Clinical Scenarios

- Scenario 1: Abdominal Pain
- Scenario 2: Annual Physical Exam
- Scenario 3: Earache
- Scenario 4: Anemia
- Scenario: COPD with Acute Pneumonia Example
- Scenario: Cervical Disc Disease

Clinical Documentation Tips

- Hypertension
- Asthma
- Underdosing
- Abdominal Pain Tenderness

Common Codes

- Abdominal Pain
- Acute Respiratory Infections
- Back and Neck Pain (Selected)
- Chest Pain
- Diabetes Mellitus w/o Complications Type 2
- General Medical Examination
- Headache
- Hypertension
- Pain in Joint
- Pain in Limb
- Other Forms of Heart Disease
- Urinary Tract Infection, Cystitis
- Diabetes Mellitus, Hypoglyemia and Hyperglycemia
- Injuries

Table Of Contents
### Abdominal Pain (ICD-9-CM 789.00 to 789.09 range)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R10.0</td>
<td>Acute abdomen</td>
</tr>
<tr>
<td>R10.10</td>
<td>Upper abdominal pain, unspecified</td>
</tr>
<tr>
<td>R10.11</td>
<td>Right upper quadrant pain</td>
</tr>
<tr>
<td>R10.12</td>
<td>Left upper quadrant pain</td>
</tr>
<tr>
<td>R10.13</td>
<td>Epigastric pain</td>
</tr>
<tr>
<td>R10.2</td>
<td>Pelvic and perineal pain</td>
</tr>
<tr>
<td>R10.30</td>
<td>Lower abdominal pain</td>
</tr>
<tr>
<td>R10.31</td>
<td>Right lower quadrant pain</td>
</tr>
<tr>
<td>R10.32</td>
<td>Left lower quadrant pain</td>
</tr>
<tr>
<td>R10.33</td>
<td>Periumbilical pain</td>
</tr>
<tr>
<td>R10.84</td>
<td>Generalized abdominal pain</td>
</tr>
<tr>
<td>R10.9*</td>
<td>Unspecified abdominal pain</td>
</tr>
</tbody>
</table>

*Codes with a greater degree of specificity should be considered first.
Acute Respiratory Infections (ICD-9-CM 462, 465.9, 466.0)
[Note: Organisms should be specified where possible]

- J02.8 Acute pharyngitis due to other specified organisms
- J02.9* Acute pharyngitis, unspecified
- J06.9* Acute upper respiratory infection, unspecified
- J20.0 Acute bronchitis due to Mycoplasma pneumoniae
- J20.1 Acute bronchitis due to Hemophilus influenzae
- J20.2 Acute bronchitis due to streptococcus
- J20.3 Acute bronchitis due to coxsackievirus
- J20.4 Acute bronchitis due to parainfluenza virus
- J20.5 Acute bronchitis due to respiratory syncytial virus
- J20.6 Acute bronchitis due to rhinovirus
- J20.7 Acute bronchitis due to echovirus
- J20.8 Acute bronchitis due to other specified organisms
- J20.9* Acute bronchitis, unspecified

*Codes with a greater degree of specificity should be considered first.

Back and Neck Pain (Selected) (ICD-9-CM 723.1, 724.1, 724.2, 724.5)

- M54.2 Cervicalgia
- M54.5 Low back pain
- M54.6 Pain in thoracic spine
- M54.89 Other dorsalgia
- M54.9* Dorsalgia, unspecified

*Codes with a greater degree of specificity should be considered first.
Chest Pain (ICD-9-CM 786.50 to 786.59 range)

R07.1 Chest pain on breathing
R07.2 Precordial pain
R07.81 Pleurodynia
R07.82 Intercostal pain
R07.89 Other chest pain
R07.9* Chest pain, unspecified

*Codes with a greater degree of specificity should be considered first.

Diabetes Mellitus w/o Complications Type 2 (ICD-9-CM 250.00)

E11.9 Type 2 diabetes mellitus without complications

General Medical Examination (ICD-9-CM V70.0)

Z00.00 Encounter for general adult medical exam without abnormal findings
Z00.01 Encounter for general adult medical exam with abnormal findings

Headache (ICD-9-CM 784.0)

R51 Headache

Hypertension (ICD-9-CM 401.9)

I10 Essential (primary) hypertension
## Pain in Joint (ICD-9-CM 719.40 to 719.49 range)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M25.511</td>
<td>Pain in right shoulder</td>
</tr>
<tr>
<td>M25.512</td>
<td>Pain in left shoulder</td>
</tr>
<tr>
<td>M25.519*</td>
<td>Pain in unspecified shoulder</td>
</tr>
<tr>
<td>M25.521</td>
<td>Pain in right elbow</td>
</tr>
<tr>
<td>M25.522</td>
<td>Pain in left elbow</td>
</tr>
<tr>
<td>M25.529*</td>
<td>Pain in unspecified elbow</td>
</tr>
<tr>
<td>M25.531</td>
<td>Pain in right wrist</td>
</tr>
<tr>
<td>M25.532</td>
<td>Pain in left wrist</td>
</tr>
<tr>
<td>M25.539*</td>
<td>Pain in unspecified wrist</td>
</tr>
<tr>
<td>M25.551</td>
<td>Pain in right hip</td>
</tr>
<tr>
<td>M25.552</td>
<td>Pain in left hip</td>
</tr>
<tr>
<td>M25.559*</td>
<td>Pain in unspecified hip</td>
</tr>
<tr>
<td>M25.561</td>
<td>Pain in right knee</td>
</tr>
<tr>
<td>M25.562</td>
<td>Pain in left knee</td>
</tr>
<tr>
<td>M25.569*</td>
<td>Pain in unspecified knee</td>
</tr>
<tr>
<td>M25.571</td>
<td>Pain in right ankle and joints of right foot</td>
</tr>
<tr>
<td>M25.572</td>
<td>Pain in left ankle and joints of left foot</td>
</tr>
<tr>
<td>M25.579*</td>
<td>Pain in unspecified ankle and joints of unspecified foot</td>
</tr>
<tr>
<td>M25.50*</td>
<td>Pain in unspecified joint</td>
</tr>
</tbody>
</table>

