ICD 10- Documentation
Suggestions for Hospitalists:
Draft-v10  6/25/2018 based on ICD-10 CM BY2018 update
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- Clinical Documentation Improvement Specialists

Suggestions collected from ACP Hospitalist Coding Corner, and ICD 10 CM report. The purpose of ICD 10 is to document the severity of illness of your patient!!!!

Incorporating these principles into your clinical documentation could potentially translate to a more accurate reflection of the patient’s severity of illness and movement of the Veteran into a higher priced allocation class.

The principal diagnosis is defined as the condition established after study to be chiefly responsible for admission of the patient to the hospital for care. This could potentially impact the veteran’s funding class as well as the DRG affecting the allotted length of stay.

Example:

A patient is admitted because of chronic cough, difficulty with breathing, and malaise; a bronchoscopy with biopsy is performed for a lung mass. The lung mass is confirmed to be adenocarcinoma of the lung. In this case, the lung adenocarcinoma is the principal diagnosis because, after study, it was determined to be the underlying cause of the patient’s malaise and respiratory symptoms as well as the reason for admission.

Each diagnosis must show that a provider is Monitoring, Evaluating, Assessing or Treating the condition.

If a condition is:

**Monitored:** Signs, symptoms, disease progress and/or disease regression.

**Evaluated:** Test results response to treatment, mediation effectiveness, positive lab results, the significance of the results of biopsies obtained during the admission must be addended to the record.

**Assessed/Addressed:** Ordering tests, discussion, review records, counseling.

**Treated:** Medications, therapies, other forms of treatment.
If any of the above listed functions are performed on the patient during the current hospital encounter the condition warrants ICD-10-CM code assignment. The provider must document a diagnosis on the condition being monitored, evaluated, assessed or treated for ICD-10-CM code assignment.

- **Suggested terminology:**
  - **Document all conditions that are currently being treated, monitored or evaluated in the present tense.** For example, “Patient presents with” compensated HFpEF and acute osteomyelitis of the right thumb,” instead “patient with a past medical history of HFpEF and osteomyelitis.”

  - **Probably and likely due to:** can be billed as if the condition exists

  - **Possibly, suspected, questionable, consistent with, appears to be, ruled out (R/O) diagnosis:** should be coded for the condition as if the condition exists however maybe coded as a symptom code per the ABQVA coders. However, per VISN 10 they should all be coded as if the condition exists.

  - **Rule out** means that the diagnosis has been eliminated as a possibility and it will not be assigned as an ICD-10 CM code.

  - Again, try to link your conditions with words like “Due to, likely due to, because of, Secondary to, associated with, and, with”. All acceptable words when you are treating a condition like it exist.

  - Example “Small cell lung carcinoma with acute respiratory failure” or “Acute nose bleed due to chronic lymphocytic leukemia with thrombocytopenia”

- **Be specific:** Left or Right, Acute or Chronic, etc.
- **Use the word “Acute” whenever appropriate otherwise it will be assumed chronic.
- **Avoid use of symptom words like “dizzy, fainting” or “chest pain.” Use diagnostic language whenever possible.
- **MCC= major complication or comorbidity**
- **CC= complication or comorbidity**
- **MCC and CC list available at e-medtools.com**
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Sepsis:

**SIRS CRITERIA:** (≥ 2 meets definition)
- Temp >38ºC (100.4ºF) or <36ºC (96.8ºF)
- HR > 90
- Resp rate > 20
- WBC >12k, <4k, or >10% bands
- Anion gap > 12

Definitions:

**Bacteremia** (positive blood cx only). This is a lab finding only. Better to use the below terms.

**Sepsis:** SIRS + infection (document suspected or known source of infection)

**Severe Sepsis:** Above + acute organ dysfunction, hypotension, hypo-perfusion (lactic acidosis, SBP<90, or SBP drop of 40mm Hg from normal). Must document the organ affected and associate with the severe sepsis (respiratory failure, encephalopathy, AKI).

**Septic Shock:** severe sepsis with hypotension unresponsive to 2L IVF or IV vasoactive agents

**Multi-organ Dysfunction Syndrome:** above with evidence of failure in ≥ 2 organ systems

- **Example:** “Sepsis due to UTI”. “Severe sepsis due to gram positive bacteria”. “Pneumonia with streptococcal sepsis”. DO NOT use UROSEPSIS!!!

- **You do not need positive blood cx to document sepsis.**

- Document a possible organism. Identify an organism you suspect may be associated with the sepsis.

- Always document associated diagnosis/conditions and complications

qSOFA: RR≥22/min, altered mental status, SBP ≤ 100mmHg. Score ≥2 indicates organ dysfunction.

