ABCs*:

Advanced age

Beta blockers

Comorbid conditions

Duration of extremis

Notes Sepsis documentation is confusing. ICD-10-CM codes are based on Sepsis-2 criteria, while current medical science uses Sepsis-3 definitions.

Insurance companies use whichever criteria are not documented, so ALL SET includes crucial elements of both Sepsis-2 and Sepsis-3 criteria.

Sepsis-2: Includes SIRS criteria in the sepsis definition:

Sepsis = Infection (+) 2 SIRS* criteria

Severe sepsis = sepsis (+) organ dysfunction

Sepsis-3: Redefined sepsis as “life-threatening organ dysfunction (‘failure’) caused by a dysregulated host response to infection [suspected or confirmed].” It eliminates the SIRS criteria and the term ‘severe sepsis’.

ICD-10-CM guidelines ignore that 70% of septic shock patients have a negative BC, stating that, “Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition; however, the provider should be queried.” Avoid queries by documenting that the patient has ‘**sepsis despite the negative BC.**’

The earlier you recognize, treat and document sepsis, the better for the patient. However, rapid recovery from early sepsis is often downgraded by non-clinical auditors who mistakenly contend that septic patients cannot recover quickly. When the patient has a rapid recovery from sepsis, avoid an audit or denial by acknowledging, in the discharge summary:

‘early detection & treatment of sepsis facilitated the patient’s rapid recovery’

Sepsis continued

Notes **Sepsis-3** includes organ failure in the definition of sepsis, which creates a coding problem since neither ICD-10-CM nor CMS Quality Measures require organ failure as part of the sepsis definition. I10 and Quality Measures define ‘sepsis-with-organ-failure’ as ‘severe sepsis’ [R65.20].

Until I10 & CMS use the new sepsis definition, document sepsis + organ failure using the term ‘**severe sepsis**’. There are no negative consequences for including the word ‘severe’ with sepsis, and it will reduce the number of queries you receive.

Read your hospital’s sepsis-documentation policy to avoid queries. If you are confused about CDI sepsis queries, request additional sepsis documentation education.

205. **Sepsis, severe** [R65.2-](MCC){HCC}

ALL
SET
DOC?

Link SIRS findings to the **Diagnosis**.

Site of infection

Etiology: Suspected organism (see list above in sepsis).

Type of sepsis: (See list above.)

Diagnosis:

‘***Severe E.coli sepsis due to UTI with ATN and septic encephalopathy, WBC 17,000, T 103, P 120, R 22, m/q/SOFAA***’

Occurrence: POA, due to indwelling Foley, etc.

Comorbid Conditions, especially those which increase SOI, cancer, HIV, injuries

Complications: Organ dysfunction or failure due to sepsis (See above Sepsis Complications)

‘...***with septic shock***’[R65.21](M){H}

‘...***without septic shock***’[R65.20](M){H}

Notes ICD-10-CM defines severe sepsis as “Infection with associated acute organ dysfunction:

- Sepsis with acute organ dysfunction
- Sepsis with multiple organ dysfunction (MOD)

Systemic inflammatory response syndrome (SIRS) due to infectious process with acute organ dysfunction”

206. **Septic shock** [R65.21](MCC){HCC}

Also see sepsis and severe sepsis for additional notes.

ICD-10-CM definition: Sepsis + organ failure + shock.

ALL
SET
DOC?

Link the Diagnosis to shock indicators:

Fluid bolus (or explain why it was not given)
Hypotension
Lactic acid measure
Mean arterial pressure
Tachycardia
Vasopressors

Notes Septic shock is associated with in-hospital mortality >40% due to profound circulatory, cellular, and metabolic abnormalities.

Septic shock is identified clinically by hypotension persisting after 30mL/kg crystalloid fluid administration AND vasopressors to maintain a mean arterial pressure >65mmHg AND serum lactate >2 mmol / L (>18mg / dL) in the absence of hypovolemia.

Sepsis-3 redefined septic shock as “sepsis with hypotension needing vasopressor therapy, after fluid resuscitation, to elevate mean arterial pressure (MAP) to 65mmHg or greater”.

This new definition of septic shock is compatible with both ICD-10-CM and the sepsis quality measures.

207. **Septicemia [A41.9](MCC){HCC}**

Think! Is it sepsis?

Notes Septicemia: “Invasion of the bloodstream by virulent microorganisms, especially bacteria along with their toxins, from a local seat of infection accompanied especially by chills, fever, and prostration — called also blood poisoning”



Septicemia is NOT sepsis. Document a Diagnosis of '**sepsis**', when you suspect sepsis; or state '**septicemia without sepsis**'.

208. **Sequela**

**ALL
SET
DOC?**

Acuity:

Date of onset of sequelae, an approximate year or timeframe is acceptable

Link the sequela to the Etiology (cardiac arrest, childbirth, CVA, trauma, etc.)

Laterality of sequela & handedness for neurological conditions

Site

Diagnosis of the sequela: with a full description of the condition

Occurrence: 7th character encounter ‘S’ for sequala

Notes A sequela (plural sequelae) is a late or residual problem. Some are present from the onset of the acute event (hemiparesis d/t CVA), others present after the acute condition has resolved (flexion deformities related to scarring from burns).

209. **Severe**

Notes It is logical to assume the adjective ‘severe’ will automatically increase severity of illness. The same logic might be applied to ‘complex’, ‘complicated’, ‘difficult’, and ‘massive’. Changes in the CPT® level of service codes have incorporated the term severe, when applied to exacerbation, progress, and treatment side effects, to distinguish between moderate and high complexity of medical-decision-making.

However, in ICD-10-CM, as the following lists illustrate, that is not the case. To the contrary, Site, Acuity, Etiology and Type will determine SOI and ‘complicated’ is used as a verb, as in “complicated by” something, not an adjective.

'Severe' Does Not Mean High Severity of Illness		
SOI		
B50.8	C -	Other severe/complicated Plasmodium falciparum malaria
F31.-	C H	Severe bipolar disorder, current episode
N18.4	C H	Severe chronic kidney disease (stage 4)
D81.-	C -	Severe combined immunodeficiency [SCID]
P91.63	M -	Severe hypoxic ischemic encephalopathy [HIE]
F72	C H	Severe intellectual disabilities
F33.-	C H	Severe major depressive disorder, recurrent
F32.-	C H	Severe major depressive disorder, single episode
F30.2	C H	Severe manic episode w psychotic symptoms
F30.13	C H	Severe manic episode wo psychotic symptoms
E08-E13.34	- H	Severe nonproliferative diabetic retinopathy
J45.50	- H	Severe persistent asthma, uncomplicated
J45.51	C H	Severe persistent asthma w (acute) exacerbation
J45.52	C H	Severe persistent asthma w status asthmaticus
O14.1-	M -	Severe pre-eclampsia
E43	M H	Severe protein-calorie malnutrition
R65.2-	M H	Severe sepsis without septic shock
H40.1-	- H	Severe stage open-angle glaucoma
E66.01	- H	Severe/morbid obesity d/t excess calories
E66.2	C H	Severe/morbid obesity w alveolar hypoventilation Severely displaced sacrum fx
S32.1(1/2/3)2A	C H	Zone I/II/III closed, initial encounter
S32.1(1/3/302B	M H	Zone I/II/III open, initial encounter
S32.1(1/2/3)2K	C -	Zone I/II/III, subsequent encounter w nonunion

