Documentation best practices

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Medicare Advantage

Disclaimer

- This training is based on coding guidelines from the Official ICD-10-CM Coding Guidelines, American Hospital Association's (AHA) Coding Clinic, and/or CMS guidance and guidelines.

- The ICD-10-CM code set is updated annually. Coding requirements and standards are subject to change, potentially impacting the accuracy of the content contained within this presentation. The individuals assigning ICD-10-CM codes are reminded to verify the accuracy, specificity, currency, and acceptability of such codes, coding methods, and supporting documentation requirements by referencing official sources with up-to-date information. This guidance is not intended to replace the provider's independent clinical judgment and expertise.

- The contents included in this presentation are for informational purposes only. We do not guarantee that the information supplied is without defect. Every attempt has been made to ensure its accuracy, completeness, and relevance. Do not copy (in any form) without our written consent.

- Coding is dependent on accurate and complete documentation in addition to diagnostic practices of providers. Providers are responsible for the accuracy of their medical record documentation. The documentation recommendations in this training are based on the official requirements for correct code assignment per the aforementioned guidelines and are not clinical guidelines. ICD-10-CM codes are the alphanumerical representation of the diseases/conditions that the provider diagnoses and substantiates in the patient's medical record.

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Agenda

1. Documentation best practices
2. Condition-specific documentation and coding guidance for common conditions
   - Dementia
   - Major depressive disorder
   - Bipolar disorder
   - Schizophrenia
   - Atherosclerotic heart disease and angina pectoris
   - Cardiac arrhythmias
   - Congestive heart failure
   - Vascular diseases
   - Chronic obstructive pulmonary disease and other respiratory diseases
   - Rheumatoid arthritis
   - Chronic kidney disease
   - Status conditions

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Documentation best practices

- **Document at least once a year:**
  - Chronic conditions (such as congestive heart failure [CHF], chronic obstructive pulmonary disease, and diabetes mellitus) that require ongoing treatment and monitoring.
  - Active status conditions (such as amputations and ostomies, congenital, or acquired absence conditions).
  - Historic conditions that may no longer exist yet have the potential for reoccurrence requiring continued monitoring.
  - All conditions that impact patient care, treatment, and/or management.

- **Be specific. For example:**
  - Include the recurrence and severity of major depression.
  - Include whether bronchitis is acute or chronic:
    - Specify type, severity and frequency of asthma.
  - Include acuity, such as acute, chronic, or acute or chronic CHF:
    - Include chronicity and type of congestive heart failure (such as systolic heart failure or heart failure with reduced ejection fraction [HFrEF], diastolic heart failure or heart failure with preserved ejection fraction [HFpEF], chronic congestive heart failure).
  - Specify the cardiac arrhythmia such as atrial fibrillation or atrial flutter.

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Documentation best practices (cont.)

- **Use words to describe the status of conditions:**
  - For example, *Hypertensive heart disease with heart failure is stable*.

- **Only use the words *history of* or *resolved* to describe conditions that no longer exist. Be mindful of the timing, especially of acute conditions. For example:**
  - Document *history of myocardial infarction (MI)* instead of *MI* after four weeks or 28 days post-onset.
  - Document *history of malignant neoplasm* after all treatment is complete.
  - Document *history of transient ischemic attack (TIA*) or *history of cerebral infarction* and whether the patient has any residual deficits, instead of *cerebral vascular attack (CVA),* after the patient leaves the hospital and is seen in follow-up.

- **Medications may suggest the presence of a condition, but a diagnosis cannot be assumed based on medications:**
  - Make sure that for every medication prescribed, a diagnosis is listed and addressed in the medical record while specifying for which condition the medication is being prescribed.

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Dementia

Documentation guidelines:

- When documenting dementia, include type, underlying conditions, and the presence of behavioral disturbance:
  - **Types of dementia:** Alzheimer's disease, vascular dementia, Lewy body dementia, frontotemporal dementia, mixed dementia
  - **Underlying conditions:** Alzheimer's disease, multi-infarct, Parkinson's disease, alcohol
  - **Behavioral disturbances:** agitation, anxiety, mood disturbance, combativeness, wandering
- Also, specify severity of dementia:
  - **Mild:** Clearly evident functional impact on daily life, affecting mainly instrumental activities. No longer fully independent — requires occasional assistance with daily life activities.
  - **Moderate:** Extensive functional impact on daily life with impairment in basic activities. No longer independent and requires frequent assistance with daily life activities.
  - **Severe:** Clinical interview may not be possible. Complete dependency due to severe functional impact on daily life with impairment in basic activities, including basic self-care.

Coding guidelines:

- Diagnosis code assignment for dementia depends on the type of dementia, underlying conditions, associated conditions, and whether or not the patient has behavioral disturbances.
- When dementia is the result of another condition, the underlying condition is reported first with code F02.8-, dementia in other diseases classified elsewhere with or without behavioral disturbance, reported as a secondary code.
- ICD-10-CM contains guidance for the use of an additional code, Z91.83, to identify wandering in dementia, if applicable.

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Dementia (cont.)

Dementia *Note: List is not inclusive.	
ICD -10 Code	**Diagnosis code description**
F01.50	Vascular dementia without behavioral disturbance
F02.80	Dementia in other diseases classified elsewhere without behavioral disturbance
F03.90	Unspecified dementia without behavioral disturbance
G30.1	Alzheimer's disease with late onset
G30.9	Alzheimer's disease, unspecified
G31.1	Senile degeneration of brain, not elsewhere classified
G31.9	Degenerative disease of nervous system, unspecified

Documentation and coding scenario

Documentation scenario:
Patient with Parkinson's disease was brought in by family following episodes of agitation and combativeness. They were recently evaluated by neurology and diagnosed with Parkinson's dementia. Based on a phone consultation with neurology, the patient was started on a low dose antipsychotic at bedtime with plans for follow-up.