SOFA and qSOFA not in ICD 10 for FY2018
**MRSA:**
- Must state “MRSA infection”
- Document severity of illness as listed above
- Document if any associated diagnosis or conditions also present (e.g. septic emboli, infective endocarditis, or pneumonia)

**MSSA:**
- Must state “MSSA infection”
- Document severity of illness as listed above
- Document if any associated diagnosis or conditions also present (e.g. septic emboli, infective endocarditis, or pneumonia)

**Rhabdomyolysis:**
- 3 categories:
  - **Traumatic or Muscle compression:** Crush syndromes from something like auto accident, fall, etc, or long lasting muscle compression like prolonged immobilization due to a fall (lying on the floor for long period of time)
  - **Nontraumatic Exertional:** marked exertion in untrained individuals, hyperthermia or metabolic myopathies
  - **Nontraumatic Nonexertional:** drugs, toxins, infections or electrolyte disorders.
Respiratory Failure:

**Suggested Words:** Acute (MCC) or Chronic (CC), Acute on Chronic, and type of respiratory failure (hypercapnic or hypoxic).

**Document:** use of tobacco (use or abuse)

The following terms are symptom codes: Severe dyspnea, respiratory distress, respiratory insufficiency, hypoxemia.

**Definition:**

**Chronic respiratory failure:** combination of hypoxemia, hypercapnia and hypercarbia (retention of bicarb). pH levels will be normal (7.35-7.45). Treatment includes supplemental O2. Chronic hypoxia = PaO2 < 60mm Hg (or SaO2 < 91%) on RA. Chronic hypercapnic PaCO2 > 50 mmHg.

- Need to document chronic respiratory failure, even if due to COPD BECAUSE:
  - This helps code the severity of your patient’s illness
  - It is a minor comorbid condition (CC), which may impact the DRG and the patient’s allotted length of stay.
  - If chronic respiratory failure is present in a Veteran with acute respiratory failure, this may place the Veteran at a higher priced allocation group.

**Acute respiratory failure** is a major comorbidity condition (MCC).

Defined as one of the following in setting of SOB:

- \( \text{pO}_2 < 60 \text{ mm Hg or SpO}_2 < 91\% \) breathing room air
- \( \text{pCO}_2 > 50 \) and \( \text{pH} < 7.35 \)
- \( \text{P/F ratio (pO}_2 / \text{FIO}_2) < 300 \)
- \( \text{pO}_2 \) decrease or \( \text{pCO}_2 \) increase by 10 mm Hg from baseline (if known)

**Hypercapnic respiratory failure** occurs commonly in COPD. Almost always requires an arterial blood gas. Don’t use “respiratory acidosis” unless you also document hypercapnic respiratory failure.

- \( \text{pCO}_2 > 50 \text{ mm Hg with pH} < 7.35, \) or
- Increased \( \text{pCO}_2 \) of 10 mm Hg or more from baseline

**Acute on chronic respiratory failure**

- \( \text{pO}_2 < 60 \text{ mm Hg / SpO}_2 < 91\% \) on usual supplemental oxygen, or
- Increasing dyspnea requiring increase in supplemental oxygen, or
- Either of the hypercapnic criteria above

DOCUMENT HYPOXIA with 02 sat with #L of 02 !!!!!
**Pneumonia**

Pneumonia + Associated Organism: Associate an organism or suspected organism with the pneumonia. For example, “Suspected bacterial pneumonia.” Associating an organism or suspected organism may impact the price class that the patient is placed into for the funding model.

- Example: “HAP probably due to gram-negative organism,” or “HAP likely due to bacterial pneumonia,” or “CAP probably due to bacterial pneumonia.”
- Other examples: “Pneumonia due to streptococcus sepsis”, “Pneumonia with hypovolemic shock”.

**Simple pna** = CAP, HAP, HCAP or nosocomial if no organism is mentioned.

**Complex pna** = in the last 90 days has the patient been:

- In SNF/Rehab facility
- Admitted to the hospital for 2 or more days
- On dialysis, infusion clinic or wound care clinics
- Admitted to ambulatory surgery center
- Concern for aspiration
- Or h/o MRSA

**Suggested words:** Probably and likely due to: can be billed as if the condition exists

- Possibly, suspected, compatible with, consistent with, appears to be, rule out (R/O) diagnosis: all maybe coded for symptoms therefore at a lower level than “probably”.
- Need to mention Xray results. If Xray is negative then need to say something like “CXray unremarkable but pneumonia is suspected by clinical findings”.

**Not Suggested:** “Evidence of,” or “coverage for”.

- Document complications like respiratory failure, sepsis, underlying lung disease.
- **Document tobacco use past or present.**
- **Aspiration pna is a complex pna but coded as “pneumonitis due to inhalation of food or vomitus”**. Risk factors are: elderly, debilitated, nursing home, bed confinement, recent vomiting or NG tube, h/o CVA or neuromuscular dz, impaired swallowing, Etoh abuse, right lower lobe infiltrate.