*Codes with a greater degree of specificity should be considered first.
### Pain in Limb (ICD-9-CM 729.5)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M79.601</td>
<td>Pain in right arm</td>
</tr>
<tr>
<td>M79.602</td>
<td>Pain in left arm</td>
</tr>
<tr>
<td>M79.603*</td>
<td>Pain in arm, unspecified</td>
</tr>
<tr>
<td>M79.604</td>
<td>Pain in right leg</td>
</tr>
<tr>
<td>M79.605</td>
<td>Pain in left leg</td>
</tr>
<tr>
<td>M79.606*</td>
<td>Pain in leg, unspecified</td>
</tr>
<tr>
<td>M79.609</td>
<td>Pain in unspecified limb</td>
</tr>
<tr>
<td>M79.621</td>
<td>Pain in right upper arm</td>
</tr>
<tr>
<td>M79.622</td>
<td>Pain in left upper arm</td>
</tr>
<tr>
<td>M79.629*</td>
<td>Pain in unspecified upper arm</td>
</tr>
<tr>
<td>M79.631</td>
<td>Pain in right forearm</td>
</tr>
<tr>
<td>M79.632</td>
<td>Pain in left forearm</td>
</tr>
<tr>
<td>M79.639*</td>
<td>Pain in unspecified forearm</td>
</tr>
<tr>
<td>M79.641</td>
<td>Pain in right hand</td>
</tr>
<tr>
<td>M79.642</td>
<td>Pain in left hand</td>
</tr>
<tr>
<td>M79.643*</td>
<td>Pain in unspecified hand</td>
</tr>
<tr>
<td>M79.644</td>
<td>Pain in right finger(s)</td>
</tr>
<tr>
<td>M79.645</td>
<td>Pain in left finger(s)</td>
</tr>
<tr>
<td>M79.646*</td>
<td>Pain in unspecified finger(s)</td>
</tr>
<tr>
<td>M79.651</td>
<td>Pain in right thigh</td>
</tr>
<tr>
<td>M79.652</td>
<td>Pain in left thigh</td>
</tr>
<tr>
<td>M79.659*</td>
<td>Pain in unspecified thigh</td>
</tr>
<tr>
<td>M79.661</td>
<td>Pain in right lower leg</td>
</tr>
<tr>
<td>M79.662</td>
<td>Pain in left lower leg</td>
</tr>
<tr>
<td>M79.669*</td>
<td>Pain in unspecified lower leg</td>
</tr>
<tr>
<td>M79.671</td>
<td>Pain in right foot</td>
</tr>
<tr>
<td>M79.672</td>
<td>Pain in left foot</td>
</tr>
<tr>
<td>M79.673*</td>
<td>Pain in unspecified foot</td>
</tr>
<tr>
<td>M79.674</td>
<td>Pain in right toe(s)</td>
</tr>
<tr>
<td>M79.675</td>
<td>Pain in left toe(s)</td>
</tr>
<tr>
<td>M79.676*</td>
<td>Pain in unspecified toe(s)</td>
</tr>
</tbody>
</table>

*Codes with a greater degree of specificity should be considered first.*
**Other Forms Of Heart Disease (ICD-9-CM 427.31)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I48.0</td>
<td>Paroxysmal atrial fibrillation</td>
</tr>
<tr>
<td>I48.2</td>
<td>Chronic atrial fibrillation</td>
</tr>
<tr>
<td>I48.91*</td>
<td>Unspecified atrial fibrillation</td>
</tr>
</tbody>
</table>

*Codes with a greater degree of specificity should be considered first.*

---

**URINARY TRACT INFECTION, CYSTITIS (ICD-9-CM 595.0 TO 595.4 RANGE, 595.81, 595.82, 595.89, 595.9, 599.0)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N30.00</td>
<td>Acute cystitis without hematuria</td>
</tr>
<tr>
<td>N30.01</td>
<td>Acute cystitis with hematuria</td>
</tr>
<tr>
<td>N30.10</td>
<td>Interstitial cystitis (chronic) without hematuria</td>
</tr>
<tr>
<td>N30.11</td>
<td>Interstitial cystitis (chronic) with hematuria</td>
</tr>
<tr>
<td>N30.20</td>
<td>Other chronic cystitis without hematuria</td>
</tr>
<tr>
<td>N30.21</td>
<td>Other chronic cystitis with hematuria</td>
</tr>
<tr>
<td>N30.30</td>
<td>Trigonitis without hematuria</td>
</tr>
<tr>
<td>N30.31</td>
<td>Trigonitis with hematuria</td>
</tr>
<tr>
<td>N30.40</td>
<td>Irradiation cystitis without hematuria</td>
</tr>
<tr>
<td>N30.41</td>
<td>Irradiation cystitis with hematuria</td>
</tr>
<tr>
<td>N30.80</td>
<td>Other cystitis without hematuria</td>
</tr>
<tr>
<td>N30.81</td>
<td>Other cystitis with hematuria</td>
</tr>
<tr>
<td>N30.90</td>
<td>Cystitis, unspecified without hematuria</td>
</tr>
<tr>
<td>N30.91</td>
<td>Cystitis, unspecified with hematuria</td>
</tr>
<tr>
<td>N39.0*</td>
<td>Urinary tract infection, site not specified</td>
</tr>
</tbody>
</table>

*Codes with a greater degree of specificity should be considered first.*
Specifying anatomical location and laterality required by ICD-10 is easier than you think. This detail reflects how physicians and clinicians communicate and to what they pay attention - it is a matter of ensuring the information is captured in your documentation.

In ICD-10-CM, there are three main categories of changes:

- Definition Changes
- Terminology Differences
- Increased Specificity

Over 1/3 of the expansion of ICD-10 codes is due to the addition of laterality (left, right, bilateral). Physicians and other clinicians likely already note the side when evaluating the clinically pertinent anatomical site(s).

