Blue Cross Blue Shield of Michigan
and Blue Care Network

Documentation and Coding Tips for Professional Offices

ICD-10-CM EDITION

None of the information included herein is intended to be legal advice and as such it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.

* Please review the ICD-10-CM coding manual for the fourth through seventh digit subcategories for greater specificity in code selection. Note that in ICD-10-CM, a dash (-) indicates additional characters are required.

It all begins with documentation

What's the reason for the office visit?

Documentation in a medical record should consistently demonstrate the nature of the presenting problem(s). The assessment, plan and diagnoses need to be complete and consistent with the visit reason in order to support medical necessity.

Follow the M.E.A.T. theory for documenting diagnoses.

- **M**anaged **E**valuated **A**ssessed **T**reated
- Don't limit documentation only to the chief complaint, but all conditions that affect the care of the patient.
- Chronic conditions that affect patient care need to be recorded at least once yearly. Document management or current status of the condition. For example, COPD can be compensated, stable or controlled by medication.

Diagnosis	M.E.A.T. concept
Atrial flutter: I48.92	Is it "managed" by medication?
Personal history of prostate cancer Z85.46	How was this condition evaluated or assessed during the visit?
Malignant neoplasm of lower outer quadrant right female breast C50.511	What is the treatment of the cancer? Treatment may include radiation or prescription while in remission, such as Tamoxifen.

It all begins with documentation

Summing up the office note:

- Documentation in the medical record should support medical necessity. Document the reason for the office visit, including chronic conditions, by clearly stating each diagnosis along with the assessment and plan of treatment.
- Describe the current status of the condition/disease. Use descriptive words such as new, stable, controlled, managed, etc.
- "History of" should only be documented in the assessment if the patient has been cured or no longer has the disease.
- For infectious diseases, document the organism if known. For example, UTI due to E. Coli.
- Caution in the use of abbreviations and symbols: Arrows **cannot** be used to determine a patient's diagnosis. For example: ↑ BP cannot be assumed to mean that the patient has high blood pressure or hypertension. Documentation requires verbiage.
- Treatment plan: document labs, tests referrals, and medications. Document if patient takes Coumadin® for atrial fibrillation.

Document any post-surgical status at least once yearly

Post-surgical status examples	ICD-10-CM codes
Liver transplant	Z94.4
Gastrostomy	Z93.1
Colostomy	Z93.3
Amputation (below the knee)	*Z89.51-

It all begins with documentation

The documentation transition from ICD-9-CM to ICD-10-CM

ICD-9-CM Documentation	ICD-10-CM Documentation	Changes
Femur fracture 821.00 closed fracture of unspecified part of femur	***Femur fracture*** S72.8X1A Closed fracture of right femur, *initial encounter *refer to tip card #1 for encounter types	Fracture specificity and encounter type
Ulcer 707.8 chronic ulcer of other specified site	***Ulcer*** L98.413 non-pressure chronic ulcer of buttock with necrosis of muscle	Ulcer specificity and location in one code
Late effect of CVA 438.20 late effect of CVA with hemiplegia of unspecified side	***Late effect of CVA*** I69.151 hemiplegia following nontraumatic intracebral hemorrhage affecting right dominant side	Stroke type and side dominance
Noncompliance with medication 780.39 seizure V15.81 non compliance with medical treatment	***Noncompliance with medication*** R56.9 seizure T42.4X6 Benzodiazepine under-dosing	Underdosing instead of non compliance or unspecified cause

Criteria for the medical record

The medical record should include:

- The office encounter should identify the patient, date of service, provider name, credential and signature.
- Pages in the medical record must flow in a way that makes patient identity and date of service clearly identifiable.
- Legible documentation.
- The medical record should be logically organized and clearly demonstrate the visit was "face-to-face."

Signature requirements

Handwritten: CMS guidelines indicate that a provider's handwritten signature is acceptable if it is:

- A fully legible signature, including credential.
- A legible first initial, last name and credential.
- An illegible signature is allowed when over a typed or printed name and credential.
- An illegible signature is allowed when the letterhead, addressograph or other information on page indicates the identity and credential of the signer.