**DOCUMENT HYPOXIA with 02 sat with #L of 02 !!!!
COPD:
Document the severity with FEV1

Document that it is acute exacerbation or decompensation
- Include association with acute lower respiratory infections and include the organism.

** Document exposure to tobacco including: tobacco smoke, history of tobacco use, occupational exposure to tobacco smoke, tobacco dependence, and tobacco use.

Document if chronic respiratory failure (CRF) is present with chronic hypoxemia, hypercapnea or compensated metabolic alkalosis (elevated bicarbonate levels).
- CRF contributes significantly to the severity level, complexity and cost of care.
- CRF typically requires home oxygen so you can consider this dx in any patient on chronic home oxygen.

Remember: hypoxia = symptom code
  Acute COPD exacerbation = diagnosis code
  Chronic respiratory failure = diagnosis code

Example: “acute respiratory failure due to acute COPD exacerbation”. See definition above under Respiratory Failure, pg 5.

DOCUMENT HYPOXIA with 02 sat with #L of 02 !!!!!!

Influenza:
List Influenza A with:
- pneumonia,
- GI manifestations,
- encephalopathy,
- myocarditis,
- otitis media etc.

Pneumonia is a major comorbidity (MCC).

DOCUMENT HYPOXIA with 02 sat with #L of 02 !!!!!!
**Asthma:**

*Document frequency* as intermittent or persistent

*Document level of exacerbation* as uncomplicated, acute exacerbation, chronic exacerbation, acute on chronic exacerbation or status asthmaticus.

*Document severity:* uncomplicated, mild intermittent, mild persistent, moderate persistent or severe persistent. All with or without exacerbation or status asthmaticus

*Document Tobacco use, abuse, dependence or past history of use*

**Definitions:**

State if uncomplicated, with acute exacerbation or with status asthmaticus. Acute exacerbation or status asthmaticus are key to capturing comorbidities (CC).

**Mild Intermittent:** symptoms of difficulty breathing, wheezing, chest tightness, coughing. Occurs less than 2x a week, nighttime symptoms <2x month. Does not interfere with normal activities.

**Mild persistent:** symptoms occur more than 2x a weeks, nighttime occur 3-4 x a month, minor limitations with daily activities. FEV1>80% predicted.

**Moderate persistent:** symptoms daily, nighttime >1x/week, some limited daily activity. FEV1>60<80%

**Severe persistent:** symptoms throughout each day, nighttime symptoms 7x/week, extremely limited activity. FEV1<60% predicted.

**Status asthmaticus:** severe asthma unresponsive to repeated courses of beta-agonist therapy such as inhaled albuterol, levalbuterol, or subcutaneous epinephrine.

Example: “Acute exacerbation of mild asthma with hypoxic respiratory failure and probable pneumonia”. List type of pneumonia if possible.

**DOCUMENT HYPOXIA with 02 sat with #L of 02 !!!!!**
CHF:
The term “CHF” is a non-specific term in ICD-10 that does not fully define the patient’s condition. Accepted term: HFrEF or systolic heart failure, HFpEF or diastolic heart failure. The following documentation is not currently codable in ICD-10, “heart failure borderline EF,” and the NYHA classes.

Must have: Acuity: Acute, acute on chronic (decompensated) or chronic (compensated) when used to describe the heart failure. Documentation of the acuity impacts the severity of illness and could potentially impact the DRG/length of stay. For example: Chronic (compensated) HFpEF is a CC. Acute on chronic (decompensated) HFpEF is an MCC.

Definition:

Systolic heart failure: EF is <55%

Diastolic heart failure: EF is normal or elevated

Acuity: be specific like “acute exacerbation” or “acute decompensation” vs chronic heart failure vs acute on chronic heart failure.

Try to link: “due to” ischemic, HTN, high-output, valvular disease, Rheumatic, or Etoh/toxic.

Need to mention EF on echo to document heart failure.

Must have beta blocker/ACE use and if not using MUST DOCUMENT WHY EACH HOSPITALIZATION.

Example: “acute decompensated left sided systolic heart failure with EF <20% due to ischemic heart disease.”

Core measures for heart failure:
- LV assessment
- ACE or ARB at DC for Left Ventricular systolic dysfunction (LVSD) (EF <40%), if not, say why.
- Beta blocker at DC for LVSD
- Spironolactone for LVSD on DC

DOCUMENT HYPOXIA with 02 sat with #L of 02 !!!!!!
ACS:
Do not use the term ACS
Need to document acute MI, location, if initial MI or if subsequent MI (occurring within the last 4 weeks).