Coding for scenario:

- Parkinson's disease [G20],
- Dementia with behavioral disturbance [F02.81]

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Major depressive disorder

Documentation guidelines:

- When documenting major depressive disorder, include type, underlying conditions, and the presence of behavioral disturbance:
  - Severity, such as mild, moderate, or severe
  - Presence of psychotic features
  - Remission status, if applicable, such as partial or full
  - Treatment plan

Severity:

- **Mild:** is specified when "Few if any, symptoms in excess of those required to make the diagnosis are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning."
- **Moderate**: The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for *mild* and *severe.*
- **Severe Depression** is specified when "the number of symptoms is substantially in excess of that required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.

DSM-5-TR criteria for major depressive disorder:

- Depressed mood or loss of interest or pleasure in daily activities for more than two weeks
- Mood represents a change from a person's baseline
- Impaired functioning: social, occupational, educational

I. Five or more of the following symptoms have been present during the same two-week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure:
   A. Depressed mood or irritable most of the day
   B. Loss of interest or pleasure
   C. Weight loss or weight gain (5%) or change in appetite
   D. Insomnia or hypersomnia
   E. Fatigue or loss of energy
   F. Psychomotor agitation or retardation
   G. Decreased ability to concentrate, think or make decisions
   H. Thoughts of worthlessness or excessive or inappropriate guilt
   I. Recurrent thoughts of death, or suicide attempt or has suicide plan

II. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

III. The episode is not attributable to the physiological effects of substance or another medical condition.

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Major depressive disorder

Coding guidelines:

- F32 – Major Depressive Disorder – Single episode:
  - A single episode of MDD lasts a minimum of two weeks with persistent symptoms throughout the day.
  - An individual can only have one single depressive episode during their lifetime.
- F33 – Major Depressive Disorder – Recurrent episode:
  - For an episode to be considered recurrent, there must be an interval of at least two consecutive months between separate episodes in which criteria are not met for a major depressive episode.

Documentation scenario
A patient with recurrent major depressive disorder comes in for a follow-up visit. The patient reports a persistent depressed mood and scored 12 on the PHQ-9. Based on the reported symptoms and associated PHQ-9 score, a moderate level of depression is indicated. The patient will be referred to psychiatry for medication adjustment.

Coding for scenario 1:
Major depressive disorder, recurrent, moderate [F33.1]

Major depressive disorder
*Note: List is not inclusive.

ICD -10 -Code	Diagnosis code description
	Major depression (single episode)
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.3	Major depressive disorder, single episode, severe with psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
	Major depression disorder (recurrent episode)
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.3	Major depressive disorder, recurrent, severe with psychotic symptoms
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.9	Major depressive disorder, recurrent, unspecified

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Bipolar disorder

Documentation guidelines:

- When documenting bipolar disorder, include:
  - Type, such as type I or type II.
  - Current episode, such as hypomanic, manic, depressed, or mixed.
  - Severity, such as mild, moderate, or severe.
  - Presence of psychotic feature.
  - Remission status, such as partial or full.

Always document ongoing treatment for bipolar disorder including antipsychotic medications, psychotherapy, and electroconvulsive therapy (ECT). Also document any recent hospitalization for inpatient treatment of these disorders.

Coding guidelines:

When MDD and bipolar disorder are documented concurrently within an encounter, ICD-10-CM requires the assignment of bipolar disorder alone. The ICD-10-CM code set contains an Excludes 1 note at F31.-, Bipolar disorder, indicating that bipolar disorder and major depressive disorder cannot be reported together.

Documentation and coding scenario

Documentation scenario
Patient recently discharged from the inpatient psychiatric unit comes in for a follow up visit. They have bipolar I disorder and were hospitalized for five days for a manic episode. They are now in full remission and report no manic nor depressive symptoms. They were instructed to continue their current antipsychotic medication regimen.

Coding for scenario:
- Bipolar disorder, in full remission, most recent episode manic [F31.74]

Bipolar disorder
*Note: List is not inclusive.

ICD -10 -Code	Diagnosis code description
F25.0	Schizoaffective disorder, bipolar type
F31.30	Bipolar disorder, current episode depressed, mild or moderate severity, unsp.
F31.4	Bipolar disorder, current episode depressed, severe, without psychotic features
F31.76	Bipolar disorder, in full remission, most recent episode depressed
F31.81	Bipolar II disorder
F31.9	Bipolar disorder, unspecified

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Schizophrenia

Documentation guidelines:

- When documenting schizophrenia, include type if known:
  - Paranoid, disorganized, catatonic, residual, or undifferentiated schizophrenia
  - Schizophreniform disorder

Document any ongoing treatment of mental and behavioral disorders including antipsychotic medications, psychotherapy, and behavioral cognitive therapy. Also document any recent hospitalization for inpatient treatment of mental and behavioral disorders.

Coding guidelines:

American Hospital Association (AHA) Coding Clinic, states that there are currently no ICD-10-CM codes that differentiate between severity or acute exacerbation of schizophrenia. Therefore, if the patient has an acute exacerbation of schizophrenia, assign code F20.9, Schizophrenia unspecified.

Documentation and coding scenario

Documentation scenario:
Patient was brought in by their spouse because they are convinced that the couple living next door are plotting to kidnap him. The patient also reported hearing voices that his spouse could not hear. The patient is known to have paranoid schizophrenia and they decided to cut their medication dose in half because of side effects. The spouse was instructed to resume the medication at the prescribed dose and to follow up with the patient's psychiatrist.

Coding scenario:
- Paranoid schizophrenia [F20.0],
- Under-dosing [T43.596A],
- Patient's noncompliance with medication regimen [Z91.14]

Schizophrenia
*Note: List is not inclusive.

