# Coding Flipbook

## Resources for providers: Made for you.

We value the relationships we build with our providers. Our goal is to provide you with a precise understanding of ICD-10-CM Codes and Official Coding Guidelines. In addition, we specialize in CMS and HHS Hierarchical Condition Categories (HCCs), documentation and risk adjustment. We offer support and understanding of reporting codes to the highest specificity.
We can provide education on risk adjustment/HCC coding, and we're always available to answer any questions you may have. We know coding is not always easy – it is our job to help.

### Online Resources for Providers:

- HealthAlliance.org
- Provider.HealthAlliance.org/Coding-Counts
- HealthAlliance.org/Resources-for-Professionals
- Informed e-newsletters

CodingCounts@HealthAlliance.org
*Contact us anytime. Let us help you with ICD-10-CM/HCC coding and documentation.*

# Behavioral Disorders

## Important Information and Helpful Coding Tips

### HCC Behavioral Disorders:

- Schizophrenia, major depressive episodes, mania, bipolar disorders, panic disorders, anxiety disorders, psychosis.

### Descriptors to use when documenting behavioral disorders:

- Type: Depressive, manic or bipolar disorder.
- Episode: Single episode or recurrent.
- Status: Identify most recent episode as manic, depressed or mixed.
- Severity: Mild, moderate, severe or with psychotic elements.

### Document self-harm when it occurs or when a sequela is being treated.

### Document when you perform a depression screening, the results and if suicide risk was assessed.

### Document suicidal or homicidal ideation.

### Document the specific treatment plan and the time invested in counseling and coordination of care.

## Examples of Documentation:

- Patient has a long history of persisting recurrent major depression that is currently in remission. Doing well on aripiprazole and bupropion. Patient has good family support. (This is an acceptable way to document: F33.40 Major depressive disorder, recurrent, in remission, unspecified.)
- Patient presents for bipolar disorder and is currently mildly depressed. This condition is managed well on fluoxetine. Continue current treatment plan. (The default code for this documentation would be F31.31 – Bipolar disorder, current episode depressed, mild.)

It's important to use as much specificity as possible. At minimum, include the severity in code selection.

# Active vs. History of Cancer

## Important Information and Helpful Coding Tips

### Active cancer:

- Cancer is present and/or your patient is currently receiving treatment. This includes neo-adjuvant and adjuvant therapy.
- Your patient isn't receiving treatment, but cancer is present (e.g., indolent disease, patient refuses treatment).

### History of cancer:

- There's no current evidence of cancer, and all active and adjuvant treatments have stopped.
- Your patient is receiving a selective estrogen receptor modulatory (SERM) drug as prophylactic treatment when cancer is not present.

### When documenting metastatic disease:

- Include regional lymph nodes as well as any distant solid organ sites.
- Use "to" and "from" in notes to help clarify the origin and site of metastatic disease. For example, "breast cancer with metastasis to the bone."
- Document and code any co-morbidities and complications that are delaying or are exacerbated by treatment for malignancy.

*Tip: Do not document "history of" for cancers that are active/ actively treated.*

| Documentation | Active or History of Cancer |
|---|---|
| Partial response/remission | Active/persisting cancer |
| Complete response/remission | History of cancer (resolved/cured) |
| No evidence of disease | History of cancer (resolved/cured) |
| Progression/no progression of disease | Active/persisting cancer |
| Surveillance | Applies to both active or history of cancer |
| History of | History of cancer (resolved/cured) |
| In remission with in remission cancer. The following cancer types have in remission codes that may be reported: Lymphoma, Multiple myeloma, Malignant immunoproliferative diseases Malignant plasma cell neoplasms, Leukemia | In remission/active/persisting |

# Morbid Obesity and BMI Status

## Important Information and Helpful Coding Tips

Morbid obesity is always clinically significant and should be documented and reported annually.

| Code | Description |
|---|---|
| E66.01 | Morbid (severe) obesity due to excess calories |
| E66.2 | Morbid (severe) obesity with alveolar hypoventilation |
| E66.813 | Obesity, class 3 |