“Troponemia” is a non-specific term describing abnormal lab values and does not correspond to a reportable diagnosis code. If troponemia is clinically associated with demand ischemia or a type II myocardial infarction document the diagnosis associated with the elevated troponins.

Definitions:

**STEMI**- EKG changes. Consideration of immediate reperfusion therapy or percutaneous coronary intervention (PCI). Need documentation of EKG changes.

Post-Cath: Document site and specific artery.
Example: “STEMI involving Lt anterior descending coronary artery”.

**NSTEMI**-no EKG changes. Release of a biomarker such as troponin I.
Document: episode of care only. Does not need site.

**Unstable Angina pectoris (UA)**-no biomarker release based on 2 samples collected at least 6 hours apart.
Need to document:
- if CAD is present or absent, otherwise will be coded as not associated to CAD.
- if due to native coronary with angina or bypassed vessel.

Example: “Pt with CAD admitted with unstable angina”.

**Angina pectoris**: part of combination code with unstable angina. Need to document if CAD is present or absent otherwise will be coded as not associated to CAD. Good if you can say if native vessel vs bypassed vessel is the cause.

**Type 2 MI or Myocardial infarction due to demand ischemia**.
DO NOT use “supply/demand ischemia”. Must say MI for it to be coded properly.
- If known, document the underlying cause of the type 2 MI, which may include but are not limited to: Heart failure, renal failure and COPD.
ACS (cont.):

NEW CODE: for subsequent MI which is a second MI within 4 weeks of a previous MI. Example: “Subsequent STEMI of anterior wall”

Other MIs:
Type 3 MI=sudden unexpected cardiac death including cardiac arrest, often with symptoms of MI accompanied by new ST elevation or new LBBB.
Type 4a MI= MI associated with PCI
Type 4b MI= MI associated with stent thrombosis as documented by angiography or autopsy
Type 4c MI=MI due to stent restenosis.
Type 5 MI= MI associated with CABG

Document Complications of AMI:
Examples:
- Rupture of chordae tendineae following AMI
- Rupture of papillary muscle following AMI
- Acquired cardiac septal defect following AMI
- Hemopericardium following STEMI, mention echo results and friction rub.

Core measures for Acute Myocardial infarction
- ASA within 24 hours
- LDL cholesterol assessed within 24 hours or 30 days prior to hospitalization
- Statin prescribed at DC (if not then need to say why)
- PCI within 90 minutes of hospitalization for STEMI
- Beta blocker prescribed at DC
- ACE or ARB prescribed at DC for left ventricular systolic dysfunction (EF <40%). If you do not prescribe ACE or ARB- YOU MUST DOCUMENT WHY EACH ADMISSION
- ASA on DC (if not, say why)
- Tobacco cessation recommendation in the last 12 months.
AKI (acute kidney injury)/Acute Renal Failure:

Suggested terminology: Acute kidney injury (nontraumatic) is synonymous with acute renal failure. Both code at N17.9. Using “acute kidney failure” or “acute renal injury” will also code for AKI (per ACP coding corner 6/2015).

“renal insufficiency” or “pre-renal azotemia” code for lower codes.

renal insufficiency is a vague term meaning “poor function of the kidneys”.

Definition: AKI: increase in serum creatinine by 0.3 mg/dl or more by at least 2 separate levels within 48 hours or increase in creatinine level 1.5 time baseline or greater within the prior 7 days or urine volume of less than 0.5 ml/kg/h for 6 hours or longer.

Link AKI to ATN (acute tubular necrosis) or AIN (acute interstitial nephritis) if possible: when it is confirmed or suspected cause of the AKI because this is assigned higher level of severity.

- Causes of ATN include: volume depletion, dehydrations, edematous state, hypotension (especially in sepsis), severe hemorrhage, or shock states. IV contrast induced AKI is usually ATN. If possible mention granular or “muddy brown” casts. ATN usually responds to IV fluid.

- Causes of AIN include: infection, immune disorders, toxins or medications. Eosinophils and leukocyte casts may be present in the urine.

- AKI is a CC. ATN is an MCC.

Example: “AKI due to ATN from dehydration.”
**CKD stages:**
Need to say what stage CKD the pt is in **and** “due to” HTN or type II DM if possible.

Other links that can cause CKD include: AKI, anemia, heart failure (systolic or diastolic) cystic disease, obesity.

Also link complications due to the CKD like: anemia of CKD, secondary hyperparathyroidism of renal origins, or severe protein calorie malnutrition.