Severe continued**Notes**

'Complex' Does Not Mean High Severity of Illness		
	<u>SOI</u>	
R56.01	C H	Complex febrile convulsions
G90.52-	C H	Complex regional pain syndrome I lower limb
G90.51-	C H	Complex regional pain syndrome I upper limb
G90.50	C H	Complex regional pain syndrome I unspecified
M99.11	C -	Complex vertebral subluxation cervical region
M99.10	C -	Complex vertebral subluxation head region
M99.18	C -	Complex vertebral subluxation rib cage
Q93.7	C H	Deletions w other complex rearrangements
A31.2	C H	DMAC (Disseminated mycobacterium avium-intracellulare complex)
Q92.5	- H	Duplications w other complex rearrangements Localization-related epilepsy/syndromes w complex partial seizures
G40.201	C H	Not intractable, with status epilepticus
G40.209	C H	Not intractable, without status epilepticus
G40.211	C H	Intractable, with status epilepticus
G40.219	C H	Intractable, without status epilepticus
D81.6/7	C H	Major histocompatibility complex class I/II deficiency

210.

Shock**ALL
SET
DOC?**

Link abnormal VS, appearance, and other findings, especially organ failure, to shock.

Acute Organ Failure <u>Linked to Shock</u>		
	<u>SOI</u>	
G93.49	C -	Brain (encephalopathy)
N17.0	M H	Kidney w ATN
K72.00	M -	Liver
J80	M H	Lung
E27.2	C H	Adrenal/cortical/Addisonian

Etiology: Causes of shock (drugs, foods, infection, medical care, are separated here for easy recall

	<u>SOI</u>	<u>Etiology of Shock d/t Drugs</u>	<u>Other Details Needed</u>
T88.6	C -	Anaphylactic drug CPPA*	Drug name
T88.2	C -	Anesthetic CPPA*	Is it CPPA?
T38.3X1	- -	Insulin accidental poisoning	Is it a poisoning?
E15	C -	Insulin CPPA*	'Intent' of
Multiple	/ /	Other ODs/poisonings	poisoning

Etiology:**Etiology of Anaphylactic Shock d/t Food**

	<u>SOI</u>	
T78.06	C -	Additives
T78.07	C -	Dairy/milk
T78.08	C -	Eggs
T78.03	C -	Fish
T78.00	C -	Food
T78.04	C -	Fruit/vegetable
T78.05	C -	Nuts/seeds/multiple
T78.09	C -	Other
T78.01	C -	Peanuts
T78.02	C -	Shellfish

Etiology of Shock d/t Infection

	<u>SOI</u>	
T81.12	M H	Also name the suspected organism
R65.21	M H	Endotoxic (procedure related)
R65.21	M H	Gram-negative
R65.21	M H	Septic (w severe sepsis)
A48.3	M H	Toxic shock syndrome

ALL
SET
DOC?**Etiology of Shock dt Medical Care**

	<u>SOI</u>	
T38.3X1	--	Accidental insulin poisoning
T88.6	C -	Anaphylactic drug CPPA*
T80.5-	C -	Anaphylactic due to serum
T88.2		Anesthetic shock
T80.51-	C -	Blood or blood products
T80.52-	C -	Immunization/vaccination
T80.59-	C -	Other serum
		Postprocedural (during/resulting from a procedure)
T81.11	M H	Cardiogenic
T81.19	M -	Hypovolemic
T81.19	M -	Neurogenic
T81.19	M -	Other procedural shock
T81.10	C -	Post procedural/operative
T81.12	M H	Septic
T81.19	M -	Vasogenic

Etiology of Shock dt Trauma

	<u>SOI</u>	
T75.4	--	Electric/taser
T75.01	--	Lightning
T79.4	M H	Hemorrhagic/hypovolemic immediate or delayed
R57.8	M H	Other named causes (burns, etc.)
T79.5	M H	Traumatic following crushing

Shock continued**ALL
SET
DOC?****Type:****Types of Shock**

	SOI	
T78.2	C -	Anaphylactic
R57.0	M H	Cardiogenic
R57.8	M H	Hemorrhagic, hematologic
R57.1	M H	Hypovolemic
R57.8	M H	Other named
F43.0	- -	Psychic
R57.9	- H	Shock

Occurrence: As with most obstetrical codes, obstetrical shock requires the timing of the shock:

Occurrence of Obstetrical Shock

	SOI	
008.3	M -	Complicating ectopic/molar pregnancy
075.1	M -	Labor & delivery
075.1	M -	Obstetric
075.1	M -	ADE during/after L&D

Occurrence: Clinical indicators that led you to diagnose shock should be linked to the Diagnosis of shock.

Notes Shock is a life-threatening condition (20% ROM) with a high SOI. Clinical indicators include abnormal vital signs (hypotension, tachycardia and tachypnea) and organ failure (often described as 'shock lung/liver/kidney').

ICD-10-CM has many shock related codes, with different SOIs, to provide epidemiological data. ALL SET DOC attempts to simplify the documentation needed to avoid queries about shock.

When patient attributes (age, beta-blockers, comorbid conditions, duration of extremis) interfere with the expected picture of shock, be sure to document why the usual findings might not be present in the patient.

211. **SIRS (systemic inflammatory reaction syndrome) not associated with infection [R65.1-](/){H}**

DEF Two of the following abnormal findings:

T > 38°C / 100.4 F or < 36°C / 96 F

P > 90 (some set the bar at 100)

R > 20

WBC > 12K or < 4K or > 10% Bands

Etiology:

ALL
SET
DOC?

Etiology of SIRS

Exercise
Heatstroke [T67.0]
Infection

Injury/trauma [S00-T88]
Other
Pancreatitis

Etiology:

ALL
SET
DOC?

Etiology of SIRS

Exercise
Heatstroke [T67.0]
Infection

Injury/trauma [S00-T88]
Other
Pancreatitis

Type:

Infectious [⚠ no code] see Sepsis
Non-infectious

This **Occurrence:**

With acute organ dysfunction [R65.11](M){H}
Without acute organ dysfunction [R65.10](C){H}

[Yes, i10 uses the term 'dysfunction' here!]

With shock

Without shock

Complications: specifics of the acute organ failure

Notes SIRS and its signs may indicate increased SOI. However, SIRS is present in mild illness, such as the common cold, and even vigorous exercise, it is no longer used to define sepsis (see Sepsis above).