**HYPERTENSION**

**Definition Change**

In ICD-10, hypertension is defined as essential (primary). The concept of “benign or malignant” as it relates to hypertension no longer exists.

When documenting hypertension, include the following:

1. **Type**
   - e.g. essential, secondary, etc.

2. **Causal relationship**
   - e.g. Renal, pulmonary, etc.

**ICD-10 Code Examples**

- I10  Essential (primary) hypertension
- I11.9 Hypertensive heart disease without heart failure
- I15.0 Renovascular hypertension
ASTHMA

Terminology Difference

ICD-10 terminology used to describe asthma has been updated to reflect the current clinical classification system.

When documenting asthma, include the following:

1. **Cause**
   - Exercise induced, cough variant, related to smoking, chemical or particulate cause, occupational

2. **Severity**
   - Choose one of the three options below for persistent asthma patients
     1. Mild persistent
     2. Moderate persistent
     3. Severe persistent

3. **Temporal Factors**
   - Acute, chronic, intermittent, persistent, status asthmaticus, acute exacerbation

UNDERDOsing

Terminology Difference

Underdosing is an important new concept and term in ICD-10. It allows you to identify when a patient is taking less of a medication than is prescribed.

When documenting underdosing, include the following:

1. **Intentional, Unintentional, Non-compliance**
   - Is the underdosing deliberate? (e.g., patient refusal)

2. **Reason**
   - Why is the patient not taking the medication? (e.g. financial hardship, age-related debility)

ICD-10 Code Examples

- **J45.30** Mild persistent asthma, uncomplicated
- **J45.991** Cough variant asthma

- **Z91.120** Patient’s intentional underdosing of medication regimen due to financial hardship
- **T36.4x6A** Underdosing of tetracyclines, initial encounter
- **T45.526D** Underdosing of antithrombotic drugs, subsequent encounter
ABDOMINAL PAIN AND TENDERNESS

Increased Specificity

When documenting abdominal pain, include the following:

1. **Location**
   e.g. Generalized, Right upper quadrant, periumbilical, etc.

2. **Pain or tenderness type**
   e.g. Colic, tenderness, rebound

ICD-10 Code Examples

- R10.31 Right lower quadrant pain
- R10.32 Left lower quadrant pain
- R10.33 Periumbilical pain

DIABETES MELLITUS, HYPOGLYCEMIA AND HYPERGLYCEMIA

Increased Specificity

The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system.

When documenting diabetes, include the following:

1. **Type**
   e.g. Type 1 or Type 2 disease, drug or chemical induced, due to underlying condition, gestational

2. **Complications**
   What (if any) other body systems are affected by the diabetes condition? e.g. Foot ulcer related to diabetes mellitus

3. **Treatment**
   Is the patient on insulin?

A second important change is the concept of “hypoglycemia” and “hyperglycemia.” It is now possible to document and code for these conditions without using “diabetes mellitus.” You can also specify if the condition is due to a procedure or other cause.

The final important change is that the concept of “secondary diabetes mellitus” is no longer used; instead, there are specific secondary options.

ICD-10 Code Examples

- E08.65 Diabetes mellitus due to underlying condition with hyperglycemia
- E09.01 Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
- R73.9 Transient post-procedural hyperglycemia
- R79.9 Hyperglycemia, unspecified
INJURIES

Increased Specificity

ICD-9 used separate “E codes” to record external causes of injury. ICD-10 better incorporates these codes and expands sections on poisonings and toxins.

When documenting injuries, include the following:

1. Episode of Care  e.g. Initial, subsequent, sequelae
2. Injury site  Be as specific as possible
3. Etiology  How was the injury sustained (e.g. sports, motor vehicle crash, pedestrian, slip and fall, environmental exposure, etc.)?
4. Place of Occurrence  e.g. School, work, etc.

Initial encounters may also require, where appropriate:

1. Intent  e.g. Unintentional or accidental, self-harm, etc.
2. Status  e.g. Civilian, military, etc.

ICD-10 Code Examples

Example 1:
A left knee strain injury that occurred on a private recreational playground when a child landed incorrectly from a trampoline:

- **Injury:** S86.812A, Strain of other muscle(s) and tendon(s) at lower leg level, left leg, initial encounter
- **External cause:** W09.8xxA, Fall on or from other playground equipment, initial encounter
- **Place of occurrence:** Y92.838, Other recreation area as the place of occurrence of the external cause
- **Activity:** Y93.44, Activities involving rhythmic movement, trampoline jumping

Example 2:
On October 31st, Kelly was seen in the ER for shoulder pain and X-rays indicated there was a fracture of the right clavicle, shaft. She returned three months later with complaints of continuing pain. X-rays indicated a nonunion. The second encounter for the right clavicle fracture is coded as S42.021K, *Displaced fracture of the shaft of right clavicle, subsequent for fracture with nonunion.*
Quality clinical documentation is essential for communicating the intent of an encounter, confirming medical necessity, and providing detail to support ICD-10 code selection. In support of this objective, we have provided outpatient focused scenarios to illustrate specific ICD-10 documentation and coding nuances related to your specialty.

The following scenarios were natively coded in ICD-10-CM and ICD-9-CM. As patient history and circumstances will vary, these brief scenarios are illustrative in nature and should not be strictly interpreted or used as documentation and coding guidelines. Each scenario is selectively coded to highlight specific topics; therefore, only a subset of the relevant codes are presented.

**Family Practice Clinical Scenarios**

**Scenario 1: Abdominal Pain**

**Scenario Details**

**Chief Complaint**
- “My stomach hurts and I feel full of gas.”

**History**
- 47 year old male with mid-abdominal epigastric pain, associated with severe nausea & vomiting; unable to keep down any food or liquid. Pain has become “severe” and constant.
- Has had an estimated 13 pound weight loss over the past month.
- Patient reports eating 12 sausages at the Sunday church breakfast five days ago which he believes initiated his symptoms.
- Patient admits to a history of alcohol dependence. Consuming 5 – 6 beers per day now, down from 10 – 12 per day 6 months ago. States that he has nausea and sweating with “the shakes” when he does not drink.