ICD -10 -Code	Diagnosis code description
F20.0	Paranoid schizophrenia
F20.1	Disorganized schizophrenia
F20.2	Catatonic schizophrenia
F20.3	Undifferentiated schizophrenia
F20.5	Residual schizophrenia
F20.9	Schizophrenia, unspecified

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Atherosclerotic heart disease and angina pectoris

Documentation guidelines:

- When documenting atherosclerotic heart disease (ASHD)/coronary artery disease (CAD), include:
  - Native coronary artery or bypass graft:
    - If present, indicate whether the graft(s) is arterial, venous, or synthetic and whether autologous or non-autologous.
  - Affected coronary artery.
  - Native or transplanted heart.
  - Presence or absence of angina pectoris. If present, indicate type of angina pectoris, such as:
    - Unstable angina is an emergent condition and as such, documentation must demonstrate a clinically appropriate treatment plan.
    - With documented spasm if present (prinzmetal angina).
    - Other, for example, stable angina of effort, angina equivalent.
- If a patient has angina as the result of ASHD, the relationship between the two conditions should be documented.

Coding guidelines

- ICD-10 CM combination codes from subcategories I25.11 and I25.7 (ASHD with angina pectoris) should be assigned if the patient has angina as a result of ASHD. A causal relationship between the two conditions can be assumed unless documented as being unrelated or angina is documented as being due to a condition other than atherosclerosis. When one of these combination codes are used, it is not necessary to use an additional code for angina pectoris.
- Documentation must specifically state the type of angina as unstable in order for it to be coded as such.
- Unstable angina is a medical emergency and will, in most cases, be treated in the inpatient setting.

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Atherosclerotic heart disease and angina pectoris (cont.)

Atherosclerotic heart disease and angina pectoris *Note: List is not inclusive.	
ICD -10 -Code	**Diagnosis code description**
	Angina pectoris
I20.0	Unstable angina
I20.8	Other forms of angina pectoris
I20.9	Angina pectoris, unspecified
I24.8	Other forms of acute ischemic heart disease
	Atherosclerotic heart disease
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
I25.118	Atherosclerotic heart disease of native coronary artery with other forms of angina pectoris
I25.119	Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris
I25.708	Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris

Documentation and coding scenarios:

Documentation scenario one:

- Patient with atherosclerotic heart disease, status post stent placement in right coronary artery two weeks ago, comes in for follow-up visit. They report no chest pain or other angina symptoms. Patient takes an aspirin daily.

Coding for scenario one:

- Atherosclerotic heart disease of native coronary artery without angina pectoris [I25.10],
- Presence of coronary angioplasty implant and graft [Z95.5]

Documentation scenario two:

- Patient with coronary artery disease status post coronary artery bypass grafting (CABG) 5 years ago, presents with exertional angina for which they take sublingual nitroglycerin with subsequent relief of symptoms. Recent coronary angiogram showed atherosclerosis and narrowing in two of the patient's saphenous vein grafts.

Coding for scenario two:

- Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris [I25.718]

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Cardiac arrhythmias

Documentation guidelines:

- When documenting cardiac arrhythmias, include:
  - Type of arrhythmia, for example, atrial fibrillation, atrial flutter, supraventricular tachycardia.
  - Chronicity, if known, for example, paroxysmal, persistent, permanent, chronic.
  - Presence of a pacemaker or an automatic implantable cardiac defibrillator (AICD) and the underlying condition necessitating the device.
  - Ongoing treatment, such as rate control, antiarrhythmics, anticoagulants
  - Previous procedures, such as radio-frequency ablation, Watchman device.

- **Ventricular arrhythmias** (ventricular tachycardia and ventricular fibrillation) are acute diagnoses and typically result in cardiac arrest. They should only be documented when the arrhythmia occurs. Patients who have an AICD placed after the initial episode of arrhythmia may have recurrent episodes, at which time the AICD will attempt to shock them back into a normal rhythm.

Coding guidelines

- ICD-10 CM combination codes from subcategories I25.11 and I25.7 (ASHD with angina pectoris) should be assigned if the patient has angina as a result of ASHD. A causal relationship between the two conditions can be assumed unless documented as being unrelated or angina is documented as being due to a condition other than atherosclerosis. When one of these combination codes are used, it is not necessary to use an additional code for angina pectoris.
- Documentation must specifically state the type of angina as unstable in order for it to be coded as such.
- Unstable angina is a medical emergency and will, in most cases, be treated in the inpatient setting.

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Cardiac arrhythmias (cont.)

Coding guidelines:

Per the American Hospital Association (AHA) *Coding Clinic*, notes that although sick sinus syndrome may be controlled with a pacemaker, the condition itself is still considered to be present and reportable as a chronic condition. It would be appropriate to assign a code for sick sinus syndrome and the presence of a cardiac pacemaker when both are documented and supported in the medical record.

Cardiac Arrhythmias *Note: List is not inclusive	
ICD -10 -Code	**Diagnosis code description**
I44.2	Atrioventricular block, complete
I47.1	Supraventricular tachycardia
I47.2	Ventricular tachycardia
I48.0	Paroxysmal atrial fibrillation
I48.19	Other persistent atrial fibrillation
I48.20	Chronic atrial fibrillation, unspecified
I48.21	Permanent atrial fibrillation
I48.91	Unspecified atrial fibrillation
I48.92	Unspecified atrial flutter
I49.5	Sick sinus syndrome

Documentation and coding scenarios:

- **Documentation scenario one**:
  Patient came in for follow up visit with cardiologist. Had a pacemaker placed three months ago for second degree AV block, Mobitz II. Patient denies chest pain or palpitations. EKG shows paced rhythm with rate of 70 beats per minute.
- **Coding for scenario one**:
  - Atrioventricular block, second degree [I44.1],
  - Presence of cardiac pacemaker [Z95.0]
- **Documentation scenario two**:
  Patient seen in the office for atrial fibrillation. They had failed multiple attempts at cardioversion and their atrial fibrillation is now permanent. They are on anticoagulation and their INR was checked this visit and is within the therapeutic range.
- **Coding for scenario two**:
  - Permanent atrial fibrillation [I48.21],
  - Long term (current) use of anticoagulants [Z79.01]

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Congestive heart failure (CHF)

Documentation guidelines:

- When documenting congestive heart failure (CHF), include:
  - Type of heart failure, such as systolic (heart failure with reduced ejection fraction HFrEF), diastolic (Heart failure with preserved ejection fraction HFpEF), or combined systolic and diastolic
  - Acuity, such as acute, chronic, or acute on chronic
  - Underlying causes, for example, hypertension (with or without chronic kidney disease), cardiomyopathy (specify type such as ischemic, dilated, restrictive, etc.), rheumatic, or non-rheumatic valvular disease.