SIRS criteria apply to heatstroke/injury/trauma with 2 SOI levels depending on the absence or presence of shock.

212. **Skin ulcer /{/}****L laterality & Site****Etiology:**

Atherosclerosis [I70.-](C){H}
 Chronic venous hypertension [I87.31-/.33-] (C){H}
 Diabetes + Type (E08/9/10/11/133.621/622]
 Infection: Name the suspected organism
 Morbid obesity
 Postphlebitic syndrome [I87.01-, I87.03-](C){H}
 Pressure [L89.-](M){H}
 Skin infections [L00-L08](C){}
 Trauma [/]
 Varicosity [I83.0-, I83.2-](C){H}

Type/stage/depth**Pressure ulcers & stages:**

**ALL
SET
DOC?**

- 1: pre-ulcer skin changes limited to persistent focal edema
 - 2: abrasion, blister, partial thickness skin loss involving epidermis / dermis
 - 3: full thickness skin loss w SQ tissue damage/ necrosis
 - 4: necrosis of soft tissues through to underlying muscle, tendon, or bone (state which)
- Unstageable due to eschar or slough

Non-pressure ulcers & depth:

- Depth of involved tissue & presence of necrosis
- Limited to skin breakdown
- Fat layer exposed
- Muscle involvement without evidence of necrosis
- Muscle involvement with necrosis
- Bone involvement without evidence of necrosis
- Bone involvement with necrosis

Other ulcers

	<p>This Occurrence: Size of each ulcer Debridement* for each ulcer <u>Type</u> of debridement 'excisional' 'non-excisional'</p> <p>ALL SET DOC?</p> <p><u>Laterality, Site, Etiology, & Type</u> of ulcer debried This <u>Occurrence</u> Size, in square centimeters, of each depth of tissue excised The deepest tissue <u>removed</u> (skin, SQ, muscle, bone) A list of the instruments used</p>
Notes	<p>Skin ulcers are generally (CCs), so it is extremely important to document them accurately, so they can be coded to correctly capture SOI and ROM and support medical-decision-making.</p> <p>Coders are permitted to code the <u>Type/stage/depth</u> of the ulcer from wound consultant notes only when the physician documents an ulcer <u>Diagnosis</u> with <u>Site</u> and <u>Etiology</u> AND acknowledges agreement with the consultation.</p> <p>If physician and wound care notes disagree, the physician will be queried requesting resolution of the conflict.</p> <p>If no wound consultant is available or ordered, the physician must document ulcer <u>Type/stage/depth</u>.</p>

213.	<p>Spinal surgery</p>
ALL SET DOC?	<p>Site: specific vertebrae Type: anterior or posterior surgical approach Diagnosis: for which the procedure is done Occurrence: Intended procedure Procedure done Reason if intended procedure was not done Preprocedural Comorbid conditions</p>

Postprocedural **Complications**

214. **Social determinants of health (SDOH) [Z00-Z99]**

Notes Social determinants of health (SDOH) codes describe social problems/conditions/risk factors impacting health and may alter the CPT® Level of E&M service (LEOS) and some codes are CCs and increase the ICD-10-CM SOI.

While some SDOHs may be recorded by other clinicians, social workers, community health workers, case managers, or nurses, all must be signed off by the physician. Some SDH codes are applied without documentation of an obvious risk (food insecurity, homelessness), while others (lives alone) require additional documentation to explain the risk or unmet patient need.

SDOHs include problems related to
 Education and literacy [Z55]
 Employment and unemployment [Z56]
 Occupational exposure to risk factors [Z57]
 Physical environment [Z58]
 Housing and economic circumstances [Z59]
 Social environment [Z60]
 Upbringing [Z62]
 Primary support group, including family circumstances [Z63]
 Psychosocial circumstances [Z64- Z65]

215. **Spontaneous & traumatic conditions**

	<p>Some conditions are unique in that they may occur spontaneously, because of medical/surgical care, or related to trauma. The ICD-10-CM codes for these different <u>Types</u> of the same condition often have different severity of illness values.</p>
ALL SET DOC?	<p><u>Laterality & Site</u> <u>Etiology</u> of the condition <u>Type:</u></p>

ALL
SET
DOC?

Non-traumatic/spontaneous/pathologic/fragility
 Medical/surgical care complication, document details
 Traumatic: include a 7th character encounter

Diagnosis:

'Pathological fracture right...'

'Traumatic fx R...'

'Spontaneous pneumothorax left...'

'L pneumothorax during subclavian line insertion'

Occurrence: Details about the trauma or medical care will assist in the selection of the appropriate code

Comorbid Conditions: Cancer, COPD, traumatic injuries

Complications: Additional documentation details should be linked to the complication

Notes

Spontaneous & Traumatic Conditions

Spontaneous	SOI	Traumatic/Medical Care Complication		
		SOI		
M79.A-	C -	T79.A-	C H	Compartment syndrome
K03.81	- -	S02.5	C -	Cracked tooth
M84	C /	S-T	/ /	Fractures
M80	C H	[]		Fractures w osteoporosis
Multiple	/ /	S-T	/ /	Hematoma
				Intervertebral disc displacement/rupture
M50.2	- -	S13.0	C -	Cervical
M51.2	- -	S(2/3)3.0	- -	Thoracic-LS
I61.4	M H	S06.36-	M H	Intracerebral hemorrhage
I62.9	C H	S06.9-	/ H	Intracranial hemorrhage
				Muscle
M79.81	- -	S00-S99	/ /	Hematoma
M62.2	- -	T79.6	- H	Ischemic infarction
M62.1	- -	S-T	/ /	Rupture
M62.0	- -	S-T	/ /	Separation
K63.1	M -	S36.5/6-	/ -	Perforation of intestine
		S36.4-	C -	Perforation small intestine
Multiple	/ /	S27.0	C -	Pneumothorax
B51.0	- -			Ruptured spleen d/t malaria
D73.5	C -	S36.09	C -	Ruptured spleen
Multiple	/ /	S-T	/ /	Shock see above*
M93.-	- -	S-T	/ /	Slipped epiphysis
M66.-	- -	S-T	/ /	Tendon rupture

Spontaneous & traumatic conditions continued

Notes Complications of medical care share codes with the corresponding traumatic conditions [S-T]. Documented details of care-related-complications permit additional codes [Y62-Y84] to be added to the trauma code.

When the condition is spontaneous, codes from non-trauma sections of ICD-10-CM apply.

As seen in the table above, the same condition often has a different severity of illness depending on the Type.

Coders may NOT presume, no matter how obvious it is, that these conditions are traumatic, physicians must document it.

Which came first, the trauma or the condition, may not be known for certain. For instance, take an MVC victim with an intracranial hemorrhage. Did the crash cause the hemorrhage or did a bleed cause the crash? The physician is expected to render a clinical opinion about which is most likely.