**Exam**
- VS: T 99.8°F, otherwise normal.
- Mild jaundice noted.
- Abdomen distended and tender across upper abdomen. Guarding is present. Bowel sounds diminished in all four quadrants.
- Oral mucosa dry, chapped lips, decreased skin turgor
Scenario 1: Abdominal Pain (continued)

Assessment and Plan

- Dehydration and suspected acute pancreatitis.
- Admit to the hospital. Orders written and sent to on-call hospitalist.
- 1L IV NS started in office. Blood drawn for labs.
- Recommend behavioral health counseling for substance abuse assessment and possible treatment.
- Patient’s wife notified of plan; she will transport to hospital by private vehicle.

Summary of ICD-10-CM Impacts

Clinical Documentation

1. Describe the pain as specifically as possible based on location.
2. When addressing alcohol related disorders you should distinguish alcohol use, alcohol abuse, and alcohol dependence. ICD-10-CM has changed the terminology and the parameters for coding substance abuse disorders. In this encounter note, as the acute pancreatitis is suspected, and the patient’s alcohol intake status is stated, the associated alcoholism code is listed.
3. Abdominal tenderness may be coded. Ideally the documentation should include right or left upper quadrant and indicate if there is rebound in order to identify a more specific code. Currently the ICD-10 code would be R10.819, Abdominal tenderness, unspecified site as the documentation is insufficient in laterality and specificity.

Coding

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-9-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>789.06 Abdominal pain, epigastric</td>
<td>R10.13 Epigastric pain</td>
</tr>
<tr>
<td>789.60 Abdominal tenderness, unspecified site</td>
<td>R10.819 Abdominal tenderness, unspecified site</td>
</tr>
<tr>
<td>782.4 Jaundice NOS</td>
<td>R17 Unspecified jaundice</td>
</tr>
<tr>
<td>276.51 Dehydration</td>
<td>E86.0 Dehydration</td>
</tr>
<tr>
<td>303.90 Other and unspecified alcohol dependence, unspecified</td>
<td>F10.20 Alcohol dependence, uncomplicated</td>
</tr>
</tbody>
</table>

Other Impacts

No specific impacts noted.
Scenario Details

Chief Complaint

- “I’m here for my annual check-up.”

History

- 73 year old male with history of coronary artery disease, stent placement, hyperlipidemia, HTN and GERD.
- Recent admission to hospital following a hypertensive crisis. Discharged home on olmesartan medoxomil 20 mg daily.
- Patient stopped taking olmesartan medoxomil due to side effects\(^2\), including a headache that began after starting the medication and still exists, and tiredness.
- Regular activity includes walking, golfing. Active social life. No complaints of chest pain, or dyspnea on exertion.
- Last colonoscopy was 9 months ago. No significant pathology found; some diverticular disease.
- Medications were reviewed.

Exam

- Chest clear. Heart sounds normal. Mental status exam intact.
- EKG shows no changes from prior EKG.
- Vitals: BP is 159/95, otherwise normal. Per patient, he had good control of BP on meds, but it has risen without medication.
- BUN/creatinine normal limits.

Assessment and Plan

- HTN noted on exam today. Change from olmesartan medoxomil to metoprolol tartrate 50 mg once daily, will titrate dosage every two weeks until BP normalizes.
- Discussed the importance of daily home BP monitoring, low sodium diet, and taking BP medication as prescribed; he verbalizes understanding.
- Schedule follow-up visit in two weeks to evaluate effectiveness of new BP medication therapy, and repeat BUN/creatinine.
Scenario 2: Annual Physical Exam (continued)

Summary of ICD-10-CM Impacts

Clinical Documentation

1. Documenting why the encounter is taking place is important, as the coder may assign a different code based on the type of visit (e.g., screening, with no complaint or suspected diagnosis, for administrative purposes). In this situation, the patient is requesting an encounter without a complaint, suspected or reported diagnosis.

2. Document that the patient is noncompliant with his medication. This “underdosing” concept can often be coded, along with the patient’s reason for not taking the prescribed medications. Document if there is a medical condition linked to the underdosing that is relevant to the encounter, and ensure the connection is clearly made. The ICD-10-CM terms provide new detail as compared to the ICD-9-CM code V15.81, history of past noncompliance. In this case there was no noted history of noncompliance. In this note the side effects of stopping the medication include headache, which remains as a patient complaint for this encounter. When documenting headache do differentiate if intractable versus non-intractable.

Coding

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V70.0 Routine medical exam</td>
<td>Z00.01 Encounter for general adult medical examination with abnormal findings</td>
</tr>
<tr>
<td>401.9 Unspecified essential hypertension</td>
<td>I10 Essential (primary) hypertension</td>
</tr>
<tr>
<td>339.3 Drug-induced headache, not elsewhere classified</td>
<td>G44.40 Drug-induced headache, not elsewhere classified, not intractable</td>
</tr>
<tr>
<td>N/A</td>
<td>T46.5X6A Underdosing of other antihypertensive drugs, initial encounter</td>
</tr>
<tr>
<td>N/A</td>
<td>Z91.128 Patient’s intentional underdosing of medication regimen for other reason</td>
</tr>
</tbody>
</table>

Other Impacts

- Assess if the new patient-centric preventative health incentives for annual exams are relevant to your practice.
- For hierarchical condition categories (HCC) used in Medicare Advantage Risk Adjustment plans, certain diagnosis codes are used as to determine severity of illness, risk, and resource utilization. HCC impacts are often overlooked in the ICD-9-CM to ICD-10-CM conversion. The physician should examine the patient each year and compliantly document the status of all chronic and acute conditions. HCC codes are payment multipliers.
Scenario 3: Earache

Scenario Details

Chief Complaint
- Right earache and ear pain.