Electronic signatures: The signature must be authenticated, password-protected and exclusively used and signed by the provider.

Electronic signature examples	
Electronically signed by	Authenticated by
Approved by	Approved electronically
Digitally signed	Validated by
Finalized by	Completed by

IMPORTANT INFORMATION TO KNOW ABOUT ICD-10-CM

Documentation involves being descriptive and supportive of the care provided

ICD-10-CM Documentation Tips to focus on:

- When describing an injury include the encounter type **A**-*initial encounter* **D**-*subsequent encounter* **S**-*sequela*
  - Subsequent encounter is after the patient has received active treatment for an injury and is receiving routine care for the injury during the healing or recovery phase (e.g., cast change, aftercare or follow-up visits.).
  - Sequela is the late effect from an acute condition or injury
- Required documentation for diabetes mellitus must show causal effect of DM and associated complications:
  - Type 1 or 2
  - Body system(s) affected
  - Identify and document all associated conditions
- Laterality - documentation should be specific. For example, right, left, upper, lower, anterior, posterior, medial, lateral or bilateral.
- Stages of ulcers-healing
- List trimesters or weeks of gestation for your pregnant patients
- Avoid use of vague and general terms; for example, foot fracture
- STEMI – now considered 4 weeks or less not 8 (provide timeline)
- Underdosing- refers to patients using less medication than prescribed.

For your patients with vascular diseases

For a comprehensive patient representation:

- Document assessment, evaluation and treatment of conditions such as peripheral vascular disease and deep vein thrombosis.
- Document and assess aortic atherosclerosis.
- Describe the **reason** for which ongoing anticoagulant therapy would be required. For example, is this a chronic condition or for prophylactic use?

Common vascular conditions	ICD-10-CM
Atherosclerosis of aorta	I70.0
PVD (peripheral vascular disease, intermittent claudication, peripheral angiopathy, spasm of artery)	I73.9
Acute DVT	*I82.40-; I82.41-; I82.42-; I82.43-; I82.44-; I82.49-; I82.4Y-; I82.4Z-
Chronic DVT	*I82.50-; I82.51-; I82.52-; I82.53-; I82.54-; I82.59-; I82.5Y-; I82.5Z-
Acute pulmonary embolism without acute cor pulmonale	*I26.9-
Chronic pulmonary embolism	I27.82

For your patients with heart disease

Heart failure - ICD-10-CM code *I50.-

- Acute, chronic, or acute and chronic
- Systolic or diastolic
  - Document to an underlying condition. For example, hypertensive congestive heart failure.

ST Elevation (STEMI) myocardial infarction and angina pectoris

- Documentation must be specific. Unspecified conditions, such as coronary artery disease or atherosclerotic heart disease, may only be coded if a more specific diagnosis is not provided.
- For encounters within 4 weeks of the STEMI, use codes from category *I21-.
- For encounters related to the MI after 4 weeks, assign subsequent encounter and specify the site.
- For an old or healed MI not requiring further care, use code I25.2.

Cardiomyopathy

- Ischemic
- Idiopathic
- Post-partum

Document any ongoing atrial fibrillation, ventricular flutter, sinus bradycardia or other arrhythmias that require medication management.

For your patients with respiratory disease

Document all chronic pulmonary diseases being managed, or that may affect patient care.

These conditions include: chronic obstructive pulmonary disease, chronic bronchitis and emphysema.

*ICD-10-CM codes to consider

J20.9 Acute bronchitis	J43.9 Emphysema	J44.9 COPD NOS	Z93.0 Tracheostomy status

Supporting a diagnosis could be expressed by documenting:

- Arterial blood gas, pulse oximetry or spirometry test
- Medication and proper inhaler use
- Use of oxygen

For bacterial pneumonia, be sure to document the specific organism ***if*** known.

For your patients with asthma

It's important that documentation is detailed and describes the level of intensity. Exacerbation or status asthmaticus, if present, needs to be documented.