In the outpatient setting, chronic CHF will be the appropriate diagnosis most of the time as acute CHF is a medical emergency typically treated in the inpatient setting.

Treatment for acute congestive heart failure may include intravenous diuretics and nitroglycerin as well as supplemental oxygen.

Coding guidelines

American Hospital Association (AHA) Coding Clinic states, “These terms HFpEF and HFrEF are more contemporary terms that are being more frequently used and can be further described as acute or chronic. Therefore, when the provider has documented HFpEF, HFrEF, or other similar terms noted above, the coder may interpret these as *diastolic heart failure* or *systolic heart failure*, respectively, or a combination of both indicated, and assign the appropriate ICD-10-CM codes.”

The heart failure code range has a *code first* guideline for heart failure due to hypertension (I11.0), heart failure due to hypertension with chronic kidney disease (I13.-), heart failure following surgery (I97.13-), and rheumatic heart failure (I09.81).

Assign combination codes for hypertension with heart failure or hypertensive heart and chronic kidney disease with heart failure when both conditions coexist in the same patient.

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Congestive heart failure (cont.)

Congestive heart failure *Note: List is not inclusive.	
ICD -10 -Code	**Diagnosis code description**
I11.0	Hypertensive heart disease with heart failure
I50.1	Left ventricular failure, unspecified
I50.20	Unspecified systolic (congestive) heart failure
I50.21	Acute systolic (congestive) heart failure
I50.22	Chronic systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.30	Unspecified diastolic (congestive) heart failure
I50.40	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
I50.810	Right heart failure, unspecified
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

Documentation and coding scenario:

Documentation scenario one:
Patient with hypertension, chronic kidney disease stage 3a and chronic diastolic heart failure comes in for a follow-up visit. They complain of persistent swelling of the lower extremities. Their dose of diuretics was increased, and blood was drawn to recheck the patient's GFR.

Coding for scenario one:

- Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease [I13.0]
- Chronic kidney disease, stage 3a [N18.31]
- Chronic diastolic (congestive) heart failure [I50.32]

Documentation scenario two:
Patient presents to the emergency department complaining of gradually worsening shortness of breath, fatigue, and cough productive of frothy sputum. They are known to have chronic systolic congestive heart failure due to ischemic cardiomyopathy. Exam findings and chest x-ray confirm acute congestive heart failure. The patient is given a dose of intravenous diuretics and a cardiology consultation is requested.

Coding for scenario two:

- Acute on chronic systolic (congestive) heart failure [I50.23],
- Ischemic cardiomyopathy [I25.5]

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Vascular diseases

Documentation guidelines:

- When documenting vascular disease, include:
  - Acuity, such as acute or chronic
  - Specify vessels involved, including laterality, for example, stricture of left renal artery, thoracic aortic aneurysm, atherosclerosis of right femoral artery
  - Complications from vascular disease like dissection and aneurysms of blood vessels, skin ulcers, and gangrene
  - Link manifestations to the underlying cause, for example:
    - Intermittent claudication due to peripheral vascular (arterial) disease (PVD/PAD).
    - Rest pain due to atherosclerosis of arteries of left lower extremity .
    - Arterial foot ulcer on right great toe.
  - Link PVD/PAD to diabetes if it is considered an underlying cause.
  - Long-term use of anticoagulants

Vascular diseases
*Note: List is not inclusive.

ICD -10 -Code	Diagnosis code description
I70.0	Atherosclerosis of aorta
I70.1	Atherosclerosis of renal artery
I70.20	Unspecified atherosclerosis of native arteries of extremities
I70.21	Atherosclerosis of native arteries of extremities with intermittent claudication
I70.22	Atherosclerosis of native arteries of extremities with rest pain
I70.23	Atherosclerosis of native arteries of right leg with ulceration
I70.24	Atherosclerosis of native arteries of left leg with ulceration
I70.25	Atherosclerosis of native arteries of other extremities with ulceration
I70.26	Atherosclerosis of native arteries of extremities with gangrene
I73.9	Peripheral vascular disease, unspecified

Documentation and coding scenario

Documentation scenario
Patient came in complaining of pain in the left leg with walking that subsides with rest. They are diagnosed with intermittent claudication and an arterial Doppler study confirms stenosis in the left femoral artery due to atherosclerosis. The patient also has history of abdominal aortic aneurysm resected two years ago and replaced with a graft. They are referred to vascular surgery for management.

Coding for scenario:
- Atherosclerosis of native arteries of extremities with intermittent claudication, left leg [I70.212]
- Personal history of other diseases of the circulatory system [Z86.79]

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Aneurysm/aortic ectasia

Documentation guidelines:

- When documenting aneurysm, include:
  - Document the initial size of the aneurysm, if known, and plans for ongoing monitoring.
  - Specify vessels involved, including laterality, for example, stricture of left renal artery, thoracic aortic aneurysm.
  - Complications from vascular disease like dissection, rupture, and aneurysms of blood vessels.
  - If an aneurysm is resected and replaced with a graft, it is considered resolved and should be documented as *history of aneurysm*.
  - On the other hand, if an aneurysm is treated with an endograft or a stent, it should still be documented as active since the aneurysm is still present.

Aneurysm/Aortic Ectasia

*Note: List is not inclusive.

(Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)

ICD -10 -Code	Diagnosis code description
I71.0-	Dissection of aorta
I71.1-	Thoracic aortic aneurysm, ruptured
I71.2-	Thoracic aortic aneurysm, without rupture
I71.3-	Abdominal aortic aneurysm, ruptured
I71.4-	Abdominal aortic aneurysm, without rupture
I71.5-	Thoracoabdominal aortic aneurysm, ruptured
I71.6-	Thoracoabdominal aortic aneurysm, without rupture
I71.8	Aortic aneurysm of unspecified site, ruptured
I71.9	Aortic aneurysm of unspecified site, without rupture
I77.1	Stricture of artery
I77.810	Thoracic aortic ectasia
I77.811	Abdominal aortic ectasia
I77.812	Thoracoabdominal aortic ectasia
I77.819	Aortic ectasia, unspecified site
I77.9	Disorder of arteries and arterioles, unspecified

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Embolisms/thrombosis

Documentation guidelines:

- When documenting embolism or thrombosis, include:
  - Acuity, such as acute or chronic
  - Documenting “deep venous thrombosis” (DVT) or “pulmonary embolism” (PE) without specifying the chronicity of the condition results in the default assignment of the acute DVT/ PE code. Acute DVT/PE codes are only appropriate to assign when the DVT/PE is first diagnosed, and initial treatment is started.
  - Once treatment is completed, whether a 6- or 9-month course of anticoagulants or insertion of an inferior vena cava filter, “history of” DVT or PE should be documented.
  - Since there is no ICD-10-CM code for “recurrent DVT” or “recurrent PE”, such documentation again results in the default assignment of the corresponding acute codes. Therefore, when a patient is on long term (or life-long) treatment with anticoagulants because of a chronic DVT or chronic PE, these should be documented as such.

Documentation and coding scenario

Documentation scenario
Patient is in the office for a follow-up visit. They have chronic DVT of the right popliteal vein and are on life-long anticoagulation. The patient’s coagulation profile was checked and was within therapeutic range. Their anticoagulant prescription was refilled during the visit.

Coding for scenario:

- Chronic embolism and thrombosis of right popliteal vein [I82.531]
- Long term (current) use of anticoagulants [Z79.01]

Embolisms/thrombosis
*Note: List is not inclusive.
(Note: A dash (-) indicates that additional character(s) are required for valid code assignment.)

ICD -10 -Code	Diagnosis code description
I26.09	Other pulmonary embolism with acute cor pulmonale
I26.99	Other pulmonary embolism without acute cor pulmonale
I27.82	Chronic pulmonary embolism
I82.4-	Acute embolism and thrombosis of deep veins of lower extremity
I82.5-	Chronic embolism and thrombosis of deep veins of lower extremity
I82.6-	Acute embolism and thrombosis of veins of upper extremity
I82.7-	Chronic embolism and thrombosis of veins of upper extremity
I82.8-	Embolism and thrombosis of other specified veins

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COPD and other respiratory diseases

Documentation guidelines:

- When documenting COPD and other respiratory diseases, include:
  - Subtype of COPD, if known (for example, emphysema, chronic bronchitis, chronic obstructive asthma)
  - Associated conditions, for example, bronchiectasis, pulmonary fibrosis, alpha-1 antitrypsin deficiency
  - Tobacco use, dependence, or a history of tobacco use or exposure to second-hand tobacco smoke
  - Complications, for example, lower respiratory tract infection, acute or chronic respiratory failure, spontaneous pneumothorax
  - Dependence on supplemental oxygen or mechanical ventilation

Acute exacerbations of COPD are treated in the inpatient setting most of the time. An acute exacerbation must be documented as such, and if caused by an infection, the type of infection and the causal organism should be documented, in addition to the management and treatment.

Accurate documentation of asthma should include the severity of asthma and describe the frequency, such as, mild intermittent, severe persistent.

Cystic fibrosis, interstitial lung disease, and pulmonary fibrosis are irreversible, life-long conditions that should be evaluated and documented yearly. Documentation should include whether the patient is under the care of a pulmonologist.

Coding guidelines

In ICD-10-CM, category J44 includes combination codes to indicate COPD with acute lower respiratory infection, COPD with (acute) exacerbation, and COPD unspecified. If there is an acute lower respiratory infection, the provider will need to document the type of infection, for example, pneumonia or acute bronchitis for appropriate secondary code assignment. ICD-10-CM coding guidelines state that “an acute exacerbation is not equivalent to an infection superimposed on a chronic condition, though an exacerbation may be triggered by an infection.” ICD-10-CM also has a *Use additional code* instruction for coders to identify tobacco smoke exposure, tobacco use, or dependence.

When COPD and emphysema are documented concurrently within an encounter, ICD-10-CM directs to report only the emphysema as the more specific, obstructive process. When chronic bronchitis and emphysema are documented concurrently within an encounter,
ICD-10-CM requires the assignment of COPD. Chronic bronchitis with emphysema is an inclusion term under the J44 code set.

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COPD and other respiratory diseases (cont.)

Chronic Obstructive pulmonary disease (COPD) *Note: List is not inclusive.	
ICD-10-CM code	**Diagnosis code description**
J41.0	Simple chronic bronchitis
J42	Unspecified chronic bronchitis
J43.9	Emphysema, unspecified
J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified
J45.20	Mild intermittent asthma, uncomplicated
J45.30	Mild persistent asthma, uncomplicated
J45.40	Moderate persistent asthma, uncomplicated
J45.50	Severe persistent asthma, uncomplicated
J45.909	Unspecified asthma, uncomplicated
J47.0	Bronchiectasis with acute lower respiratory infection
J47.1	Bronchiectasis with (acute) exacerbation
J47.9	Bronchiectasis, uncomplicated
J70.9	Respiratory conditions due to unspecified external agent
J84.10	Pulmonary fibrosis, unspecified
J84.9	Interstitial pulmonary disease, unspecified
J99	Respiratory disorders in diseases classified elsewhere

Documentation and coding scenario

Documentation scenario one
Patient with known COPD due to heavy tobacco use in the past presents complaining of a dry cough and low-grade fever for the past 3 days. Denies shortness of breath beyond baseline. Chest x-ray does not show evidence of pneumonia. Patient is diagnosed with acute bronchitis and is sent home with a course of oral antibiotics

Coding scenario one:
- Chronic embolism and thrombosis of right popliteal vein [I82.531]
- Long term (current) use of anticoagulants [Z79.01]

Documentation scenario two:
Patient is in the office for re-evaluation of their COPD. They had a chest CT and pulmonary function test the week prior which confirmed the presence of emphysema. They have been dependent on home oxygen since they were placed on it 6 months ago and today reported no shortness of breath. Their pulse oximetry in the office showed a concentration of 97%.