Guessing may be easy, as in the case of the 17-year-old driver, BAL over 240 [Y90.8], speeding >100 MPH (traumatic); or the 75-year-old driver, BAL=0, history of a previous CVA with no residual, on an anticoagulant for AF (nontraumatic).

At other times, guessing will be more difficult, as in the 17-year-old driver with no alcohol or drugs in his blood who was traveling the speed limit or the healthy 75-year-old driver with no alcohol in the blood, who takes no medication.

Since traumatic codes are different from non-traumatic ones, physicians must document which one is suspected, so an accurate code can be applied.

216. **STEMI** [I21-](/){} See myocardial infarction for additional details.

Acuity:

Acute: < 4 weeks

Subsequent: < 4 weeks since previous

Old: > 4 weeks

**ALL
SET
DOC?**

Laterality & Site of vessel involved

Site of wall involved

Etiology Coronary artery disease leading to a thrombosis

Comorbid Conditions

Complications

- Notes** To a coder, a '**STEMI**' is a myocardial infarction from coronary artery disease leading to a thrombosis, a Type1 MI.

Medically a Type2 MI (infarction NOT due to coronary artery disease) could be either a STEMI or a NSTEMI. However, there is only a single code for Type2 MI which includes both STEMI and NSTEMI.

Do NOT document a **Type2 STEMI**, since the coder will have to send you a query asking which is it, a STEMI or a Type2 MI?

-
217. **Stroke:** See CVA
-

218. **Subsequent (CPT®)**

- Notes** This term describes all patient encounters after the single-initial visit for CPT® level of service Evaluation and Management codes for hospital visits, consultations, office visits, etc.
-

219. **Subsequent (ICD-10-CM 7th character encounter)**

Notes i10 talk: ‘Active-treatment’ is done during multiple ‘initial’ encounters. ‘Care-for-routine-healing’ is done at ‘subsequent’ encounters.

There is no medical definition of when ‘active-treatment’ becomes ‘care-for-routing-healing.’ Physicians must determine when encounters become subsequent for each individual patient and condition. Don’t obsess on it; an ED or hospitalized patient is receiving active treatment, hence it’s an initial encounter. All other visits are subsequent.

220. **Syncope [R55]()****Etiology / Type**

Syncope Etiology/Type		
	<u>SOI</u>	
I20.8	- H	Angina
R00.1	- -	Bradycardia
R55	- -	Cardiac
G90.01	- H	Carotid sinus vagal activation
G97.1	- -	Due to spinal (lumbar) puncture
T67.1	- -	Heat
R05	- -	Laryngeal
F48.8	- -	Psychogenic
I45.9	- -	Spens' syndrome (w heart block)
R55	- -	Syncope (near) (pre-)
R05	- -	Tussive
R55	- -	Vaso constriction/pressor/motor/vagal

ALL
SET
DOC?

Diagnosis: ‘syncope due to...’

‘**Syncope** [R55]() *d/t sick sinus syndrome* [I49.5](){}H} *with intermittent complete heart block* [I44.2](C){H}’

Occurrence: Documentation of the symptoms, signs & test results linked to syncope may help determine additional suspected diagnoses

Comorbid Conditions, especially those that might explain the syncope, A. fib, arrhythmias, PHO CVA, etc

Complications: Include all injuries suffered if syncope resulted in a fall.

Notes Syncope: is a sign, NOT a Diagnosis. A suspected Etiology or Comorbid Condition may have a higher SOI than 'syncope'.

221. Tachycardia

Type:

Tachycardia Type		
	SOI	
I47.19	C H	Atrial
I47.19	C H	AV
I47.19	C H	AV re-entrant
O76	- -	Fetal tachycardia complicating L&D
I47.11	C H	Inappropriate sinus tach (IST)
I47.19	C H	Junctional
O36.83	- -	Maternal care for fetal tachycardia
P29.11	- -	Neonatal tachycardia
I47.19	C H	Nodal
I45.89	C -	Nonparoxysmal AV nodal tachycardia
I47.19	C H	Other SVT
I47.29	C H	Other V tach
I47.9	- H	Paroxysmal tachycardia
G90.A	- -	POTS (postural orthostatic tachycardia syndrome)
I47.0	C H	Re-entry ventricular
I49.5	- H	Sick sinus syndrome
R00.0	- -	Sinoauricular tachycardia
R00.0	- -	Sinus tachycardia
I47.10	C H	SVT
A52.06	C -	Syphilitic tachycardia
I49.5	- H	Tachycardia-bradycardia syndrome
		Tachycardia complicating:
000-007, 008.8	- -	Abortion/ectopic/molar pregnancy
O75.4	- -	Obstetric surgery/procedures
I47.21	C H	Torsades de pointes
I47.20	C H	Vtach

ALL
SET
DOC?

Complications: Acute/chronic (non-ischemic) myocardial injury, etc

Notes Although tachycardia is a sign, supraventricular and other named tachycardias diagnoses with a higher SOI.

222. Test results

Test results are coded only when the physician documents them in the Diagnosis section of the record

and indicates their significance. Abnormal labs can be coded when the Greek terms ‘hypo-‘ or ‘hyper’ are used.

223. **Thrombocytopenia****Etiology / Type****Thrombocytopenia Etiology/Type**

**ALL
SET
DOC?**

	<u>SOI</u>	
D82.0	C H	Aldrich-Wiskott syndrome (eczema)
D89.82	- H	Autoimmune lymphoproliferative syndrome [ALPS]
D69.42	C H	Congenital/hereditary thrombocytopenia purpura
D69.59	- -	Dilutional thrombocytopenia
D69.59	- -	Due to blood transfusion
D69.59	- -	Due to drugs
D69.59	- -	Due to extracorporeal circulation of blood
D69.3	C H	Essential/idiopathic
D69.41	- H	Evans syndrome
D69.3	C H	Frank's essential thrombocytopenia
D69.3	C H	Hemorrhagic (thrombocytopenic) purpura
D75.82	- H	Heparin induced thrombocytopenia (HIT)
D69.3	C H	Idiopathic thrombocytopenic purpura
D69.3	C H	Immune thrombocytopenic purpura
036.82-	- -	Maternal care for fetal anemia & thrombocytopenia
		Neonatal due to
P61.0	M -	Exchange transfusion
P61.0	M -	Idiopathic maternal thrombocytopenia
P61.0	M -	Isoimmunization
P61.0	M -	Transient thrombocytopenia
P77.2	M -	Stage2 necrotizing enterocolitis
D69.49	- H	Other primary thrombocytopenia
D69.59	- -	Other secondary thrombocytopenia
D69.59	- -	Platelet alloimmunization
O72.3	- -	Postpartum thrombocytopenia
D69.1	- H	Thrombocytopathy (dystrophic) (granulopenic)
D69.6	- H	Thrombocytopenia, unspecified
D69.3	C H	Tidal platelet dysgenesis
Q87.2	C -	TAR (thrombocytopenia with absent radius)
M31.19	M -	Thrombotic thrombocytopenic purpura

Notes When thrombocytopenia contributes to medical-decision-making, it should be documented in the Diagnosis List as specifically as possible.