History
- This 20 year old male is an established patient and well known to me. He is a full-time college student, and presents with a right sided ear pain, noted 8/10. The symptoms started yesterday and continue to worsen with no pain relief using acetaminophen. Denies discharge, hearing loss, or ringing/roaring. He denies trauma or recent barotrauma to ear. He denies fever, sore throat, and cough today. He reports recently having an URI that resolved with OTC medications.
- He is up to date on his influenza, HPV, Tdap, and meningococcal immunizations.
- Patient does not use tobacco, alcohol, or illicit drugs. He denies exposure to second hand smoke.
- Medical history includes major depressive disorder with recurrent episodes of mild severity, and bipolar II disorder. His current medications include aripiprazole, and duloxetine.
- No known allergies.
- 16 point review of systems negative except for notations above.

Exam
- Healthy appearing male. A&Ox3. He appears calm and is cooperative.
- Vital signs: BP: 130/78 HR: 70 bpm T: 99.8 °F Wt: 235 lbs Ht: 5' 10".
- Integumentary: Skin is flushed, warm, and dry with no edema. Mucous membranes are moist.
- Respiratory: Lungs clear CTA with normal respiratory effort.
- Abdomen: non-tender, no organomegaly.

Assessment and Plan
- New onset AOM AD, suppurative, with pain unrelieved by acetaminophen.
- Prescriptions: amoxicillin for AOM; ibuprofen for pain.
- Return in one week if symptoms persist.
Scenario 3: Earache (continued)

Summary of ICD-10-CM Impacts

Clinical Documentation

1. In diagnosing otitis media using ICD-9-CM you should document items such as acute, chronic, not specified as acute or chronic, nonsuppurative or suppurative, and with or without spontaneous rupture of the eardrum. In ICD-10-CM, you will need to document these characteristics plus left, right or bilateral that are affected and is the problem initial or recurrent to assign a correct code.

2. In this fictional test case we gave this young male a diagnosis of bipolar II disorder. You would not report the bipolar disorder unless it affects treatment at today’s encounter. Conditions that are not treated or that do not affect patient treatment nor are treated should not be reported.

Coding

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>382.00</td>
<td>H66.001</td>
</tr>
<tr>
<td>Acute suppurative otitis media without spontaneous rupture of eardrum</td>
<td>Acute suppurative otitis media without spontaneous rupture of ear drum, right ear</td>
</tr>
</tbody>
</table>

Other Impacts

No specific impact noted.
Scenario Details

Chief Complaint

- Discuss laboratory results.

History

- 38 year old established female seen by me over one week ago for decreased exercise tolerance and general malaise over the past four weeks when doing her daily aerobics class. Labs were ordered on that visit. She presents today with pale skin, weakness, and epigastric pain; symptoms are unchanged since previous visit. Laboratory studies reviewed today are as follows: HGB 8.5 gm/dL, HCT 27%, platelets 300,000/mm3, reticulocytes 0.24%, MCV 75, serum iron 41 mcg/dL, serum ferritin 9 ng/ml, TIBC 457 mcg/dL; Fecal occult blood test is positive.
- She takes Esomeprazole daily for GERD with esophagitis and reports taking OTC antacids at bedtime for epigastric pain for the past three months. She also uses ibuprofen as needed for headaches.
- Current pain is 0/10.
- Medical history significant for GERD, peptic ulcer, pre-eclampsia with last pregnancy.
- LMP: two weeks ago, normal flow, unchanged in last three months.
- Married; three children ages 15, 12, and 1 year old.
- Patient does not use tobacco, alcohol, or illicit drugs.
- No known allergies.
- No changes in interval history and review of systems noted from encounter 8 days ago.

Exam

- Well-nourished, well groomed, pleasant female who shows good judgment and insight. Oriented X 3. Good recent and remote memory. Appropriate mood and affect.
- Vital signs: T 98.7, RR 18, BP: 118/75, standing 120/60, HR: 90.
- HEENT: PERRLA.
- Neck: Supple. No thyromegaly.
- Lungs: clear to auscultation with normal respiratory effort.
- Cardiovascular: Regular rate and rhythm. No pedal edema.
- Integumentary: Pale, clear of rashes and lesions, no ulcers. Early cheilosis noted.
- Rectal: No gross blood on exam one week ago; stool sample results noted above.
- Lymphatics: No lymphadenopathy.
- Musculoskeletal: The patient had good, stable gait.
Scenario 4: Anemia (continued)

Assessment and Plan

- Iron-deficiency anemia secondary to blood loss.
- Continue esomeprazole as prescribed.
- Replace ibuprofen use with acetaminophen extra strength for headaches, dosage as per label.
- Prescribed iron sulfate supplements for three month trial. Counseled patient on appropriate use of iron supplementation and side effects.
- Patient to return in one week for repeat laboratory studies.

Summary of ICD-10-CM Impacts

Clinical Documentation

1. In ICD-10-CM, gastro-esophageal reflux disease is differentiated by noting “with esophagitis” versus “without esophagitis.” “With esophagitis” must be documented in the record.

Coding

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>280.0</td>
<td>D50.0</td>
</tr>
<tr>
<td>Iron deficiency anemia</td>
<td>Iron deficiency anemia</td>
</tr>
<tr>
<td>secondary to blood loss</td>
<td>secondary to blood loss</td>
</tr>
<tr>
<td>(chronic)</td>
<td>(chronic)</td>
</tr>
<tr>
<td>530.81</td>
<td>K21.0</td>
</tr>
<tr>
<td>Disease, Gastroesophageal</td>
<td>Gastro-esophageal reflux</td>
</tr>
<tr>
<td>reflux (GERD)</td>
<td>disease with esophagitis</td>
</tr>
</tbody>
</table>

Other Impacts

- 530.11 Reflux esophagitis is not coded when GERD is coded in ICD-9-CM because 530.11 is an “excluded code” from 530.81 in ICD-9-CM but it is a combination code in ICD-10-CM.
Scenario: COPD with Acute Pneumonia Example

Scenario Details

Chief Complaint
- “I just got out of the hospital 2 days ago. I’m a little better, but still can barely breathe.”

