

ICD-10: Interactive Training Guide

Let's Get Started!







Inform Educate Assist

Navigating this document









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- **1. Menu -** The menu allows the user to jump to any section of the book.
- **2. Back / Next -** These buttons allow for page-to-page navigation.
- **3. Medical Specialty Selection -** This takes you to the medical specialty selection screen.
- **4. ICD-10 Conversion Charts -** Opens a browser window with ICD-10 reference material providing a comparison of ICD-9 codes to their ICD-10 counterparts.







■ ICD-10: Interactive Guide

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Introduction







Introduction

The History of International Classification of Diseases

The World Health Organization (WHO) first established diagnosis coding with the 6th edition of a published classification of index of diseases, reformatted to become the International Classification of Diseases (ICD). WHO defines the classification as "The standard diagnostic tool for epidemiology, health management and clinical purposes. This includes the analysis of the general health situation of population groups. It is used to monitor the incidence and prevalence of diseases and other health problems." (1)

This translates into codified data detailing the diseases and other health problems recorded on many types of health and vital records including death certificates and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological, and quality purposes, these records provide the basis for the compilation of national mortality and morbidity statistics by WHO member states. It is also used for reimbursement and resource allocation decision-making by countries.







ICD-9: Today

The current method of diagnosis coding in the U.S. is ICD, 9th Edition, Clinical Modification (ICD-9). It has become obsolete, contains outdated terminology and does not allow for updates in healthcare, medicine and technology that have occurred in the 21st century. Due to these limitations, it has been mandated that all healthcare providers in the United States comply with the International Classification of Diseases, 10th Edition, Clinical Modification / Procedure Coding System (ICD-10). ICD-10 will fully replace ICD-9.

On March 31, 2014, the US Senate voted to approve H.R. 4302, Protecting Access to Medicare Act of 2014. This included language delaying the implementation of ICD-10 to October 1, 2015.

ICD-10: Future

ICD-10 is not a simple update to ICD-9. The structural changes throughout the coding system are substantial, and the increased level of complexity requires not only training for your coders but also requires significant involvement from the physicians, billing staff, and any areas in your practice that currently utilize ICD-9. The objective of this ebook is to serve as a resource tool to understand, train, and successfully implement ICD-10.











The Specifics

ICD-9 has long lacked necessary specifics, such as similar injuries on opposite limbs having the same ICD-9 code. This reduces documentation effectiveness and has caused confusion on many different levels. ICD-10 offers a greater degree of specific information in areas such as right versus left, initial or subsequent encounter, and other relevant clinical information. This greater degree of specificity is utilized with a number of different methods, many of which are covered in this ebook.

odes Almost 5x the Codes
odes Longer Codes
odes Combination Codes
Only Use of Alphabet
ology Modern Technology
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Number of Codes

As part of the effort to provide more information, ICD-10 currently has roughly 68,000 available codes, with flexibility for adding new ones, in comparison to ICD-9's 14,000 codes and limited space for additions. ICD-10 codes are different than before, so education is crucial in understanding new coding rules, guidelines, and documentation requirements, as well as understanding the indexing for the many new codes.

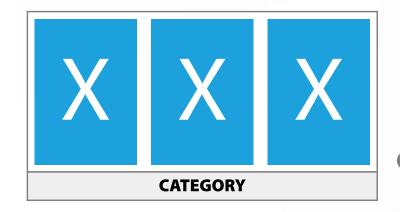


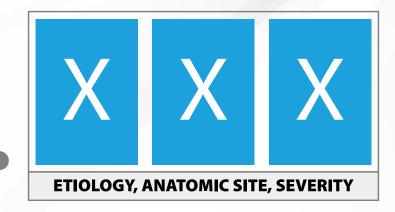














Length of Codes

The expanded number of characters of the ICD-10 diagnosis codes provides greater specificity to identify disease etiology, anatomic site, and severity.

ICD-10 Code Structure:

- ♣ Characters 1-3 Category
- ◆ Characters 4-6 Etiology, anatomic site, severity, or other clinical detail
- Character 7 Extension

The following example shows the more detailed information gained through the added characters.

- **\$52** Fracture of forearm
- **\$52.5** Fracture of lower end of radius
- **\$52.52** Torus fracture of lower end of radius
- **\$52.521** Torus fracture of lower end of right radius
- **\$52.521A** Torus fracture of lower end of right radius, initial encounter for closed fracture

In this example, S52 is the category. The fourth and fifth characters of "5" and "2" provide additional clinical detail and anatomic site. The sixth character in this example indicates laterality, i.e., right radius. The seventh character, "A", is an extension that provides additional information, which means "initial encounter".