Stage 1 with normal or high GFR (GFR > 90 mL/min)
Stage 2 Mild CKD (GFR = 60-89 mL/min)
Stage 3A Moderate CKD (GFR = 45-59 mL/min)
Stage 3B Moderate CKD (GFR = 30-44 mL/min)
Stage 4 Severe CKD (GFR = 15-29 mL/min)
Stage 5 End Stage CKD (GFR <15 mL/min)

**Example:** CKD stage 3 with GFR 40 due to DM and HTN.

**Document if on hemodialysis or Peritoneal Dialysis**

**Diabetes:**

**DM:** no longer coded as controlled or uncontrolled. Note if hyperglycemia present.
Link to insulin use if possible

Complications: link if possible

a. Diabetic ketoacidosis (DKA) specify if diabetes is type I or II and if coma is present.

b. Circulatory complications

c. Kidney complications

d. Neurological complications
e. Ophthalmic complications

State something like “insulin dependent type II DM with hyperglycemia and complications including peripheral neuropathy and CKD stage III”. Or “Insulin dependent type II DM with ketoacidotic coma.”
Anemia:
If from **acute blood loss anemia** need to say this. Acute blood loss anemia can be from GI bleeding or even expected post op anemia. Transfusion is not required for the diagnosis of acute blood loss anemia.

**Document** if the anemia is hereditary, acquired, enzyme disorder, autoimmune, or non-autoimmune

**Document type of anemia:**
- a. **Nutritional**- Fe def, chronic blood loss anemia, B12 def, malabsorption, Vegan anemia, Folate deficiency (dietary or drug induced), protein def anemia
- b. **Hemolytic**- due to: “enzyme disorders” (like G6PD ect), Thalassemia (alpha, beta, delta-beta, thalassemia minor ect), Sickle cell disorder with or without crisis, sickle cell thalassemia with or without crisis.
- c. **Aplastic**- chronic, transient, drug-induced, radiation induced, document pancytopenia or myelophthisis if present, Document any if present “anemia in neoplastic disease”, “anemia in chronic kidney disease”, “anemia in other chronic disease”. Also if due to “anemia due to antineoplastic chemotherapy.”
- d. **Pancytopenia**-due to antineoplastic chemotherapy, drug induced pancytopenia, myelodysplastic syndrome, leukemia, HIV.
- e. **Acute blood loss anemia**
- f. **Due to neoplasm**

Document “cause and effect” relationship between the intervention and the blood or immune disorder if possible.

Link laboratory findings

Document any associated diagnosis/conditions

**GI bleeding/GI hemorrhage:**
**Document Gastrointestinal hemorrhage if acute GI bleeding.**
Document symptoms and if it is an Upper or Lower GI bleed. Need to state something like: “upper GI hemorrhage due to ... secondary to (state the probable underlying cause (e.g. PUD, gastritis or esophageal varices)).

Also should document **acute blood loss anemia second to GI bleed.**
**Hepatitis:**
Causes of severe transaminitis in the 1000s:
- Ischemic hepatitis (usually has a elevated LDH)
- Acute viral hepatitis (HAV, HBV but not HCV)
- Drug/toxin induced liver injury (Tylenol most common)
- Autoimmune Hepatitis
- Acute Budd Chiari
- HELLP
- Hepatic infarct

Document: Acute or Chronic. If a patient has a history of hepatitis C, document is acute or chronic every hospitalization.

Document: Alcoholic (normally AST/ALT rises not >500), drug induced or viral (type A, B, C or E). If due to alcohol, specify the severity of the alcohol use disorder as (see section on substance use disorder). If due to drug (s), specify the name of the drug (s), and if applicable document if there is an associated drug use disorder.

Document: with or without hepatic coma

Document any associated diagnosis or conditions.

**Hepatic encephalopathy**
Document the stage of hepatic encephalopathy.

Document Acute, subacute or chronic

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<th>Neurologic Findings</th>
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<td>Normal</td>
<td>Normal</td>
<td>Normal examination; if impaired psychomotor testing, consider MHE</td>
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<td>Mild lack of awareness</td>
<td>Shortened attention span</td>
<td>Impaired addition or subtraction; mild asterixis or tremor</td>
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<td>Lethargic</td>
<td>Disoriented; Inappropriate behavior</td>
<td>Obvious asterixis; Slurred speech</td>
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<td>3</td>
<td>Somnolent but arousable</td>
<td>Gross disorientation; Bizarre behavior</td>
<td>Muscular rigidity and clonus; Hyperreflexia</td>
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<td>4</td>
<td>Coma</td>
<td>Coma</td>
<td>Decerebrate posturing</td>
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Cirrhosis of the Liver:
Document if associated with alcohol or not
Document if associated with ascites or not

Document cause of the cirrhosis: alcohol, viral, toxic. Say if acute or chronic.