History
- 67-year-old male with 40 pack/year history of cigarette use (still smoking) and severe oxygen dependent COPD developed cough with increased production of green/gray sputum 2 weeks prior to office visit. Admitted to hospital through Emergency Department with diagnosis of presumed pneumonia superimposed on severe COPD. Hospital exam confirmed acute RLL pneumococcal pneumonia. Patient treated with an IV cephalosporin as he has known penicillin allergy, and was discharged from hospital to home 2 days prior to office visit.
- PMH shows severe O2 dependent COPD, with type II diabetes mellitus secondary to chronic prednisone therapy, which is treated with oral hypoglycemics. Patient also has known hypertension, on ACE inhibitor therapy.

Review of Systems, Physical Exam, Laboratory Tests
- T 99, BP 145/105, P 92 and irregular, RR 28
- Chest exam shows decreased lung sounds throughout all lung fields except in RLL where there were mild rhonchi and wheezes noted
- ABG’s on 2L O2 by nasal cannula show PO2 62, PCO2 47, pH 7.40
- CXR shows hyperinflation of lungs with small RLL alveolar infiltration. Comparison to CXR from hospitalization shows approximately 75% resolution of pneumonia.
- ECG reveals persistent atrial fibrillation which was not present on previous ECG of 6 months earlier, but had been found at time of recent hospitalization. Labs show finger stick glucose of 195mg%.

Assessment and Plan
- Acute Community Acquired Pneumococcal Pneumonia: continue oral cephalosporin. Schedule office follow up visit in 1 week with repeat CXR.
- Severe COPD: continue O2, low dose Prednisone, and inhaled bronchodilator.
- Chronic Hypoxemic, Hypercarbic Respiratory Failure
- Persistent Atrial Fibrillation: continue digoxin initiated during recent hospitalization
- Hypertension: continue ACE inhibitor therapy
- Diabetes Mellitus, Type II, secondary to prednisone therapy; continue oral hypoglycemic therapy
- Penicillin Allergy
- Tobacco Dependence
**Summary of ICD-10-CM Impacts**

**Clinical Documentation**

- ICD-10-CM separates pneumonia by infectious agent. Document the infectious agent of pneumonia, as there are discrete ICD-10-CM codes for each type.
- ICD-10-CM separates by acuity of respiratory failure, and hypoxia or hypercapnia, if present.
- Document drug allergies with ICD-10-CM status “Z” codes from Chapter 21 to identify these.
- Document the type of cardiac arrhythmia. Atrial fibrillation in ICD-10-CM separates into paroxysmal, persistent, chronic, typical, atypical, unspecified. Acute atrial fibrillation defaults to unspecified in ICD-10-CM.
- The Table of Drugs & Chemicals has a code assignment for Adverse effect of the drug that would be followed by the secondary diabetes code. Go to the Volume 3 Index to Table of Drugs and Chemicals. Along the left hand side proceed alphabetically to “Glucocorticoids” and then move horizontally across to the column for Adverse Effect”. In Volume 1 (Tabular List) the instruction at the beginning of the code category T38 are the instructions for the 7th character.
- Note: Drug-induced Diabetes Mellitus is a secondary type of diabetes due to the use of glucocorticoids. This code can only be coded as an “additional code” and would never be first-listed

**The code categories for secondary diabetes are:**

- Due to underlying disease (E08)
- Due to drug (E09)
- Due to other specified condition such as post pancreatectomy. (E13)

*These three categories can never be first-listed per ICD-10-CM guidelines. The underlying cause would be first-listed diagnosis.*

**Coding**

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>481 Pneumonia, Pneumococcal</td>
<td>J13 Pneumonia due to Streptococcus pneumoniae</td>
</tr>
<tr>
<td>496 COPD</td>
<td>J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection</td>
</tr>
<tr>
<td>V46.2 Oxygen dependence</td>
<td>Z99.81 Dependence on supplemental oxygen</td>
</tr>
<tr>
<td>427.31 Atrial fibrillation</td>
<td>I48.1 Persistent atrial fibrillation</td>
</tr>
<tr>
<td>249.00 Diabetes, secondary, drug induced</td>
<td>E09.9 Drug or chemical induced diabetes mellitus without complications</td>
</tr>
<tr>
<td>E932.0 Therapeutic use of Prednisone</td>
<td>T38.0x5A Adverse effect of glucocorticoids and synthetic analogues, initial encounter</td>
</tr>
<tr>
<td>401.9 HTN</td>
<td>I10 Essential (primary) hypertension</td>
</tr>
<tr>
<td>V14.0 Allergy, Penicillin</td>
<td>Z88.0 Allergy status to penicillin</td>
</tr>
<tr>
<td>305.1 Tobacco dependence</td>
<td>F17.210 Nicotine dependence, cigarettes, uncomplicated</td>
</tr>
</tbody>
</table>
Scenario: Cervical Disc Disease

Scenario Details

Chief Complaint
• “My neck hurts and I have a tingling pain sensation going down my right arm.”

History
• Patient is a 68 year-old male with history of neck pain that has been worsening over the last two years. Recently, he has experienced some numbness and a painful tingling sensation in his right arm going down to his thumb. No other symptoms or pertinent medical history.

Review of Systems, Physical Exam, Laboratory Tests
• Review of systems is negative except for the neck pain and sensations in his right arm described above. No history of acute injury to neck or arm.
• Physical exam is normal except for neurological exam of the right upper extremity, which reveals slight decrease to sensation in the thumb and forefinger region of the hand in the C6 nerve root distribution. No evidence of weakness in the muscles of the arm or hand.
• MRI scan of the neck shows degenerative changes of the C5-6 disc with lateral protrusion of disc material. No other abnormalities noted.