### BMI status:

- BMI can be documented by any clinical staff (e.g., RN, CNA, NP, PA, MD, MA, Dietitian, Technicians).
- BMI can only be used for coding/ abstracting purposes when a provider documents an associated condition such as obesity, morbid obesity or other BMI-related diagnoses in the record.
- Cannot be reported as the primary diagnosis.
- When reporting BMI in pediatric patients, use pediatric BMI codes Z68.51 – Z68.56.
- Do not assign BMI codes during pregnancy. Report ICD-10-CM codes from O99.210 – O99.214, Obesity complicating pregnancy and childbirth, with the specific obesity code from category E66.X.

| Code | Description |
|---|---|
| Z68.41 | Body Mass Index (BMI) 40.0 – 44.9, Adult |
| Z68.42 | Body Mass Index (BMI) 45.0 – 49.9, Adult |
| Z68.43 | Body Mass Index (BMI) 50.0 – 59.9, Adult |
| Z68.44 | Body Mass Index (BMI) 60.0 – 69.9, Adult |
| Z68.45 | Body Mass Index (BMI) 70 or greater, Adult |

# Rheumatoid Arthritis (RA)

## Important Information and Helpful Coding Tips

Rheumatoid arthritis is a chronic autoimmune disease that progresses over time. It's characterized by pain, swelling and inflammation in the joints and surrounding tissues. It can also affect other organs in the body.

### Things to remember when documenting and coding RA:

- Laterality.
- Site.
- Joint vs. organ.
- With rheumatoid factor (seropositive) vs. without rheumatoid factor (seronegative).

### Examples of documentation:

- Patient 1: 89-year-old female referred to rheumatology for shoulder pain and stiffness. The patient has pain and stiffness in multiple joints and complains of swelling in both wrists and hands. This has been going on for many months. The patient is diagnosed with seronegative rheumatoid arthritis affecting multiple joints.

  The correct code for this documentation scenario is: **M06.09 - Rheumatoid arthritis without rheumatoid factor, multiple sites**

- Patient 2: 51-year-old female returns to rheumatology clinic for follow up on seropositive RA of right wrist.

  The correct code for this documentation scenario is: **M05.731 - Rheumatoid arthritis with rheumatoid factor of right wrist without organ or systems involvement**

Notice how in both examples the laterality and site were documented with ease. Be as specific as possible and avoid using unspecified codes. Rheumatoid arthritis documentation must include the word "rheumatoid" – otherwise it will be coded to arthritis.

# Status Coding

## Important Information and Helpful Coding Tips

Status codes are not only informative, but they can also affect your patient's course of treatment and health outcomes. We depend on your help to document and report the following, when applicable, in a face-to-face encounter with your patient at least once every calendar year. A great opportunity to capture these status codes is during an annual physical or wellness check.

Status codes should be used when a circumstance or problem is not currently active, but still influences a patient's health status. For example: Physicians who are not "treating" a patient's existing and healed amputation still consider the amputation when weighing the patient's health status, because the amputation relates to overall health and wellness. The amputation should therefore be documented and coded.

Below are some commonly missed status codes. Keep these in mind when documenting and coding visits:

| Code | Description |
| --- | --- |
| Z21 | Asymptomatic HIV status |
| Z93.0 | Tracheostomy status |
| Z93.1 | Gastrostomy status |
| Z93.2 | Ileostomy status |
| Z93.3 | Colostomy status |
| Z93.4 | Other artificial opening of GI tract |
| Z93.5X | Cystostomy status |
| Z89.43X | Foot amputation status |
| Z89.44X | Ankle amputation status |
| Z89.51X | Below the knee amputation status, unspecified |
| Z89.61X | Above the knee amputation status, unspecified |

Tip: "X" is a placeholder character and is not reflective of a complete code. For accurate code selection, please reference the official ICD-10-CM code set for the current year.