Alcohol, Tobacco or Substance Use Disorder:
Describe frequency of usage as: Use, abuse, dependence or in remission.

- **Dependence** = a withdrawal syndrome or withdrawal symptoms are likely to occur when discontinued.: Examples of documentation of substance dependence: “(Name of substance) use disorder, moderate,” or (Name of substance) use disorder, severe.

- **Abuse** = withdrawal symptoms are not likely to occur when discontinued use. Describes a maladaptive pattern of drug use but not reached dependence yet. Drug and ETOH abuse are not considered significant inpatient comorbidities. Example of documentation of substance dependence: “(Name of substance) use disorder, mild”.

- **Use** = occasional use. Example of documentation of substance use: “(Name of substance) use disorder, mild”.

- **Remission** = complete cessation of alcohol or drug intake for 3 months

- Need also current clinical state of use: uncomplicated, intoxication, remission. Also document the relationship to any mental health disorders.

**Etoh**: no code for use or abuse in ICD10. Document if withdrawal is uncomplicated or associated with delirium or with perceptual disturbance (hallucinations without delirium). Withdrawal is NOT toxic encephalopathy or toxic effect from Etoh. DTs are coded as Etoh withdrawal with delirium. Intoxication with delirium IS acute toxic encephalopathy.

**Tobacco**: Describe mode of nicotine use as cigarettes, chewing tobacco, pipe or gum. Need to document if pt has use, developed a dependence on tobacco or nicotine and if there is remission or withdrawal due to Etoh. In addition to documenting the severity of the tobacco use disorder, also note if the patient has COPD. The cause and effect relationship between COPD and tobacco use is not assumed. “COPD due to smoking one pack of cigarettes a day for 40 years,” is an example of documentation linking the cause and effect relationship between smoking cigarettes and COPD.
Complications due to Medications and Toxic Substances:

Adverse therapeutic drug reactions: adverse effects, poisoning or underdosing.

1. **Adverse effect:** a condition caused by a medication that is correctly prescribed and properly administered.

2. **Poisoning:** consequence of taking a drug improperly. (wrong person, wrong dose, wrong route, combination with other medications not prescribed, combination with OTC medications without physician approval, combination with Etoh, or intentional overdose).

3. **Underdosing:** taking less of a medication than prescribed or contrary to the manufacturer’s instruction. This includes nonadherence and any complications of taking less of the drug than was intended.

4. **Toxic effect:** consequence of exposure to a nonmedicinal substance (toxin).

ACP coding corner: “Medication “toxicity” is not considered a toxic effect but is considered either an adverse effect or a poisoning.”

Also note if pt is taking a medication properly or improperly. Problems due to properly taking a medication=adverse effect Improperly taking a medication=poisoning
Delirium (i.e. Chronic or Acute Encephalopathy):

Avoid using “delirium” in the chart for billing purposes.

Definition:
Chronic encephalopathy is characterized as permanent, irreversible, structural changes within the brain itself. Examples include: anoxic brain injury, chronic traumatic encephalopathy, heavy metal, HIV related, Korsakoff or spongiform.

Acute encephalopathy is an acute or subacute global, functional alteration in mental status due to some type of systemic factors. It is reversible. Defined as “due to” toxic, metabolic or toxic-metabolic conditions.

Types of acute encephalopathy: this is an MCC (major complication)
Toxic: due to medications, illicit drugs, or toxic chemicals.
Metabolic: Due to medical issues

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<tr>
<th>Metabolic</th>
<th>Toxic</th>
<th>Hypoxic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uremia</td>
<td>ETOH</td>
<td></td>
</tr>
<tr>
<td>Hepatic</td>
<td>Rx – toxic</td>
<td>- withdrawal</td>
</tr>
<tr>
<td>Septic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes – hypoglycemia</td>
<td></td>
<td>DKA</td>
</tr>
</tbody>
</table>

- From ACP Hospitalist Coding Corner: “Coding: delirium vs encephalopathy. ICD 10 is calling what we would normally call “delirium”, it is calling encephalopathy. Therefore you can write something like “Toxic encephalopathy due to phenytoin, causing delirium.” Need to say something like “Acute encephalopathy due to ... second to underlying cause (if known).”
**Malnutrition stages:**
Classification of chronic malnutrition defined as lasting 3 months or more. Need 2 indicators (albumin/prealbumin are 1 indicator):