Coding scenario two:
- Emphysema, unspecified [J43.9]
- Dependence on supplemental oxygen [Z99.81]

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Rheumatoid arthritis

Coding guidelines:

- Rheumatoid arthritis classifies to the categories listed below and is further indexed to juvenile, seronegative, seropositive, and unspecified:
  - Seronegative means the patient does not test positive for rheumatoid factor or anti-cyclic citrullinated peptide (anti-CCP) antibodies. Seronegative ICD-10-CM codes index to category M06.-.
  - Seropositive means the patient does test positive for rheumatoid factor or other antibodies (anti-CCP). Seropositive ICD-10-CM codes index to M05.9.
- Extra-articular involvement of RA can include organs such as the heart, skin, and lungs. In the ICD-10-CM Index under arthritis, rheumatoid, is the linking term “with” for carditis, lung involvement, vasculitis, etc. This directs users to extra-articular conditions; for example, rheumatoid carditis indexes to M05.30.
- Since there is not an ICD-10-CM code for long term current use of immunosuppressants, code Z79.899, Other long term (current) drug therapy, should be assigned to capture the long-term use of immunosuppressants.
- Severe joint pain should not be coded separately as this is a characteristic of rheumatoid arthritis. Also, do not assign codes for an immunocompromised state as immunosuppressants are used for this condition.
- For conditions where one bone, joint, or muscle is involved, such as osteoarthritis, there is a *multiple sites* code available.
  Any time a condition affects more than one anatomic site, for example hand and ankle, and a *multiple sites* option is available within the category, assign the designated *multiple sites* code. When a condition affects a single site, bilaterally, for example, right and left hands, assign each code independently rather than assigning a code for *multiple sites*. A code for multiple sites should be reserved for instances where the condition affects more than one anatomic location.

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Rheumatoid arthritis (cont.)

Documentation guidelines:

- When documenting rheumatoid arthritis, include:
  - Limb(s) and joint(s) involved, including laterality.
  - Positive (seropositive) or negative (seronegative) rheumatoid factor.
  - Type, such as juvenile or adult-onset.
  - Complications, for example, joint destruction and deformities.
  - Organ or system involvement (extra-articular), for example, lung, skin.
  - Severity, such as mild, moderate, or severe.
  - Current status, for example, active or in remission.
- Document any current symptoms of rheumatoid arthritis reported by the patient (joint pain, swelling or stiffness, fatigue, episodes of fever, etc.); associated physical exam findings (such as joint deformity, etc.) and related laboratory or diagnostic imaging test results.
- Referrals to rheumatology and other specialists should be documented, including physical and occupational therapists and orthopedic surgeons.
- Document a specific and concise treatment plan, such as laboratory tests and diagnostic imaging, patient education including self-management, clear link between the rheumatoid arthritis diagnosis and all medications being used to treat the condition.

Documentation guidelines (cont.):

- Document whether the patient is being treated with a disease-modifying anti-rheumatic drug (DMARD). If not on a DMARD, document the reason and list other long-term medications being used such as NSAIDS, opioids, steroids, and immunosuppressants.
- Best documentation practices regarding DMARD therapy include specific details of current DMARD therapy with clear linkage to rheumatoid arthritis, or specific information describing any contraindication to DMARD therapy, or documentation statement of patient refusal of DMARD therapy and the reason for refusal.
- Do not document rheumatoid arthritis as a confirmed condition if it is only suspected and not truly confirmed. Rather, document signs and symptoms in the absence of a confirmed diagnosis.
- If rheumatoid arthritis is a confirmed diagnosis, do not describe it with terms that imply uncertainty (such as *apparently, likely, consistent with, probable*, etc.).
- Rheumatoid arthritis that is in remission should be documented as *in remission* and not as *history of*. *History of* is interpreted as the patient no longer has the condition.

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Rheumatoid arthritis (cont.)

Rheumatoid arthritis *Note: List is not inclusive.	
ICD -10 -Code	**Diagnosis code description**
L40.50	Arthropathic psoriasis, unspecified
M05.79	Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement
M06.4	Inflammatory polyarthropathy
M06.9	Rheumatoid arthritis, unspecified
M32.9	Systemic lupus erythematosus, unspecified
M35.00	Sicca syndrome, unspecified
M46.06	Spinal enthesopathy, lumbar region
M46.1	Sacroiliitis, not elsewhere classified
M46.90	Unspecified inflammatory spondylopathy, site unspecified
M46.96	Unspecified inflammatory spondylopathy, lumbar region

Documentation and coding scenario

Documentation scenario one
Patient recently diagnosed with rheumatoid arthritis came in for a follow-up visit. Patient has joint involvement in both hands, and they tested positive for rheumatoid factor. They are tolerating treatment with methotrexate well and were given a refill today.

Coding scenario one:

- Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems involvement [M05.741],
- Rheumatoid arthritis with rheumatoid factor of left hand without organ or systems involvement [M05.742],
- Other long term (current) drug therapy [Z79.899]

Documentation scenario two
Patient with rheumatoid lung disease comes in complaining of pain in the right shoulder. Examination and imaging findings confirm rheumatoid arthritis involving the right shoulder. The lung disease had been well controlled on DMARD therapy. The patient is referred to rheumatology for possible medication regimen adjustment.

Coding scenario two:

- Rheumatoid lung disease with rheumatoid arthritis of right shoulder [M05.111],
- Other long term (current) drug therapy [Z79.899] .