# Sequela Codes

## Important Information and Helpful Coding Tips

For all resolved conditions, you should consider if complications due to the condition remain. There are more than 800 sequela codes used for such circumstances. Sequelae impact the care and decision-making of your patient. Here is a list of common sequela codes:

| Code | Description |
|---|---|
| I69.041 | Monoplegia of lower limb following nontraumatic subarachnoid hemorrhage affecting right dominant side |
| I69.165 | Other paralytic syndrome following nontraumatic intracerebral hemorrhage, bilateral |
| I69.951 | Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side |
| I69.334 | Monoplegia of upper limb following cerebral infarction affecting left nondominant side |
| I69.051 | Hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage affecting right dominant side |
| S14.111S | Complete lesion at C1 level of cervical spinal cord, sequela |

## Examples of Documentation:

- Hemiparesis due to CVA: Mr. Smith uses a walker for stability.
- Delayed wound healing due to protein calorie malnutrition: continue treatment at wound clinic.

# Diabetes with Complications

## Important Information and Helpful Coding Tips

When documenting complicated diabetes conditions, link the etiology (diabetes) with the manifestation (the condition caused by your patient's diabetes), using as many codes as needed to identify your patient's conditions.

- Report the complication using cause and effect language to clearly relate the two conditions.
- Use language such as "due to" or "with" to link conditions.
- When a patient has a common diabetic manifestation that is unrelated to the patient's diabetes, the provider must state the conditions are unrelated.

### Include the following in combination codes:

- Type of diabetes mellitus.
- Body system affected.
- Complications affecting that particular body system.

## Example of Documentation:

Type 2 diabetes mellitus with diabetic chronic kidney disease, stage 3A (E11.22, N18.31)

*Chronic kidney disease, stage 3A due to type 2 diabetes mellitus. Last A1C: 11/8/22 7.2, DUE. Last GFR: 11/8/22 52. Foot exam: 11/8/23, OK. Eye exam: neg in 10/2023. Current medications: Metformin ER 500MG BID, Novolog 70/30, varying doses due to a few low BG readings, esp at night. Hemoglobin A1C 7.8 on 5/15/23. This is an increase from February when it was 7.3. She feels her chronic diarrhea and stress are related to her fluctuating blood sugars.*

## Commonly Missed Codes:

Two of the most commonly underutilized and inadequately supported diabetes mellitus diagnoses codes are:

- Type 2 diabetes mellitus with other circulatory complication (E11.59).
  - Requires circulatory complication to be documented and reported.
  - Example: CAD due to DM type II: continue insulin and Lipitor
- Type 2 diabetes mellitus with other specified complication (E11.69).
  - Requires other specified complication to be documented and reported.
  - Example: Hearing loss due to diabetes – see RD for improved blood sugar control and refer to Hearing Services.

# Diabetes Without Complications

## Important Information and Helpful Coding Tips

All diabetes mellitus code sets include a "without complication" designation. Diabetes mellitus without complications should only be reported when there's no causal relationship between diabetes and another condition such as kidney disease, circulatory disease, neuropathy, etc.

When documenting a condition that could be caused by or related to a patient's diabetes but isn't, the provider should clearly state that the conditions are unrelated. This ensures a clear differentiation between diabetes with and without complications. For example: "Patient has type 2 diabetes managed by insulin. Polyneuropathy due to chemo has recently worsened – will start Gabapentin."

In this scenario, it is clear the polyneuropathy is unrelated to the diabetes, therefore reporting both E11.9 type 2 diabetes mellitus without complications and G62.0 drug induced polyneuropathy would be appropriate instead of E11.42 type 2 diabetes mellitus with diabetic polyneuropathy.