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albumin (g/dl)</td>
<td>≤ 3.0</td>
<td>≤2.5</td>
<td>&lt; 2.0</td>
</tr>
<tr>
<td>Prealbumin (mg/dl)</td>
<td>&lt;15.0</td>
<td>&lt;10.0</td>
<td>&lt;5.0</td>
</tr>
<tr>
<td>Ideal body weight</td>
<td>&lt;90%</td>
<td>&lt;80%</td>
<td>&lt;70%</td>
</tr>
<tr>
<td>Usual body weight</td>
<td>&lt;95%</td>
<td>&lt;85%5</td>
<td>&lt;75% or weight loss</td>
</tr>
<tr>
<td>BMI (kg/m2)</td>
<td>&lt;18.5</td>
<td>&lt;17</td>
<td>&lt;16</td>
</tr>
<tr>
<td>Muscle Wasting</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Temporal Wasting</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Avoid documenting a range of severity ie “moderate to severe”. Pick one. If meets criteria for severe malnutrition, then this will code for more severe illness. Severe malnutrition is an MCC (major complication)

**BMI:**

<19="underweight", “nutritional risk", or “malnutrition" if nutrition consult is requested for malnutrition.
19-24 normal
25-30=overweight
30-40=Obesity
>40=morbid obesity, obesity or overweight also qualify

Document if due to: excess calories, pregnancy, drug induced obesity. Document if alveolar hypoventilation is a complication of morbid obesity.

Definition of alveolar hypoventilation= insufficient ventilation leading to hypercapnia (increase in PaCO2).

BMI <19 or > 40 are CC (complications/comorbid conditions)
CVA:

**Suggested words:** Cerebral infarct, Cerebral artery occlusion: need location of occlusion within the artery, laterality.

**Also need:** Dominant or Non-dominant to the left or right hemiparesis or weakness due to CVA and need to mention which hand is dominant.

**Document:** hemorrhagic or non-hemorrhagic. Embolic versus thrombotic, laterality, and specific artery affected

Example: acute cerebral infarction due to thrombosis of the left carotid artery.

Document if patient meets/not meet criteria for thrombolytic therapy (if not meet, describe contraindication).

Also need to mention what the pt looked like on discharge. Was there improvement in symptoms or is there residual hemiparesis or dysphagia/aphasia, hemiplegia, etc.

**SEQUELAE OF CVA:**

If a patient is experiencing sequelae due to a prior stroke during the current admission link the present condition with the prior stroke. For example: “Dysphagia due to a previous CVA.”

Examples of key conditions associated with a prior CVA to be documented include: **Aphasia, dysphasia, dysarthria, monoplegia** (also specify limb affected i.e. RUE), **hemiplegia** (specify laterality), **hemiparesis** (specify laterality), **quadriplegia** (also specify complete or incomplete and the cervical spinal level), **apraxia**, **dysphagia** and **ataxia**.
**Pulmonary Embolism:**

Document:
- Acute vs Chronic: Pulmonary embolism is coded as an acute condition unless otherwise documented.
- With or Without acute cor pulmonale
- Was the PE septic or not.
- Documents saddle embolus of pulmonary artery and if acute cor pulmonale is present or not.

**Definition of cor pulmonale:**
Caused by Right heart dysfunction due to pulmonary HTN. This is acute whenever decompensated. Clinical findings include jugular venous distension, prominent v=wave in jugular venous pulsation, narrow S-2 split or no split or, in advance stages peripheral edema or ascites.

**DOCUMENT HYPOXIA with 02 sat with #L of 02  !!!!!**

**DVT:**

**Document:** Left or Right and location. Acute or chronic. DVT is coded as acute unless otherwise documented.

Example is “Chronic left DVT in the common femoral vein.”
**Pulmonary HTN:**

**Definition:** mean pulmonary artery pressure of 25mm Hg or more.

**Classified as:** primary (without apparent cause) or secondary due to:

**Causes of secondary pulmonary HTN: bolded are new codes**

- Acute or **chronic pulmonary embolism**
- **COPD or hypoxia**
- Interstitial lung disease, including pulmonary fibrosis
- Primary pulmonary hypertension (hereditary and idiopathic)
- Obstructive sleep apnea
- **Left-heart disease**
- Intra-cardiac shunt
- **Other chronic pulmonary disease**
- Progressive neuromuscular degenerative disorders
- Medication or drugs **including amphetamines**
- HIV infection causing pulmonary angiopathy

Chronic pulmonary HTN does not add to the severity of the pt in the chart.

**Definition: Pulmonary heart disease or cor pulmonale:** caused by Rt heart dysfunction due to pulmonary HTN. This is acute whenever decompensated. Clinical findings include jugular venous distension, prominent v=wave in jugular venous pulsation, narrow S-2 split or no split or, in advance stages peripheral edema or ascites.

Acute decompensation or “pulmonary HTN with acute right heart strain” or other evidence of acute pulmonary heart disease to document severity of illness should be reflected in the chart.