When anemia and leukopenia are also present, document them as pancytopenia with the Etiology. When an isolated problem, document the suspected Etiology / Type as illustrated in the table below. SOI and ROM are dependent on these specifics.

224.

TIA (transient ischemic attack) [G45.9](CC){}

Link Diagnosis to symptoms and signs:

'TIA with weakness RUE with trouble speaking for 3 ½ hrs, no current residual'

Diagnosis: Consider alternatives to explain the findings that led to the Diagnosis of TIA. **'On antiplatelet therapy post MI'**

TIA Diagnosis Alternatives

	SOI	
I67.82	C -	(Chronic) cerebral ischemia
I67.81	C -	Acute cerebrovascular insufficiency
G45.3	C -	Amaurosis fugax
G45.1	C -	Carotid artery syndrome (hemispheric)
I63.9	M H	CVA aborted Embolism/narrowing/(complete/partial) obstruction/occlusion/stenosis/thrombosis
I65.-	- H	Precerebral (carotid/basilar/vertebral) artery
I66-	- H	Cerebral (anterior/middle/posterior/cerebellar/ perforating/etc.) artery
G45.2	C -	Multiple/bilat precerebral artery syndromes
P91.0	M -	Neonatal cerebral ischemia
I67.0	M H	Nonruptured dissection of cerebral artery
G45.8	C -	Other cerebral TIA/related syndromes
G45.-	- H	Precerebral artery insufficiency
I67.83	- -	Post reversible encephalopathy syndrome (PRES)
I67.841	C -	Reversible cerebrovascular vasoconstriction S.
I60.7	M	Ruptured cerebral artery
G45.4	C -	Transient global amnesia
H34.0-	C -	Transient retinal artery occlusion
G45.0	C -	Vertebo-basilar artery syndrome

**ALL
SET
DOC?**

Occurrence: Link to imaging findings, especially if they suggest a possible alternative Diagnosis; duration and details of neurologic symptoms and signs; GCS; historian supplying the details of the event.

Comorbid conditions, especially those that may help establish an alternative Diagnosis

'A.fib with suspected embolic event'

'3 weeks post hysterectomy for uterine cancer suspect hypercoagulability' [D68.59](C){H}

Notes

Thoroughly document TIA symptoms and signs, and think about alternatives to a TIA, such as an interrupted CVA/stroke (higher SOI); dissection, embolus, obstruction

occlusion, stenosis, or thrombus without infarction;
migraine.

225. **Tobacco exposure /{}**
**ALL
SET
DOC?**
Type**Type of Tobacco/Nicotine Exposure**

SOI	
P04.2	- - Newborn, in utero
P96.81	- - Newborn, second hand
	- - None
Z77.22	- - Second-hand smoke
Z57.31	- - Second-hand occupational
Multiple / /	Use disorder (see below)
Z72.0	- - Use without dependence

Notes For non-smokers with no smoking history, document '**no tobacco exposure**.' If this information is missing, a query may be generated requesting it be added to the record.

226. **Tobacco/nicotine toxic effect**
**ALL
SET
DOC?**
Etiology + Occurrence**Tobacco/Nicotine Toxic Effect**

SOI	Etiology	Occurrence
T65.22-	Cigarettes	Required for 7th character of code
T60.2X-	Insecticide	Accidental
T65.29-	Tobacco	Intentional self-harm Assault Intent not determined

227. **Tobacco use disorder [F17-](/){}**

None of these phrases have codes [], yet:


Non-smoker
Smoker
X ppd smoker
**ALL
SET
DOC?**
Acuity: Number of years

Link tobacco use to all related suspected diseases

Etiology (substance)

Chewing tobacco

Cigarettes

E-cigarettes

ALL
SET
DOC?

E-cigarettes with hazardous substance
Vaping

Type**Type of Tobacco/Nicotine Use Disorder****SOI**

F17-	- -	Dependence in remission
F17-	- -	Dependence, "uncomplicated"
F17-	C -	Dependence with withdrawal
Z81.2	- -	FH tobacco dependence
	- -	None
O99.33-	- -	Obstetrical O99.33- (T1/2/3, L&D, Puerperium) Other nicotine disorder (document details)
Z87.891	- -	PHO dependence
Z72.0	- -	Use without dependence

Diagnosis examples:

- ‘No tobacco/nicotine exposure’
- ‘Tobacco use without dependence’
- ‘Tobacco dependence’
- ‘Tobacco dependence w withdrawal’
- ‘Tobacco dependence in remission’
- ‘Tobacco dependence obstetrical’

Occurrence:

Document if counseling/surveillance is being done at this visit [Z71.6]

Packs per day should be recorded, for medical reasons even though it doesn’t have a code yet.

Comorbid Conditions: Many conditions require coding of tobacco use, for example:

Medical Conditions Requiring Tobacco Documentation

I20-I22	Angina-MI
I70	Atherosclerosis
	Carcinoma in situ
D00.0	Lip
D02	Middle ear & respiratory system
I60-I69	Cerebrovascular diseases
I25	Chronic ischemic heart disease
K05	Gingivitis & periodontal diseases
I10-I15	Hypertensive diseases
	Malignant neoplasms
C32-C34	Larynx-lung
C00-C14	Lip-pharynx
Z85	PHO malignant neoplasm
C39	Respiratory/intrathoracic organs
H65-H66	Otitis media
J00-J99	Respiratory system diseases
K11-K14	Salivary gland-tongue

Tobacco use disorder continued

Link to Complications: 'With nicotine-induced...'

ALL
SET
DOC?

Complications of Tobacco/Nicotine

	SOI	
Multiple	/ -	Cancer
J44.9	- H	COPD
J44.1	C H	COPD exacerbation
J44.9	- H	COPD w lower respiratory infection
I73.00	- -	Raynaud's wo gangrene
I73.01	C H	Raynaud's w gangrene
/	/ /	Other tobacco related conditions
		Smoker's
J41.0	- H	Bronchitis/cough
K13.24	- -	Mouth/palate/tongue
J31.2	- -	Throat

Notes Tobacco/nicotine use disorder has a low SOI unless it is '**with withdrawal.**' When medication to diminish withdrawal-symptoms is ordered and '**with withdrawal**' is documented, SOI increases.

Tobacco and nicotine-use documentation is required for ALL respiratory [J00-J99], many GI [K00-], and some other diagnoses.

For non-smokers with no smoking history document '**no tobacco exposure.**'

Cannabis [F12-] is not coded to tobacco. It has its own codes (see addiction* above).