**Codes for diabetes mellitus without complications:**

| Code | Description |
|---|---|
| E08.9 | Diabetes mellitus due to underlying condition without complications |
| E09.9 | Drug or chemical induced diabetes mellitus without complications |
| E10.A0 | Type 1 diabetes mellitus, presymptomatic, unspecified |
| E10.A1 | Type 1 diabetes mellitus, presymptomatic, Stage 1 |
| E10.A2 | Type 1 diabetes mellitus, presymptomatic, Stage 2 |
| E10.9 | Type 1 diabetes mellitus without complications |
| E11.9 | Type 2 diabetes mellitus without complications |
| E13.9 | Other specified diabetes mellitus without complications |

# Chronic Obstructive Pulmonary Disease

## Important Information and Helpful Coding Tips

Ensure all aspects of COPD and asthma are documented in the medical record.

### Document:

- Severity: mild, moderate or severe.
- Acute or chronic respiratory failure:
  - Acute respiratory failure even if it does not require intubation.
  - Chronic respiratory failure for any encounter in which it affects patient care.
  - Hypoxia or hypercapnia/acidosis.
- If pulmonary hypertension is due to COPD.
- Type of asthma with severity:
  - Mild severity and intermittent.
  - Mild severity and persistent.
  - Moderate severity and persistent.
  - Severe severity and persistent.
  - Uncomplicated.
  - With exacerbation.
  - With status asthmaticus.
    - Type: Cough variant
    - Cause: Detergent, inhalation of fumes, allergic/allergy

### Signs and symptoms of COPD or asthma that are separately reportable:

- Hypercapnia.
- Hypoxemia.
- Polycythemia.
- Acute or chronic respiratory failure.
- Dependence on ventilator or supplemental oxygen.
- Tobacco use or dependence.
- Exposure to secondary smoke: workplace, environment, perinatal.
- Type of tobacco in current use: chewing tobacco, cigars, electronic cigarettes, cigarettes, etc.

# Vascular Diseases

## Important Information and Helpful Coding Tips

Avoid using acronyms when discussing peripheral vascular disease.

### Best practices for documenting vascular diseases:

- Identify the specific arterial or venous disorder and site.
- When documenting atherosclerosis, identify:
  - Type of vessel: native or graft.
  - Graft:
    - Autologous.
    - Nonautologous biological.
    - Nonbiological.
  - Laterality: right, left, bilateral.
  - Any complicating factor:
    - Claudication.
    - Rest pain.
    - Ulceration (identify specific site and stage).
    - Gangrene.
  - Use causal language such as "due to" or "secondary to" to link conditions to atherosclerosis.
- When documenting thrombophlebitis:
  - Identify the vessel, laterality, and whether the condition is acute, chronic or resolved.
- Only document "history of DVT" if the thrombosis is completely resolved.
  - Anticoagulants prescribed to prevent recurrence of DVT are an appropriate time to document and report history of DVT.
- Aortic aneurysms that have not been surgically repaired by open graft method should be evaluated and reported annually:
  - Document the site of the aneurysm: valve, root, ascending, descending, abdominal or thoracic.
  - Identify severity:
    - Ectasia or aneurysm.
    - Dissection or infection.

# Specified Heart Arrhythmias

## Important Information and Helpful Coding Tips

### Forms of cardiac arrhythmia:

- Atrial fibrillation (AFib).
- Atrial flutter.
- Sick sinus syndrome (sinoatrial node disease or sinus dysfunction).
- Complete atrioventricular block.
- Re-entry ventricular arrhythmia.
- Ventricular tachycardia.
- Paroxysmal tachycardia.
- Junctional premature depolarization.

### Documentation Tips:

- Identify the type: paroxysmal, permanent, longstanding persistent, chronic or unspecified.
- Do not document "history of SSS" if the patient's heart rate and rhythm continue to be normal/controlled as a result of medication or pacemaker/ICD.
- Do document "history of AFib" if the patient's AFib is resolved and not being treated.
- Do not document atrial fibrillation as "AF." This could be mistaken for: atrial flutter, aortofemoral and numerous other conditions.

# Congestive Heart Failure

## Important Information and Helpful Coding Tips

ICD-10-CM has specific code classifications for heart failure. Documentation should specifically state if CHF is acute, chronic, or acute on chronic. Heart dysfunction and heart failure are not synonymous.