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Chronic kidney disease (CKD)

Documentation guidelines:

- When documenting CKD, include:
  - Stage of CKD based on estimated glomerular filtration rate (eGFR).
  - Underlying cause, if known, such as diabetes mellitus (DM) or hypertension.
  - Presence of arterio-venous (AV) shunt or other form of intravenous access for dialysis .
  - Whether the patient is on dialysis and if non-compliant with dialysis.
  - History of kidney transplant, if applicable.
- Although kidney function can improve or worsen over time, providers should avoid documenting multiple stages of CKD in the same encounter. The stage of CKD documented should reflect the patient's kidney function at the time of that encounter to the best of the provider's knowledge.
- Once a patient receives a kidney transplant, their end stage renal disease (ESRD) is considered cured and should no longer be documented. Status-post kidney transplant should be documented. If the patient has any residual CKD after the transplant, this should be documented with the current stage.

Documentation guidelines (cont.):

- Document the presence or absence of current symptoms related to CKD (e.g., fatigue, weakness, changes in urine output, etc.), associated physical exam findings (such as elevated blood pressure, edema, weight loss, etc.), related diagnostic test results, and presence of any surgically placed arteriovenous shunt for the purpose of dialysis, along with related exam findings (e.g., presence of a thrill or bruit).

Acute kidney failure
Acute kidney failure (AKF) is an acute/emergent condition that is not likely to be treated in the provider's office or during an in-home assessment; this condition is typically seen in the emergency department (ED) or inpatient (IP) setting.

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Chronic kidney disease (cont.)

Coding guidelines:

- ICD-10-CM classifies the severity of CKD into stages one through five, and ESRD based on estimated glomerular filtration rate (eGFR) values and dialysis treatment.
- The stage of CKD must be explicitly stated in the record to ensure accurate code selection. Code selection cannot be assigned based on documented eGFR by the coder.
- ICD-10-CM assumes a cause-and-effect relationship between CKD and DM and between CKD and hypertension. Assign the appropriate combination code when these diagnoses coexist unless the documentation states one or the other as the underlying cause, or a different underlying cause is documented.
- Per American Hospital Association (AHA) Coding Clinic, if a patient has diabetes, hypertension, and CKD, and the provider documents CKD due to diabetes, assign a code for the diabetic CKD. Do not assign a code for hypertensive CKD; the hypertension would be coded separately.
- Patients who have had a kidney transplant may still have some degree of CKD; therefore, having CKD post-transplant may not constitute a complication of the transplant.
- Per ICD-10-CM guidelines, assign the appropriate N18 code for the patient's CKD stage and code Z94.0, Kidney transplant status. If a complication of the transplant such as failure or rejection occurs, assign a code from category T86.1-.
- Category N17 is for acute kidney failure, which is the sudden interruption of renal function and is typically an emergent condition.
- Chronic kidney disease is a common diabetic complication. For patients who are status post kidney transplant with diabetes and CKD, assign the appropriate N18 code for the patient's CKD stage, E08-E13.22 Diabetes with diabetic kidney disease and code Z94.0, Kidney transplant status.
- Code Z99.2, Dependence on renal dialysis, contains the inclusion phrase of presence of AV shunt for dialysis. Therefore, Z99.2 should be reported when the AV fistula is being used for active dialysis per AHA Coding Clinic.

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Chronic kidney disease (cont.)

Documentation and coding scenario

Documentation scenario one
Patient with CKD stage 3b due to hypertension came in for follow-up visit. Blood pressure is controlled and eGFR is stable at 41 mL/min based on most recent labs.

Coding scenario one:

- Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease [I12.9],
- Chronic kidney disease, stage 3b [N18.32]

Documentation scenario two
Patient with ESRD, on regular hemodialysis three times a week, came into the office complaining of generalized weakness. Their lab results showed a low hemoglobin confirming anemia due to ESRD. They were referred to be evaluated for treatment with erythropoietin injections.

Coding scenario two:

- End stage renal disease [N18.6],
- Anemia in chronic kidney disease [D63.1],
- Dependence on renal dialysis [Z99.2]

Stage	Loss of kidney function	eGFR	ICD-10-CM code
1	Normal to slightly decreased	> 90	N18.1
2	Mild	60-89	N18.2
3a	Mild to Moderate	44-59	N18.31
3b	Moderate to Severe	30-44	N18.32
4	Severe	15-29	N18.4
5	Kidney failure not requiring dialysis	< 15	N18.5
6	End stage renal disease requiring dialysis	< 15	N18.6

Chronic kidney disease (CKD)	
ICD -10 -Code	**Diagnosis code description**
N17.0	Acute kidney failure with tubular necrosis
N17.8	Other acute kidney failure
N17.9	Acute kidney failure, unspecified
N18.30	Chronic kidney disease, stage 3 unspecified
N18.31	Chronic kidney disease, stage 3a
N18.32	Chronic kidney disease, stage 3b
N18.4	Chronic kidney disease, stage 4 (severe)
N18.5	Chronic kidney disease, stage 5
N18.6	End stage renal disease
Z99.2	Dependence on renal dialysis

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Status conditions

Documentation guidelines:

- When documenting, include presence of:
  - Ostomies or artificial openings (such as colostomy, gastrostomy, ileostomy, etc.)
  - Amputation status (such as above knee amputation [AKA], below knee amputation [BKA], feet, toes, arms, hands, etc.)
  - Organ transplant status (such as lung, liver, stem cell, etc.)
  - Heart assists devices/artificial heart (for example, implantable cardioverter defibrillator, pacemaker, ventricular assist device [VAD]).
  - Ventilator status
  - Prosthetic or mechanical devices
  - Congenital defects (for example, congenital heart disease, cleft lip/palate, Down syndrome, spina bifida, club foot, etc.)
  - Sequela or residual of a past disease or condition (such as sensory or visual disturbances, hemiparesis or hemiplegia, hearting loss, cognitive impairment, etc).
  - Dialysis status
  - Body Mass Index (BMI)
  - Long-term use of insulin
  - HIV status

Documentation guidelines (cont.):

- Status codes indicate that a patient is a carrier of a disease, has the sequela or residual of a past disease or condition, or has another factor influencing a person's health status.
- A status condition is distinct from a history code. The history code indicates that the patient no longer has the condition." The status code may or may not affect the course of treatment and its outcome.
- When documenting ostomies or artificial openings, include type, status, and opening condition.
- When documenting amputation status, include limb, laterality, status of stump, and presence of any artificial prosthetic device.
- Presence of arterio-venous (AV) shunt or other form of intravenous access for dialysis, and documentations must include whether the patient is on dialysis and if non-compliant with dialysis.
- When documenting organ transplant status, mention organ, date of transplant to best of your knowledge, and immunosuppressant (anti-rejection) drugs if any.
- When documenting heart assist devices, include type of device, condition being treated with device, and any potential complication as a result of device malfunctioning and treatment plan.