Assessment and Plan
• Cervical transforaminal injection at C5-6
### Scenario: Cervical Disc Disease (continued)

#### Summary of ICD-10-CM Impacts

**Clinical Documentation**
- Subcategory M50.1 describes cervical disc disorders. M50.12 Cervical disc disease that includes degeneration of the disc as a combination code. The 5th character differentiates various regions of the cervical spine (high cervical C2-3 and C3-4; mid-cervical C4-5, C5-6, and C6-7; cervicothoracic C7-T1 and the associated radiculopathies at each level). This is a combination code that includes the disc degeneration and radiculopathy.

#### Coding

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>722.0</td>
<td>M50.12 Cervical disc disorder with radiculopathy, mid-cervical region</td>
</tr>
<tr>
<td>722.4</td>
<td></td>
</tr>
<tr>
<td>Cervical disc displacement without myelopathy</td>
<td></td>
</tr>
<tr>
<td>Degeneration of cervical intervertebral disc</td>
<td></td>
</tr>
</tbody>
</table>
Scenario: Abdominal Pain

Scenario Details

Chief Complaint
- “My stomach hurts.”

History
- Patient is a 65-year-old male admitted to the hospital with abdominal pain. He has a history of Crohn’s disease of the large intestine. He also has a history of coronary artery disease, had a heart attack 5 years ago, but has had no problems since then. He smoked cigarettes for 45 years, but quit after his myocardial infarction. He also has a history of allergic reactions to Penicillins and Cephalosporins.

Review of Systems, Physical Exam, Laboratory Tests
- 99.8
- Abdomen: diffuse tenderness over entire abdomen
- CT scan of abdomen: abscess secondary to Crohn’s disease of descending colon

Assessment and Plan
- Crohn’s disease, large intestine with abscess.
- Awaiting GI consultation
### Summary of ICD-10-CM Impacts

#### Clinical Documentation
- Crohn’s disease in ICD-10-CM is separated by small, large intestine or both (small and large intestine), with or without complications of rectal bleeding, obstruction, fistula, or abscess (combination codes).

#### Coding

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>555.1</td>
<td>K50.114</td>
</tr>
<tr>
<td>Regional enteritis, large intestine</td>
<td>Crohn’s disease of the large intestine with abscess</td>
</tr>
<tr>
<td>567.22</td>
<td>I25.2</td>
</tr>
<tr>
<td>Abscess, abdominal</td>
<td>Old myocardial infarction</td>
</tr>
<tr>
<td>412</td>
<td>Z87.891</td>
</tr>
<tr>
<td>Old myocardial infarction</td>
<td>Personal history of nicotine dependence or personal history of tobacco use.</td>
</tr>
<tr>
<td>V15.82</td>
<td>Z88.0</td>
</tr>
<tr>
<td>History of tobacco use</td>
<td>Allergy status to Penicillin</td>
</tr>
<tr>
<td>V14.0</td>
<td>Z88.1</td>
</tr>
<tr>
<td>History of allergy to Penicillin</td>
<td>Allergy status to other antibiotic agent</td>
</tr>
<tr>
<td>V14.1</td>
<td></td>
</tr>
<tr>
<td>History of allergy to other antibiotic (cephalosporins)</td>
<td></td>
</tr>
</tbody>
</table>

#### Other Impacts
- Coding allergies to specific medications allows the providers who share a common EHR to be notified of these allergies. They can be placed into the ongoing problem list therefore becoming available whenever relevant for coding on the claim.
- At the beginning of Chapter 10 Respiratory conditions this instruction is found: **Use additional code, where applicable, to identify:**
  - exposure to environmental tobacco smoke (Z77.22)
  - exposure to tobacco smoke in the perinatal period (P96.81)
  - history of tobacco use (Z87.891)
  - occupational exposure to environmental tobacco smoke (Z57.31)
  - tobacco dependence (F17.-)
  - tobacco use (Z72.0)
- These tobacco-related codes should also be coded into the ongoing problem list for future coding situations as indicated in ICD-10-CM.
Scenario Details

Chief Complaint
- “I am here for my quarterly evaluation of my diabetes.”

History
- Patient is a 50-year-old woman with Type 1 diabetes since childhood. She has been on insulin since age 13. As a result of her diabetes she has chronic kidney disease and is currently on dialysis for ESRD. She also has diabetic neuropathy affecting both lower extremities.

Review of Systems, Physical Exam, Laboratory Tests
- No changes in underlying condition during the last 3 months. She continues to perform self-testing of her blood sugar levels on a daily basis, is on dialysis every other day, most recently 24 hours ago, and has not noticed any changes in the numbness in her legs.
  - BP 140/75, P 80, R 16 and T 98.8
  - Dialysis fistula without any signs of infection
  - Decreased sensation over lower extremities below the knees
  - Lab: BUN/Cr nl, K+ 3.5, glu 105, Hgb A1c 7.9

Assessment and Plan
- Continue BS checks daily with sliding scale as previously prescribed
- Start Capsaicin topically and defer to nephrologist for any Rx at this time. She has an appointment 10 am tomorrow.
Summary of ICD-10-CM Impacts

Coding

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.41 Diabetes with renal manifestations, type 1, not stated as uncontrolled</td>
<td>E10.22 Type 1 diabetes mellitus with diabetic chronic kidney disease</td>
</tr>
<tr>
<td>585.6 End stage renal disease</td>
<td>N18.6 End-stage renal disease</td>
</tr>
<tr>
<td>250.61 Diabetes with neurological manifestations, type 1, not stated as uncontrolled</td>
<td>Z99.2 Dependence on renal dialysis</td>
</tr>
<tr>
<td>357.2 Polyneuropathy in diabetes</td>
<td>E10.42 Type 1 diabetes mellitus with polynephropathy</td>
</tr>
<tr>
<td>V45.11 Renal dialysis status</td>
<td>Presence of AV shunt for dialysis</td>
</tr>
</tbody>
</table>

Other Impacts

E10.22 is a combination code in ICD-10-CM incorporating both the type of diabetes (type 1 is E10) and the manifestation chronic kidney disease (after decimal point.22). Instructions from Volume 1 under the code E10.22 is to “use additional code to identify stage of chronic kidney disease N18.1 –N18.6”. In this documentation the ESRD is documented.