228. **Transplants**

**ALL
SET
DOC?**

Type: ALWAYS document this

Type of Transplant

Bone	Heart-lung	Other transplanted tissue
Bone marrow	Kidney	Pancreas
Cornea	Liver	Skin allograft
Intestine	Lung	Skin autograft
Heart	Multiple organ	Stem cell

Occurrence: Current status**Occurrence of Transplant**

SOI		
Z76.82	- -	Awaiting organ transplant
Z48.2-	C H	Encounter for aftercare following organ transplant
Z94-	C H	PHO transplanted organ/tissue
Y83.0	- -	Transplant as the cause of late complication
Z76.82	- -	Transplant candidate
Z98.85	- -	Transplanted organ removed previously
Z95-	- -	Vascular graft

Complications:**Complications of Transplant [T86-]**

Arteriosclerosis	Inflammation
CKD (see notes)	Malignant neoplasm [C80.2]
Failure	Mechanical
Hematopoietic stem cell transplantation-associated thrombotic microangiopathy (HSCT-TMA) [M31.11]	Other Rejection PTLD (Post-transplant lymphoproliferative disorder) [D47.21]
Infection (+suspected organism)	

Notes Kidney transplant patients may have CKD when the transplant does not restore complete kidney function. Therefore, CKD alone is not a transplant complication.

A condition is considered a transplant complication only if the complication affects the function of the transplanted organ. Documentation must identify the complication and its impact on the transplanted organ. If documentation is unclear, the physician must be queried.

Post-transplant lymphoproliferative disease (PTLD) is lymphoid/plasmacytic proliferation due to immunosuppression after solid organ or allogeneic hematopoietic cell transplantation.

PTLD can be Epstein-Barr virus (EBV) positive or negative. EBV PTLD [D47.Z1](CC){H} is an acute, rare, and potentially fatal (non-Hodgkin) lymphoma complicating transplants.

229. **Trauma**

List all injuries, with details, from most to least serious in the H&P, in at least one progress note, and in the Discharge Summary.

**ALL
SET
DOC?**

L laterality and Site

Type: For traumatic conditions that can also happen spontaneously (see above) state '**traumatic**'

Type of Trauma

Abrasion	Burn, thermal	Laceration
Bite	Contusion	Puncture wound
Blister, non-thermal	External constriction	Sprain
Blister, thermal	Foreign body	Strain
Burn, non-thermal	Fracture	

Occurrence: 7th character encounter, initial, subsequent, sequelae

Complications, especially life/limb threatening ones

Complications of Trauma

Acute respiratory failure	Sepsis, severe sepsis, septic shock
Acute blood loss anemia	Shock
Compartment syndrome	SIRS
Rhabdomyolysis	Etc.

230. **Traumatic brain injury (TBI)**

**ALL
SET
DOC?**

L laterality

Site: Changes the code set used and SOI

Sites of Traumatic Brain Injury

Diffuse	Internal carotid artery, intracranial portion
Focal	Other specified intracranial site
Cerebrum	Unspecified
Cerebellum	Intracranial
Brainstem	Brain
Epidural	Head
Extradural	
Subdural	
Subarachnoid	

Etiology: For traumatic brain injuries include the mechanism of injury (blunt trauma, crush, penetrating, etc.).

Type:

Type of TBI		
/	/ /	Non-traumatic brain injuries
P52.4	M H	Intracerebral (nontraumatic) neonatal hemorrhage
P15.8		Other specified birth injuries
S06.-		Traumatic intracranial injury
S06.0X-	/ -	Concussion
S06.1-	M H	Traumatic cerebral edema
S06.2X-	/ H	Diffuse traumatic brain injury (TBI) w LOC
S06.2X0	- H	Diffuse traumatic brain injury (TBI) wo LOC
S06.2X-	/ H	Diffuse axonal brain injury
S06.37-	M H	Cerebellar
P10.1	M H	Cerebral hemorrhage due to birth injury
S06.A1	M H	Traumatic brain compression w herniation
S06.A0	- H	Traumatic brain compression wo herniation
S06.3-	/ H	Focal TBI contusion/laceration/hemorrhage w LOC
S06.3-0	- H	Focal TBI contusion/laceration/hemorrhage wo LOC
S06.4-	M H	Traumatic epidural/extradural hemorrhage
S06.5-	M H	Traumatic subdural hemorrhage
S06.6-	M H	Traumatic subarachnoid hemorrhage
S06.8-	/ H	Other specified intracranial injuries
S06.9	/ H	Unspecified traumatic intracranial/brain/head injury

ALL
SET
DOC?

Diagnosis: include ALL SET DOC? details

Occurrence: These details will affect SOI and COMDM

GCS evaluations [R40.21- to R40.24-];

Without loss of consciousness

Duration of loss of consciousness duration (<30 min, 31 - 59 min, 1 - 5 hr 59 min, 6 - 24 hrs, >24 hrs)

Return to pre-existing conscious level

Without return to pre-existing conscious level

Patient surviving;

Death due to brain injury prior to regaining consciousness

Screening for traumatic brain injury [Z13.850]

PHO traumatic brain injury [Z87.820]

Comorbid Conditions:

Associated open wounds of the head [S01.-], skull fractures [S02.-], other injuries. Diseases causing non-traumatic brain injury.

**ALL
SET
DOC?**

Traumatic brain injury (TBI) continued

Complications:

S06.1X8 Traumatic cerebral edema

Mental disorders d/t physiological conditions [F01-F09]

Dementia

Sequelae of injury

Etc.

- Notes** Although TBI, head injuries, brain injuries, and non-traumatic intracranial problems are hard to document and to code, data from the codes are crucial to current research into the long term impact of traumatic and non-traumatic insults to the brain/head. Be patient as the needed details are refined and documentation requirements evolve.
- Personal history of traumatic brain injury [Z87.820] is not coded when residual conditions persist, rather the sequelae are coded with a TBI code [S06.9]

231. **Trimesters T1, T2, T3**

- Notes** ICD-10-CM obstetrical codes have a temporal (T1, T2, T3, childbirth, puerperium) element, which must be documented each encounter. Trimesters are counted from the first day of the last menstrual period. If weeks of gestation [Z3A] are documented, coders may use weeks to assign the appropriate trimester codes.

T1: < 14 weeks 0 days

T2: 14 weeks 0 days to < 28 weeks 0 days

T3: 28 weeks 0 days until delivery

232. **Tropionin elevation:** See elevated tropionin

233. **Ulcer of skin:** See skin ulcer

Physician's Documentation Prescription 2023

234. **Uncertainty**

**ALL
SET
DOC?**

'Evidence of' **Diagnosis** includes X, Y, Z...

Occurrence:

Inpatients: ICD-10-CM permits other terms, but auditors tend to honor '**suspect**', '**probable**' or '**likely**'.'

Outpatients: Signs and symptoms must be linked to any '**suspected**', '**probable**' or '**likely**' **Diagnosis**

Diagnostic test requisitions: Include clinical information, HPI, symptoms, signs, and test results. Link them to the 'suspected' **Diagnosis** to provide 'clinical correlation' for more accurate test interpretation and appropriate billing information (regardless of the ultimate findings).