**DOCUMENT HYPOXIA with 02 sat with #L of 02  !!!!!**
Neoplasms:

Document:
- primary, secondary or in-situ
- Secondary sites Document the anatomic location of all secondary sites including lymph nodes.
- Laterality (specify Lt or Rt)
- Anatomical site
- Any other conditions associated with the malignancy (dehydration, anemia, etc.).
- State estrogen receptor status if possible
- If a patient is currently being treated for the condition and if yes, what sites are being treated. For example, “The patient is receiving ongoing palliative radiation for bone cancer due to his metastatic prostate cancer. His last treatment was on May 21, 2018.
- If pt is on treatment or primary or metastatic sites.

Document any associated diagnosis/conditions
Complications of chemotherapy/radiation: included but not limited to: Anemia (pancytopenia), polyneuropathy and burns associated with radiation.

Anemia (pancytopenia)
Pain
Pathologic fractures

Functional quadriplegia: R53:2
This is an MCC (major complication)
Definition: “the lack of ability to use one's limbs or to ambulate due to extreme debility. This condition is not associated with a neurological deficit or injury.”
These patients normally required “total care” including turning, feeding, or hygiene.

Most common causes of functional quadriplegia include neurologic degeneration from dementia, hypoxic injury, ALS, Huntington’s dz, multiple sclerosis or similar conditions.

Physical or functional quadriplegia in severely impaired patients who require “total care” or near total care in association with diseases will substantially increase the severity of illness.

Make sure you evaluate for pressure ulcers and ADLs to support the diagnosis.
Pressure Ulcers:

Document site including:
- Left or Right. Elbow, upper back, lower back, sacral, hip, buttock, ankle, heel, head etc.

Document:

- **Unstageable**: full thickness tissue loss in which the base of the sore is covered with slough
- **Stage 1**: intact skin with non-blanchable redness in a localized area.
- **Stage 2**: partial-thickness dermal loss, which presents as a shiny or dry shallow open ulcer with a red-pink wound bed, without sloughing or bruising, or as an intact or ruptured serum-filled blister
- **Stage 3**: full-thickness dermal loss. Subcutaneous fat may be visible, but there is no exposed bone, tendon, or muscle
- **Stage 4**: full-thickness skin loss with exposed bone, tendon, or muscle
- **Suspected deep tissue injury**: localized area of discolored intact skin (purple or maroon-colored), or a blood-filled or thin blister over a dark wound bed

**IMPORTANT**: YOU AS THE PHYSICIAN MUST DOCUMENT IF PRESENT ON ADMISSION! Doctors must document the pressure ulcer and may say, for example: “Per skin integrity note, pt with Lt sided sacral stage III pressure ulcer”. Coders cannot use the skin integrity note.

Pressure Ulcer stage III or IV are a MCC. Make sure you document if **present on admission**. VERY IMPORTANT. Otherwise coded as an in-hospital complication.
**Depression:**
Need to say if recurrent or single episode, PLUS
Acuity= mild, moderate, severe, severe with psychotic symptoms or in remission.

Example: Pt with recurrent mild MDD.

**Problems Related to Primary Support Group**

1. Problems in relationship with spouse or partner (Z63.0)
2. Absence of family member (Z63.3)
3. Other Specified problems related to primary support (Z63.8)
   a. Family discord
   b. Family estrangement
   c. High expressed emotional level within family
   d. Inadequate family support
   e. Inadequate or distorted communication with family.
4. Disappearance or death of family member (Z 63.4)
MCC conditions:

Congestive Heart Failure, Acute, Acute on Chronic, systolic or diastolic
Cor Pulmonale, Acute
CVA, Stroke, cerebral infarct or hemorrhage
Cerebral Edema
Coma
Endocarditis or Myocarditis, Acute
MI, Acute
Pulmonary Embolism, Acute.

Aspiration Bronchitis, Aspiration pneumonia
HIV Disease
Peritonitis
Pneumonia, including viral
Pulmonary edema, non-cardiac
Respiratory failure, Acute
Sepsis, severe sepsis, septic shock

Acute Renal failure with ATN
Aplastic anemia, anemia due to drugs, chemotherapy, infection, xrt
Diabetic ketoacidosis or diabetic with hyperosmolarity
Encephalopathy-Metabolic or toxic or other
End stage renal disease
GI disorder with hemorrhage, gastritis, duodenitis, diverticular dz.
GI ulcer with perforation, hemorrhage or obstruction
Ischemic Colitis, acute
Major injuries
Malnutrition, Severe
Pancreatitis, Acute
Pressure ulcer stage 3 or 4
Quadriplegia or Functional Quadriplegia
SIRS due to noninfectious process with acute organ dysfunction
Volvulus.

MCC if discharged alive:
Cardiac arrest
Cardiogenic shock
Respiratory Arrest
Ventricular Fibrillation
Other Shock without trauma.