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Status conditions (cont.)

Coding guidelines:

- **Artificial/stoma openings**:
  - Stoma or opening must be documented as currently present in order to code. Documentation of *takedown* or re-anastomosis will be coded as Z98.89 for Other specified post-procedural states.

Coding guidelines (cont.):

- **Amputations status**:
  - Traumatic amputation should only be coded for acute treatment. If the patient had a traumatic amputation of the lower extremity in the past, correct coding would fall under the Z89 category, Acquired absence of limb.

Artificial openings (*Note: List is not inclusive.)

ICD-10-Code	Diagnosis code description
Z93.0	Tracheostomy status
Z93.1	Gastrostomy status
Z93.2	Ileostomy status
Z93.3	Colostomy status
Z93.9	Artificial opening status, unspecified

Amputation status (*Note: List is not inclusive.)

ICD-10-Code	Diagnosis code description
Z89.0	Acquired absence of thumb and other finger(s)
Z89.1	Acquired absence of hand and wrist
Z89.2	Acquired absence of upper limb above wrist
Z89.3	Acquired absence of toe(s), foot, and ankle
Z89.9	Acquired absence of limb, unspecified

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Status conditions (cont.)

Coding guidelines:

- **Organ transplant:**
  - A status code should not be used with a diagnosis code from one of the body system chapters if the diagnosis code includes the information provided by the status code. For example, code Z94.1, Heart transplant status, should not be used with a code from subcategory T86.2, Complications of heart transplant. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

Coding guidelines (cont.):

- **Heart assists devices/artificial heart:**
  - The purpose of a heart assist device (Z95.811) is to help maintain the pumping ability of a heart that cannot effectively work on its own due to end-stage heart failure (for example, ventricular assist device (VAD)). Devices such as implantable cardioverter defibrillator (ICD) (Z95.810) and pacemakers (Z95.0) are for heart rhythm control

Organ transplant status (*Note: List is not inclusive.)

ICD-10-Code	Diagnosis code description
Z94.0	Kidney transplant status
Z94.1	Heart transplant status
Z94.2	Lung transplant status
Z94.3	Heart and lungs transplant status
Z93.9	Transplanted organ and tissue status, unspecified

.Presence of cardiac and vascular implants and grafts
(*Note: List is not inclusive)

ICD-10-Code	Diagnosis code description
Z95.0	Presence of cardiac pacemaker
Z95.810	Presence of automatic (implantable) cardiac defibrillator
Z95.811	Presence of heart assist device
Z95.812	Presence of fully implantable artificial heart
Z95.818	Presence of other cardiac implants and grafts

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Status conditions (cont.)

Coding guidelines (cont.):

- **Ventilator status**
  - Dependence on a respirator, also known as a ventilator, (Z99.11) is when an individual is reliant upon equipment to mechanically assist or replace spontaneous breathing as their breathing is very weak or they are unable to breathe independently. Dependence on supplemental oxygen (Z99.81) should be used if the individual is able to initiate inspirations and exhalations on their own but needs assistance with getting more oxygen into their lungs to breathe easier.
- **Long-term of insulin:**
  - Additional code(s) should be assigned from category Z79 to identify the long-term (current) use of insulin, oral hypoglycemic drugs, or injectable non-insulin antidiabetic, as follows:
    - If the patient is treated with both oral hypoglycemic drugs and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs, should be assigned.

Coding guidelines (cont.):

- If the patient is treated with both oral hypoglycemic drugs and insulin, both code Z79.4, Long term (current) use of insulin, and code Z79.84, Long term (current) use of oral hypoglycemic drugs, should be assigned.
- If the patient is treated with both insulin and an injectable non-insulin antidiabetic drug, assign codes Z79.4, Long term (current) use of insulin, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.
- If the patient is treated with both oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign codes Z79.84, Long term (current) use of oral hypoglycemic drugs, and Z79.85, Long-term (current) use of injectable non-insulin antidiabetic drugs.
- Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient's blood sugar under control during an encounter.

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Status conditions (cont.)

Coding guidelines (cont.):

- **Dialysis status:**
  - Renal dialysis must be documented as currently receiving dialysis in order to code Z99.2 for renal dialysis status.
  - Code Z99.2, Dependence on renal dialysis, contains the inclusion phrase of presence of AV shunt for dialysis. Therefore, Z99.2 should be reported when the AV fistula is being used for active dialysis.
- **Body Mass Index (BMI):**
  - There must documentation of an associated clinical condition, (such as malnutrition, cachexia, anorexia, overweight, obesity, morbid obesity, etc.) to justify reporting a secondary BMI code (Z86.-)

BMI

*Note: A Dash (-) indicates that additional character(s) are required for a valid code assignment

ICD -10 -Code	Diagnosis code description
Z68.1	BMI less than 20
Z68.2-	BMI 20.0 – 29.9
Z68.3-	BMI 30.0 – 39.9
Z68.4-	BMI above 40

Coding guidelines (cont.)

- **HIV status:**
  - Z21, Asymptomatic human immunodeficiency virus [HIV] infection status, is to be applied when the patient without any documentation of symptoms is listed as being "HIV positive;' "known HIV;' "HIV test positive:' or similar terminology.
  - Do not use these codes if the term "AIDS" is used, if the patient is treated for any HIV- related illness,or is described as having any condition(s) resulting from his/her HIV positive status; use B20 in these cases.
  - Patients previously diagnosed with any HIV illness (B20) should never be assigned to R75 or Z21, Asymptomatic human immunodeficiency virus [HIV] infection status.

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