Inpatients, outpatients, and requisitions: Documenting '**evidence of ...**' turns a **Diagnosis** into your clinical opinion and permits application of the corresponding ICD-10-CM code, in all situations, without a query.

Notes Document known-diagnoses.

It is acceptable to be uncertain about a diagnosis since there are few 'gold-standards.' Physicians determine treatment based on evidence that takes them from a differential diagnosis to a suspected/probable/likely diagnosis.

Until a diagnosis is "certain", use uncertainty terminology throughout the record (consistency is important, especially to auditors). In the Discharge Diagnosis List ,if a **Diagnosis** is still uncertain, continue to document '**evidence for dx**'.

235. **Unspecified**

Notes It is acceptable to use unspecific diagnoses (**heart failure** or **CHF**) when details are not yet known. As more information, test results, response to treatment, etc. becomes available, **Diagnosis** documentation should become more specific.

Insurers may choose not to pay for an unspecified code, so whenever possible include the details as itemized in

the ALL SET DOC?™ mnemonic. This usually provides enough specificity to support medical necessity and prevent payment denials.

236.

Urosepsis



Urosepsis has no ICD-10-CM code []

Etiology: A suspected organism

Diagnosis:

ALL
SET
DOC?

'Sepsis due to E.coli urinary tract infection'

'Sepsis d/t E.coli UTI'

'UTI' (reserve this for patients who are not sick and only have a UTI and reconsider if admission is really necessary)



When you admit a patient with urosepsis, you have admitted someone with NO Diagnosis.

237.

UTI (urinary tract infection)

Site in the urinary tract where infection is suspected:

Bladder

Kidney

Other

ALL
SET
DOC?

Etiology: (Suspected) organism: use the antibiogram*

'Due to' Foley, suprapubic catheter, GU procedure

Complications:

'Sepsis d/t suspected E.coli UTI'

'Severe sepsis d/t E.coli UTI'

'Septic shock d/t E.coli UTI'



When you admit a patient with a UTI, think about it. Why would you admit someone with a simple UTI? This is the question the auditors will ask.

238. **Vegetative state** [R40.3](CC){HCC}**ALL
SET
DOC?****Etiology**

Non-traumatic: give details

Traumatic

Type

Persistent > 1 month

Permanent vegetative state:

Non-traumatic > 3 months

Traumatic > 1 year

Occurrence

Glasgow Coma/Confusion Scale /{/}

Coma Recovery Scale-Revised (CRS-R) []



Unlike the GCS, the Coma Recovery Scale-Revised (CRS-R) has no ICD-10-CM codes, yet. However, it is a useful tool for tracking progress and determining appropriate level of service.

239.

Ventilator associated pneumonia (VAP) [J95.851](C){H}**ALL SET
DOC?**

Etiology: (Suspected) organism: use the antibiogram*
'VAP due to Pseudomonas'

Notes

A patient may be admitted with one type of pneumonia and develop VAP, both should be documented and coded.

240.

Weeks-of-gestation (WOG) [Z3A](){}**Notes**

Codes from category Z3A are for use only on the maternal record to indicate the weeks of gestation of the pregnancy, if known. Coders may use the weeks to calculate trimesters*.

Include WOG on every OB chart.

241. **Z-codes**

Notes Few Z-codes are designated as a Comorbid Condition In the Medicare DRG system. The ALL SET DOC mnemonic applies to medical-status Z-codes for conditions like amputations, ostomies and transplants.

Z-codes are taking on more importance as CMS proposes to increase their numbers to report patient risk determination in the Hierarchical Condition Category (HCC) system, for patients at increased risk d/t to socioeconomic and other non-medical health determinants. Physicians must master appropriate terminology for application of these codes.

Z-codes: Occurrence = Encounter for Attention to

	<u>SOI</u>	
Z43.0	- H	Tracheostomy
Z43.1	- H	Gastrostomy
Z43.2	- H	Ileostomy
Z43.3	- H	Colostomy
Z43.4	- H	Other artificial openings of digestive tract
Z43.5	- H	Cystostomy
Z43.6	- H	Other artificial openings of urinary tract
Z43.8	- H	Other artificial openings
Z43.9	- H	Unspecified artificial opening

**Z-codes: Occurrence = Encounter for Fitting/Adjustment
of External Prosthetic Device**

SOI: All are HCCs

Laterality:

Site: Arm [Z41-] Eye [Z42-] Other [Z44.8]
 Breast [Z43-] Leg [Z41-]

Type: Complete or partial artificial

9: TERMS TO AVOID

	Term	Why	Alternatives
1.	Acute ischemic stroke (AIS)	No code	See CVA
2.	Admit	Implies inpatient	Inpatient or Observation
3.	Admission orders	Implies inpatient	Initial orders
4.	AMI	Might represent injury or infarction	AMinj & AMinfarc
5.	AMS	It's a sign	'AMS d/t E'
6.	Anemia of chronic disease	No code	'Anemia d/t E'
7.	Bacteremia (in a septic patient)	Lab finding with low SOI	'Septicemia' 'Sepsis' if present
8.	Buckle fracture	No code	See list of fracture <u>Types</u> above
9.	Cachectic	No code	'Cachexia' 'Malnutrition' if present
10.	CAP/HAP	Not specific	Name an organism
11.	Debility	No code	Diagnosis with...describe findings of debility
12.	Deconditioning	No code	See Deconditioning
13.	Delirium	Coding confusion	'Delirium d/t E w...' details of abnormal behavior

Physician's Documentation Prescription 2023

14.	Demented	No code	Dementia, <u>Etiology</u> or describe findings
15.	Distress	It's a sign No code	<i>Describe the distress; a <u>Diagnosis</u> or <u>Etiology</u></i>
	Term	Why	Alternatives
16.	Dysfunction	Often no code Low SOI	Failure if present
17.	Empirical treatment for...	Negates the <u>Diagnosis</u> that follows the term	Just document the <u>Diagnosis</u> as specifically as possible
18.	History of	<u>Diagnosis</u> is not active; it is over & done	Just state the <u>Diagnosis</u> with an <u>Acuity</u>
19.	HIV/AIDS	Separate codes for each	HIV = + test AIDS has disease
20.	Hypertension: Uncontrolled Accelerated Malignant	Each term codes to benign HTN	Hypertensive ' urgency ', ' emergency ' and/or ' crisis '
21.	Insufficiency	Often no code or one with a low SOI	' Failure ' if present
22.	Mass effect	No code	Cerebral edema, herniation
23.	Midline shift	No code	Herniation
24.	Multifactorial	No code	List factors
25.	Post-op	Interpreted to mean 'due to the operation'	Clarify if it is ' After ' or ' due to ' surgery
26.	Sepsis syndrome	No code	' Sepsis '