Example of a treatment plan may include:

- Regular asthma checkups
- Medication compliance
- Patient education — triggers and avoidance

Asthma with other respiratory conditions	ICD-10-CM codes
Moderate persistent asthma with exacerbation	J45.41
Asthma with status asthmaticus	J45.902
Asthma exacerbated with COPD	J44.1
Exercise-induced bronchospasm	J45.990

- Specify the type of asthma and indicate exacerbation or status asthmaticus.
- Asthma can also be seen with COPD or characterized as obstructive.

For office/billing staff:

Asthma is a condition that can be found in diseases of the respiratory system. It affects people of all ages, but most often begins during childhood. This is a long-term condition that doesn't go away, so treatment is focused on controlling the disease.

For your patients with cancer

Active cancer diagnoses

Documentation must support treatment which may include surgical intervention, chemotherapy, radiation therapy, hormone or adjuvant therapy.

- Patients who haven't received any treatment for their malignancy should continue to have an active cancer diagnosis.
- Patients on adjuvant therapy (Tamoxifen, Lupron, Casodex® and 5-FU) are coded as if they have active disease, i.e. breast cancer* (C50.-) category or prostate cancer (C61).

History of cancer diagnosis

- ICD-10-CM coding manual guidelines identify personal history of cancer (*Z85-) as "a patient's past medical condition that no longer exists and is not receiving any treatment but that has potential for recurrence and may require continued monitoring."

  Note: Exceptions are the different forms of leukemia.

All tumors require documentation of behavior:

- Primary
- Secondary
- Benign
- Malignant
- Unspecified
- Uncertain
- In situ

For example, metastatic carcinoma to the brain from lung: Primary-Lung C34.90, Secondary-Brain C79.31

Documentation should indicate remission or relapse status.

For your patients with rheumatoid arthritis & inflammatory connective tissue disease

- Document the type of arthritis. For example, rheumatoid arthritis.
- Pathological fractures require documentation of the condition that has caused the fracture.
- *Osteomyelitis* requires documentation describing the area or site.
- Manifestations associated with the diagnosis of lupus should be noted. For example, lupus nephritis.
- Fracture documentation should describe the encounter type (i.e. initial encounter, subsequent encounter or sequela. Also mention the site and laterality.

Unspecified diagnoses	Specified diagnoses
Arthritis	Rheumatoid arthritis
Fracture	Pathological fracture
Hip and back pain	Sacroiliitis
Joint disorder	Osteoarthritis

Supporting diagnosis could be expressed by noting:

- Joints affected
- *Symmetrical* joint pain
- Rheumatoid nodules
- Erosion on X-ray
- Morning stiffness

For your patients with neurological diseases

Since there are different types of neuropathy, specificity is key for documentation. Examples may include:

- Peripheral neuropathy
- Polyneuropathy
- Diabetic neuropathy

Assessment for neuropathy may include:

- Monofilament test
- Labs
- EMG

*Hemiplegia is **not** inherent to an acute CVA (if the condition happens to be due to a CVA then it needs to be documented as such in order to correctly capture the condition).*

Document any managed or treated chronic neurological conditions.

Conditions to consider	ICD-10-CM code
Parkinson's	G20 or *G21.-
Cerebral palsy	*G80.-
Multiple sclerosis	G35
Paraplegia/Quadriplegia	*G82.2- & *G82.5-
Epilepsy and recurrent seizures	G40.909

For your patients with convulsions/seizure disorders

Physician documentation must specify the reason for the seizure or convulsion, if known, such as **seizure disorder** or **epilepsy**. If the cause is unknown or documentation is lacking, only the symptoms can be coded.

Important to reference epilepsy seizure types	
Grand mal	Tonic
Myoclonic	Clonic
Atonic	Absence

Epilepsy and recurrent seizures require a fifth character code to describe if intractable epilepsy is present or not.

Condition	ICD-10-CM codes	Condition	ICD-10-CM codes
Seizure	R56.9	Seizure disorder	G40.909
Complex febrile seizure	R56.01	Febrile seizure	R56.00
Epilepsy	G40.909	Epilepsy - grand mal	*G40.4-
Convulsion	R56.9	Febrile convulsion	R56.00

For office/billing staff:

The terms seizure and convulsion are interchangeable, both the result of a manifestation that occurs after an episode of abnormal electrical activity in the brain. These symptoms may vary according to which part of the brain was affected. There can be multiple causes leading to a seizure.