Code the type of diabetes and each associated complication (diabetes with renal disease and diabetic neuropathy) in ICD-10-CM.

Code the stage of the patient’s chronic kidney disease per instruction under the diabetic code E10.22.

Code the dialysis and AV graft by the use of “status codes” (Z codes). The key word to find this status code in the Index to Diseases from Volume 3 is “Dependence” and then sub indent to the word “on” and then to the words renal dialysis Z99.2.
Scenario: ER Follow Up

Scenario Details

Chief Complaint
- “Seen in the ER over the weekend.”

History
- Mrs. Jones is a 64-year-old female, with a history of morbid obesity, type 2 diabetes with nephropathy, and asthma, presents here for follow-up ER visit two days ago for shortness of breath. Patient was discharged with a diagnosis of bronchitis, an Albuterol and Beclomethasone inhaler prescription, along with five day course of Z pack and a six-day steroid dose pack. Patient is improving on the regimen. She is no longer wheezing and her phlegm is now scant. Her sugars however, have been poorly controlled with the Prednisone with fasting sugars greater than 200.
- Patient has long-standing asthma with 2-3 exacerbations per week and daily need for rescue inhalers. Patient is still smoking half a pack a day. She is compliant with her inhalers when she is not feeling well.
- Patient has diabetes with overt proteinuria with her last creatinine of 1.3
- Hypertension
- Morbid Obesity

Review of Systems, Physical Exam, Laboratory Tests
- BMI 44; central adiposity; no respiratory distress; able to speak in full sentences
- BP 142/64 HR94 RR 12 Sats: 98% on RA
- HEENT: TM clear; conjunctiva clear; no sinus tenderness; mallampati 3 airway
- Neck: thick; no adenopathy
- Lungs: scattered wheezing; no consolidation prolonged expiratory phase
- Ext: thin no edema

Assessment and Plan
- Asthma: moderate persistent, with acute exacerbation
- Bronchitis
- Current Smoker
- Diabetes Type 2 with nephropathy and poorly controlled hyperglycemia secondary to prescribed use of steroid medication
Summary of ICD-10-CM Impacts

Clinical Documentation

- Choosing the first-listed diagnosis in this scenario is determined by the Section IV Guidelines of ICD-10-CM found in Volume 2 of ICD-10-CM
- Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services
- Selection of first-listed condition
- In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.
- ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit
- List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.
- Asthma was chosen as first-listed in this scenario.
- Asthma is classified as mild, moderate and severe with additional detail as intermittent, persistent and severe; include if there is acute exacerbation or status asthmaticus. Bronchitis was not specified as “acute” so the assignment is made to not specify as acute or chronic. In ICD-10-CM both bronchitis and asthma are reported separately.
- Bronchitis is reported separately from asthma per ICD-10-CM guidelines. Bronchitis was not specified as acute or chronic and the default code would be J40. Conditions involving infectious processes will have “acute” versus “chronic” choice. Providers should document whenever possible “acute” or “chronic”.
- Guidelines require reporting of tobacco use or exposure for respiratory, vascular and some other chronic illnesses such as oral and esophageal cancer codes. The guideline message for using these codes is found at the beginning of the respiratory Chapter 10 in this scenario.
- Diabetic manifestations are incorporated into the primary code for Diabetes Mellitus (combination codes). In this case diabetes with nephropathy is a combination code.
- “Uncontrolled” diabetes is no longer a concept in ICD-10. Diabetes that is poorly controlled should include whether hyperglycemia or hypoglycemia is present; whenever either is present it should be coded accordingly. This patient would also have hyperglycemia reported as the recorded Blood sugars show hyperglycemia.
- Adverse effects of prescribed medications are reported from the Table of Drugs & Chemicals and then a final code assignment from Tabular List for the 7th character. Identify which medications are causing adverse reactions and go to The Table of Drugs and Chemicals found in Volume 3 of ICD-10-CM. Along the left side of that table find the drug or (drug class if individual drug is not found.) Then the 7th characters are found at the beginning of the T38 category in Volume 1 (Tabular List) of ICD-10-CM. The choices for 7th character for this Table are:
  A= initial encounter
  D= subsequent encounter
  S= Sequela
**Clinical Documentation (continued)**

- In this scenario it would be an initial encounter as this is the first time this provider is evaluating the patient for this adverse effect.
- Hypertension and Obesity are documented as co-morbid conditions and reported when treatment is given for affected by these conditions. Instructions found at the obesity code instruct to also report the BMI if documented.
- Note: In ICD-10-CM “Nephritis” is not referenced in the diabetes complication codes with nephropathy

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>493.92</td>
<td>J45.41 Moderate persistent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>N/A</td>
<td>J40 Bronchitis, not specified as acute or chronic</td>
</tr>
<tr>
<td>305.1</td>
<td>F17.210 Nicotine dependence, cigarettes, uncomplicated</td>
</tr>
<tr>
<td>250.42</td>
<td>E11.21 Type 2 Diabetes Mellitus with diabetic nephropathy</td>
</tr>
<tr>
<td>583.81</td>
<td>N/A</td>
</tr>
<tr>
<td>N/A</td>
<td>E11.65 Type 2 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>995.20</td>
<td>T38.0x5A Adverse effect of glucocorticoids and synthetic analogues, initial encounter</td>
</tr>
<tr>
<td>401.9</td>
<td>I10 Essential (primary) hypertension.</td>
</tr>
<tr>
<td>278.01</td>
<td>E66.01 Morbid (severe) obesity due to excess calories</td>
</tr>
<tr>
<td>V85.41</td>
<td>Z68.41 Body mass index (BMI) 40.0-44.9, adult</td>
</tr>
</tbody>
</table>