Document "heart failure with systolic or diastolic dysfunction," instead of solely documenting "systolic or diastolic dysfunction."

| Code | Description |
|---|---|
| I50.1 | Left ventricular failure |
| I50.20-I50.23 | Systolic (congestive) heart failure |
| I50.30-I50.33 | Diastolic (congestive) heart failure |
| I50.40-I50.43 | Combined (congestive) heart failure |
| I50.810-I50.814 | Right heart failure |
| I50.82 | Biventricular heart failure |
| I50.83 | High output heart failure |
| I50.84 | End stage heart failure |
| I50.89 | Other heart failure |
| I50.9 | Heart failure, unspecified |

ICD-10-CM assumes a causal relationship between heart failure and hypertension. If hypertension and heart failure coexist, use codes:

| Code | Description |
|---|---|
| I11.0 | Hypertensive heart disease with heart failure |
| I13.0 | Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease |
| I13.2 | Hypertensive heart and chronic kidney disease with heart failure and with stage 5 CKD, or end stage renal disease |

When reporting I11.0, I13.0 or I13.2, use additional codes to identify the type of heart failure (I50.1-I50.9) and the chronic kidney disease stage (when applicable) (N18.1-N18.9).

# Common Coding Errors

## Language Errors

It is important to understand ICD-10-CM coding terminology to ensure the proper code is supported in documentation. Here are some common documentation and coding errors based on terminology selection:

- Uncontrolled ≠ Hyperglycemia.
  - Instead of "Uncontrolled," select and document:
    - Hyperglycemia.
    - Hypoglycemia.
    - Out of control.
    - Inadequately controlled.
    - Poorly controlled.
- Wound ≠ Ulcer.

## Historical Errors

Do not report conditions that are no longer active or that can be described in the following ways:

- History of.
- Cured.
- No evidence of disease.
- Resolved.
- Repaired.
- Treated prophylactically.

## Examples of Coding Errors:

### History of vs. Active

**Documented:** History of breast cancer of left breast - no evidence of disease, continue annual mammograms

**What is reported:** C50.912 - Malignant neoplasm of unspecified site of left female breast

**What documentation actually supports:** Z85.3 - Personal history of malignant neoplasm of breast

### Wound vs. Ulcer

**Documented:** Open wound on left foot, refer to wound clinic for care and further assessment

**What is reported:** L97.529 Non-pressure chronic ulcer of other part of left foot with unspecified severity

**What documentation actually supports:** S91.302A Unspecified open wound, left foot, initial encounter

### Uncontrolled vs. Hyperglycemia

**Documented:** Uncontrolled diabetes, increase Insulin and referral to RD

**What is reported:** E11.65 DM II with hyperglycemia

**What documentation actually supports:** E11.9 DM II, uncomplicated

# Specificity

## Always provide complete and detailed documentation.

Document and code to the highest degree of specificity to accurately reflect your patient's conditions. This also ensures your patients get the care they need. Below are some examples of common specificity errors. Documentation that is not reflective of code selection can have many negative impacts.

### Error example #1:

**Documented:** Depression taking Celexa

**What is reported on the claim:** F33.41 - Major depressive disorder, recurrent, in partial remission

**What documentation actually supports:** F32.A Depression, unspecified

### Error example #2:

**Documented:** CKD follow up with Nephrology

**What is reported on the claim:** N18.4 - Chronic kidney disease, stage 4

**What documentation actually supports:** N18.9 - Chronic kidney disease, unspecified

### Sample of HCC Model:

Specificity impacts the proper Hierarchical Condition Category.

- Chronic kidney disease, unspecified, stage 1, stage 2 (No HCC)
- Chronic kidney disease, stage 3a or 3 unspecified (HCC 329)
- Chronic kidney disease, stage 3b (HCC 328)
- Chronic kidney disease, stage 4 (HCC 327)
- Chronic kidney disease, stage 5 or ESRD (HCC 326)
- Acute kidney failure, unspecified (No HCC)
- Dependence on renal dialysis (No HCC)

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