For your patients with diabetes and neuropathy

Document the ***cause and effect relationship*** if your patient's neuropathy is secondary to diabetes.

Documentation must indicate a link between diabetes and neurological manifestation, such as:

- Neuropathy due to diabetes
- Peripheral neuropathy secondary to diabetes
- Diabetic polyneuropathy
- Neuropathy caused by diabetes
- Polyneuropathy associated with diabetes

For example, when documentation supports a "link" between type 2 diabetes with hyperglycemia and polyneuropathy on insulin, the code assignment would be:

- E11.42: Type 2 diabetic polyneuropathy
- E11.65 Hyperglycemia
- Z79.4: Long-term (current) use of insulin

For office/billing staff:
Noting the cause and effect of a condition in the medical record establishes a complete picture of the patient's office visit, which can be accurately coded.

For your patients with diabetes and peripheral vascular disease

Document the **cause and effect relationship** if your patient's peripheral vascular disease is secondary to diabetes.

Establish a "link" between diabetes and peripheral vascular disease by documenting the following:

- Diabetes associated with peripheral vascular disease
- Diabetic peripheral vascular disease
- Gangrene caused by diabetes
- Peripheral vascular disease secondary to diabetes

For example, when documentation supports a link between diabetes type 1 and peripheral angiopathy on insulin, the code assignment would be:

- E10.51: Type 1 diabetic peripheral angiopathy without gangrene
- Z79.4: Long term (current) use of insulin

If gangrene is present:

- E10.52: Type 1 diabetic peripheral angiopathy with gangrene

For office/billing staff:
Noting the cause and effect of a condition in the medical record establishes a complete picture of the patient's office visit, which can be accurately coded.

For your patients with diabetes and ophthalmic complications

Document the **cause and effect relationship** if your patient's eye disease is due to diabetes.

You can establish a "link" between diabetes and an eye condition by documenting the following:

- Diabetes associated with nonproliferative retinopathy
- Diabetic macular edema
- Proliferative retinopathy due to diabetes
- Cataract caused by diabetes

For example, when documentation supports a "link" between diabetes mellitus type 2 and diabetic nonproliferative retinopathy on insulin, the code assignment would be:

- E11.329: Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
- Z79.4: Long-term (current) use of insulin

For office/billing staff:
Noting the cause and effect of a condition in the medical record establishes a complete picture of the patient's office visit, which can be accurately coded.

For your patients with diabetes and kidney disease

Document the **cause and effect relationship** if your patient's chronic kidney disease is due to diabetes.

Establish a "link" between diabetes and kidney condition by documenting the following:

- Diabetes associated with chronic kidney disease, Stage 4
- Diabetic chronic kidney disease, Stage 5
- Chronic kidney disease, Stage 4 due to diabetes
- Chronic kidney disease, Stage 5 secondary to diabetes

For example, when documentation supports a "link" between diabetes type 2 and chronic kidney disease, Stage 4, the code assignment would be:

- E11.22: Type 2 diabetes mellitus with diabetic chronic kidney disease
- N18.4: Chronic kidney disease, Stage 4

For office/billing staff:
Noting the cause and effect of a condition in the medical record establishes a complete picture of the patient's office visit, which can be accurately coded.

For your patients with chronic kidney disease

The National Kidney Foundation endorses the term chronic kidney disease. Documentation of CKD must be classified into one of the five stages:

ICD-10-CM Stages of CKD	
Stage 1	GFR>90
Stage 2	GFR 60-89
Stage 3a	GFR 44-59
Stage 3b	GFR 44-30
Stage 4	GFR 15-29
Stage 5	GFR<15

Report Z99.2, Renal dialysis status if applicable

Supporting documentation could be expressed by noting:

- Baseline/current lab values
- GFR
- Monitoring weight fluctuation
- Dietary restrictions

For office/billing staff:
Chronic renal disease and chronic renal insufficiency are nonspecific terms and can mean any degree of kidney failure.