TERMS TO AVOID

27.	Septicemia	A finding, not a diagnoses	(Severe) sepsis (shock)
28.	Sharp debridement	Medical procedure	'Excisional debridement' if any viable tissue is removed
29.	Shift to R/L	No code	Cerebral edema, herniation

Physician's Documentation Prescription 2023

	Term	Why	Alternatives
30.	SIRS (due to infectious source)	No code	' Sepsis'
31.	Stable (patient or vital signs)	Means unchanging, but is without severity perspective	Give details about the VS or condition (fair, guarded, serious, critical)
32.	Status post (S/P)	Interpreted as 'due to'	' After' ' Following'
33.	Troponinemia Troponin leak Troponin elevation	No code or abnormal lab code	Demand Ischemia, NSTEMI, STEMI, or other suspected-diagnosis (see above)
34.	Type2 NSTEMI	No code	Type2: infarction without CAD NSTEMI; infarction d/t CAD
35.	Type2 STEMI	No code	Type2: infarction without CAD STEMI: infarction d/t CADs
36.	Unresponsive	No code	' Unconscious' codes to coma, include duration of unconsciousness & GCS
37.	Urosepsis	No code	' Septic from a UTI'
38.	Valvular heart failure	No code	See <u>Type</u> of HF
39.	VSS/AF	Often inaccurate	Document normal values

ABOUT THE AUTHOR

In the beginning, there were only words.

Hi, I'm Pam Bensen and I want to give you an idea how I came to write this book that seems so far removed from the path I set out on over seventy years ago. I cannot remember not wanting to be a doctor and made my first diagnosis (appendicitis) at age four; a story my grandmother was fond of telling. My diagnosis might have been accurate, but the treatment, perfume atomized air, was definitely amiss. Thanks to the intervention of a competent surgeon, my first patient survived and the rest, so they say is history.

I entered Woman's Medical College (WMC) in 1966; the year the American Medical Association (AMA) introduced CPT®; a year after Medicare was signed into law; and two years before ICDA-8 was adopted for coding diagnostic data for official United States morbidity and mortality statistics. In keeping with the times, WMC had a physical diagnosis course, which included documentation, and trained me in traditional history and examination record keeping (words only, handwritten, of course).

Sophomore year, I stopped briefly in the ER (it was really one room back then) and fell hopelessly in love, for the second time. My next three years were consumed with learning medicine and devising a plan to train for a lifetime in the often-chaotic world of emergencies. That part of my story is but one among many that culminated in the creation of American medicine's twenty-third specialty, Emergency Medicine.

I completed my home-grown, AMA approved Emergency Medicine residency in 1973 and accepted employment, at St. Mary's Hospital in Lewiston, Maine. With more emergency training than any physician in Maine, legible handwriting and organized medical records, I became a frequent lecturer for the Maine JUA, a physician owned malpractice company. I was charged with explaining to physicians why legible records were important for risk management and quality. I taught my

Physician's Documentation Prescription 2023

colleagues how to create patient charts efficiently using Dr. Larry Weed's newly introduced SOAP note format.

ABOUT THE AUTHOR

Then, the government discovered codes.

By 1983, when Congress mandated that Medicare initiate a money saving Inpatient Prospective Payment System (IPPS), I had become a prominent figure in emergency medicine and was serving as the first woman elected to the American College of Emergency Physicians (ACEP) Board of Directors. That same year, the US government adopted CPT® codes for reporting of physician services for Medicare Part B Benefits.

By 1985, when Medicare implemented the IPPS using ICD-9-CM hospitalization diagnoses codes combined into diagnosis-related groups (DRGs), I had been teaching clinical documentation to Maine physicians for over a decade. As CEO of Emergency Medicine Associates (EMA), a newly formed private practice of emergency physicians, I was acutely aware that payment of physicians depended not on what a physician did, but on the words and thus codes used to report those actions, so I added CPT® code documentation requirements my lectures.

When EMTALA was enacted in 1986, I incorporated other federally mandated medical record components into our ED forms and my documentation presentations. My goal was to help physicians incorporate everything that needed to be documented into a single, complete, coherent medical record. Needless to say, in that pre-computer environment, documentation efficiency became the challenge for emergency physicians, especially when, ten years later, HIPAA heaped on additional legal nuances.

In 1999, I accepted a half-time position reviewing inpatient admission records and educating the physicians who wrote them how to better document the diagnoses for DRGs, so the hospital could be paid appropriately. In this job, I got to see how subtle improvements to documentation could have a positive impact on the quality of care and the hospital's bottom line. Legibility, organization, brevity, and completeness were the keys to better communication, better care, and accurate payment.

In 2010, with ICD-10-CM on the horizon, I was recruited to develop an e-learning i10 anatomy and physiology course for coders. Coders and CDISs nationwide used my course to prepare for ICD-10-CM and ICD-10-PCS. My research into ICD-10-CM for the course led me to become

Physician's Documentation Prescription 2023

an AHIMA approved ICD-10-CM/PCS trainer; and I spent the next six years traveling the country teaching physicians about i10 documentation.

During 2014, while working intensively with the medical staff of St. Joseph's Medical System in Paterson, NJ, I forged the key ICD-10-CM severity of illness components, as identified in my lectures, into an efficient, simple documentation tool. In the next year, St. Joseph's leadership and staff supported me as we turned my ALL SET DOC?™ mnemonic into a system wide educational program that paved the way for a tranquil transition to i10 implementation. The mnemonic, which simplifies the documentation that impacts severity of illness through ICD-10-CM codes, is now used by thousands of physicians to make their clinical documentation more accurate, specific and easier.

In 2021, for the first time since their 1995 and 1997 Documentation Guidelines were published, the AMA did a major overhaul of CPT® Evaluation & Management (E&M) codes and documentation guidelines. This major revision was implemented in 2023. With streamlined documentation requirements and levels of service based on complexity of medical-decision-making, rather than history, exam, and risk, accurate ICD-10-CM codes will become even more important for physician payment. Payers will now develop software programs to link Diagnosis codes to levels of service to fully automate payment denials.

This book, the culmination of five decades of clinical documentation instruction for physicians, is my attempt to share my knowledge so all American physicians can spend more time doing what we love best, seeing patients. I hope, as you strive to efficiently use your EHR, that you find my documentation prescription useful, so you can accurately represent the severity of illness and complexity of medical-decision-making of your patients. Write it right the first time, avoid time consuming documentation queries, and get paid for thinking as well as doing.

Please send me your comments and ideas, so I can make this book more useful to you.

Sincerely,

Pam Bensen

icd10MD@gmail.com

ABOUT THE AUTHOR

Coming soon

Watch for these adjuncts to the
Physician's Documentation Prescription:
 Physicians Documentation Pearls
 Physician's Documentation Prescription App
 Physician's Documentation Prescription for CDI
 Physician's Documentation Prescription for Residents
 Physician's Query Prescription