For your post-cerebrovascular accident patients

Caution: "History of" or late effects of CVA should be documented when the patient is following up in the provider's office after the initial episode.

- ICD-10-CM diagnosis code *I63.- is used for the **initial** episode for an acute cerebrovascular accident. Acute CVAs are usually only seen or treated in the hospital.
- History of a CVA with no residual effects can be coded using Z86.73.
- Sequela (late effects): *I69.- describes sequelae of cerebrovascular disease. This category is used to indicate conditions in code categories *I60.- through*I67.-
  - The sequela may be present from the onset or may arise any time after the acute phase.
  - There is no time limit for coding the sequela of a CVA
  - The sequela may be documented as long as the condition persists
  - Weakness vs. Hemiparesis. *Please be specific.*

For your patients experiencing chronic ulcers of the skin

- Document conditions such as wound, sore or skin breakdown to avoid confusion with chronic ulcers of the skin.
- In ICD-10-CM, additional codes have been added to identify site and laterality.
- It's not necessary to note the stage when documenting chronic skin ulcers (unlike decubitus ulcers).
- Risk factors for pressure or decubitus ulcers include:
  - Bedridden patients
  - Chronic conditions such as diabetes mellitus or vascular disease
  - Immobility due to brain or spinal injury
  - Wheelchair dependent

Decubitus ulcers ***require*** progression of the ulcer to be documented. For example:

Pressure or decubitus ulcer stages:

- Unspecified stage
- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Unstageable

Documentation should also indicate location of the ulcer, and whether it's heal**ed** or heal**ing**.

For your patients with mental, behavioral and neurodevelopmental disorders

For mental, behavioral and neurodevelopmental disorders, clearly indicate severity of condition.

- Mild
- Moderate
- Severe, *with* or *without* mention of psychotic features
- Severe, *with* or *without* mention of psychotic symptoms
- In *partial* or *full* remission

Major depressive disorder *F32.-

- Major depressive disorder, recurrent in remission *F33.4-
  - Major depressive disorder, recurrent moderate F33.1

Bipolar disorder *F31.-

- Bipolar disorder current episode depressed, moderate *F31.32
  - Bipolar disorder in partial remission, most recent episode, mixed. F31.77

For office/billing staff:
Conditions that affect mental health cover a broad spectrum of diagnoses for children as well as adults.

For your patients with mental, behavioral and neurodevelopmental disorders

Clear documentation is required for differentiating substance abuse *and* dependence.

Alcohol abuse *F10.1-

- Alcohol abuse with intoxication, unspecified F10.129

Alcohol dependence *F10.2-

- Alcohol dependence, in remission F10.21
- Alcoholic cirrhosis of the liver with ascites K70.31

Schizophrenia, autism and other common behavioral and emotional disorders require M.E.A.T when documented

Schizophrenia *F20.-

- Schizoaffective disorder, bipolar type F25.0

Autistic disorder F84.0

- Asperger's disorder F84.5

Attention-deficit hyperactivity disorder *F90.-

- Attention-deficit hyperactive disorder, combined type F90.2

Conduct disorder, *F91.-

- Conduct disorder, childhood-onset type F91.1

For your patients experiencing complications with implants or medical devices

Describe conditions that are a result of medical care or trauma and **document** accordingly.

Examples:

- Post-traumatic wound infection.
- Mechanical failures of pacemakers or implantable cardiac defibrillators, such as broken lead wires, defective housing or device recall.
- Mechanical complications of orthopedic device or implant.
- Infection or inflammation of internal device or implant.
- To accurately capture an infection or inflammatory reaction as a result of an indwelling *urinary* catheter, the catheter must have been in place before the infection occurred and the documentation must demonstrate that the catheter caused the infection.

For office/billing staff:
Complication codes for medical implants or other medical devices can be found in the *T82.- through *T85.- series in the coding manual.

Note: In ICD-10-CM some complication codes have been re-assigned to the specific body system chapter.

For patients at risk for malnutrition

Supporting evidence for malnutrition could be expressed by documenting:

- Severity of malnutrition
- BMI
- Dietary consults
- Supplementary feedings via nasogastric tube
- Total parenteral nutrition

Protein-calorie malnutrition may accompany:

- Normal aging
- Cancer
- Drug or alcohol abuse and/or dependence
- Liver disease
- Anemia

Documentation and coding examples of malnutrition:

Cachexia	R64
Protein calorie malnutrition – mild	E44.1
Protein calorie malnutrition – moderate	E44.0
Severe protein calorie malnutrition	E43

Obesity

A diagnosis of obesity *must* be documented by the **physician**. Body Mass Index (*Z68.-) may be assigned based on medical record documentation from clinicians, including nurses and dietitians.

Please document when obesity is morbid and note the BMI

- Overweight (E66.3)
- Obese (E66.9)
- Morbid obesity (E66.01)

Examples of plan/treatment documentation

- Impact on health
- Diet
- Exercise
- BMI

Note: Only Documenting the BMI does not support the obesity type.

BMI categories and ICD-10-CM codes (listed in parentheses)	
Examples:	
Obesity, unspecified (E66.9) *BMI between 30.0-39.9	Morbid obesity (E66.01) *BMI 40 or greater

For your pregnant and postpartum patients

Important facts:

Any condition that occurs during pregnancy, childbirth or the puerperium is considered to be a **complication** unless documentation indicates otherwise. Conditions present prior to pregnancy must be documented.

- *Always* document **pre-existing** conditions as a condition *prior* to pregnancy.
- Indicating **pregnancy trimester** (or number of weeks gestation) is necessary for accurate documentation:
  - First trimester - describes the gestation period less than 14 weeks and 0 days.
  - Second trimester - 14-weeks, 0-days gestation to less than 28 weeks and 0 days.
  - Third trimester - 28 weeks, 0-days gestation until delivery.

For office/billing staff:

Important terms to know:

- Antepartum - The period of pregnancy from conception to childbirth.
- Postpartum - The period beginning right after delivery and including the next six weeks.
- Puerperium - The clinical term for the postpartum period.
- Post-term pregnancy - Completion of 40 through 42 weeks of gestation.
- Prolonged pregnancy - Advanced gestation beyond 42 completed weeks.
- "At term" - 37 weeks, but less than 42 weeks of gestation.

For your pregnant and postpartum patients

Situations seen during pregnancy and postpartum	ICD-10-CM codes
Pregnant state incidental – Document when the patient is seen for a condition that is completely unrelated to the pregnancy. For example, patient visits physician for a fracture, and happens to be pregnant. **Note:** Physicians must document that the pregnancy is incidental to the reason for the encounter.	Z33.1
High Risk Pregnancy – describes a patient that is either 35 or older or 16 years old or younger. The 5th character describes the patient's trimester	*O09.9-
Routine Prenatal Care – Use this category when there are no complications present. The 5th character describes the patient's trimester.	*Z34.9-
Spontaneous abortion – The loss of pregnancy without intervention.	O03.9
Postpartum complications – Any complication that occurs after delivery through the six-week postpartum period should be documented as a postpartum complication. For example, deep vein thrombosis postpartum.	O87.1 DVT postpartum (use additional code *I82.4- to identify the DVT)
Late effect (sequelae) of complication of pregnancy, childbirth, or the puerperium – assign when an initial complication develops a sequela that requires treatment at a later date. Eg., Patient develops nipple abscess postpartum following cracked nipple from lactation.	O91.03 Nipple abscess due to lactation O94 Sequelae of complication of pregnancy, childbirth, and puerperium

Immunizations

- ICD-10-CM uses only one diagnosis code Z23 to describe the need for prophylactic vaccination (This differs from ICD-9-CM because specific diagnosis codes were assigned for each vaccination)
- Immunizations may not be carried out due to contraindications such as illness or allergy. Refer to *Z28.0-
- Refusal of vaccination may be due to beliefs and can be referenced with Z28.1
- Patient decision for other and unspecified reasons for immunization refusal can be found with *Z28.2-
- Caregiver refusal or patients having had a disease is another common reason for immunization refusal. Refer to *Z28.8-

***It is important to note that procedure codes are required with the diagnosis to identify the types of immunization that are given.**