E11.22 - Type 2 diabetes mellitus with diabetic chronic kidney disease

ICD-10 I50.21 - Acute systolic (congestive) heart failure

ICD-10 I13.1 - Hypertensive heart and chronic kidney disease without heart failure

Combination Codes

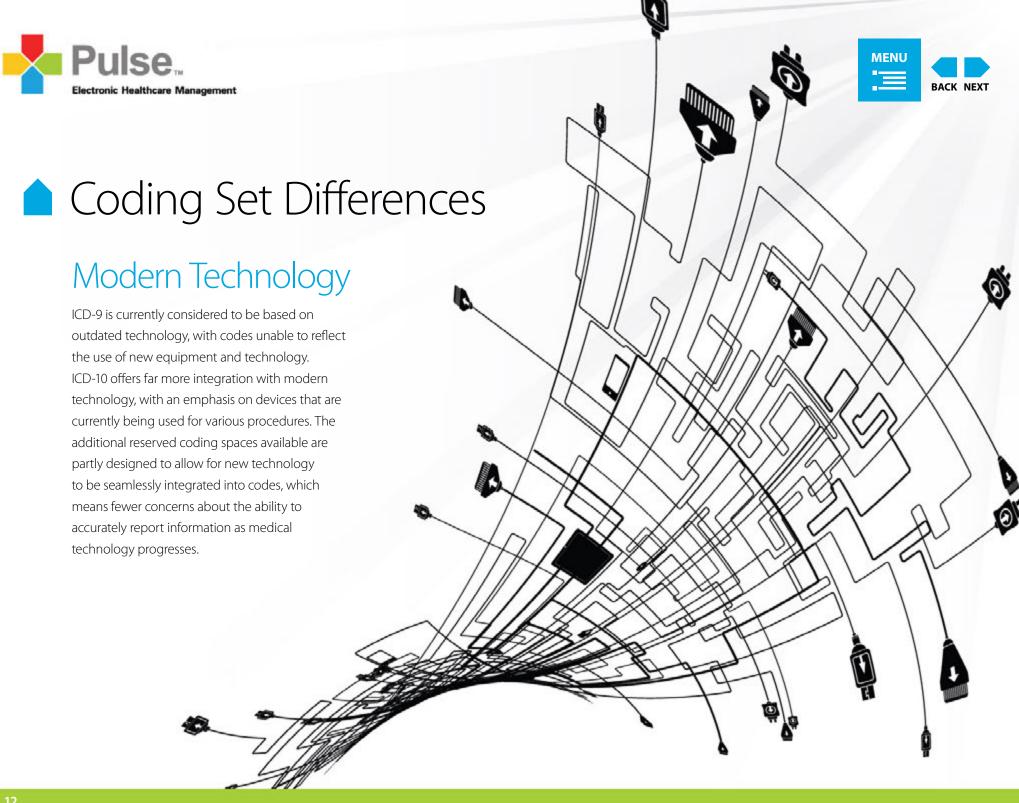
ICD-10 provides further use of combination codes that can be used to classify such things as multiple diagnoses or a diagnosis with a complication.

These are expressed as single codes, reducing the number of codes that need to be made while still providing information that is as specific as possible.

Example: ICD-10 requires only one code, E08.42 "Diabetes mellitus due to underlying condition with diabetic polyneuropathy", while ICD-9 would require a minimum of two codes, 357.2 and a code from the code range 249.6-250.6.

Use of Alphabet

ICD-9 only utilized numeric codes. In contrast, ICD-10 utilizes alpha-numeric codes as part of its effort for more specificity. The characters will not be case sensitive, and both alphabetic and numeric codes are intended to retain identical meanings as much as possible throughout code sets and procedure sections.











Improvement areas to consider

Documentation will be significantly impacted by ICD-10 implementation. The changes in the documentation requirements to allow for the granular level of coding required by the new code set must be properly documented in order for the coder to assign the correct code set to the record. Repeated inquiries to the physician to clarify documentation will slow down the revenue cycle. Educating the clinicians on the new documentation requirements is essential to a successful ICD-10 implementation. Consider these suggestions to evaluate and monitor your documentation improvement initiative:

- + Assess documentation for ICD-10 readiness. Take a sampling of current records and analyze the documentation as to whether it meets the requirements for the ICD-10 code. If the documentation states only "fracture of the right patella" it would be missing five other documentation requirements required for a proper code assignment.
- **★** Implement early clinician education. If the clinician begins documenting the record with the new requirements now, impact will be greatly reduced.

Post Implementation Assessment

Establish a concurrent documentation review program. Closely monitor claims being denied due to incomplete documentation and implement a process for an audit and feedback to the providers.









Are you ready?

The best way to prepare for ICD-10 is to start utilizing workflows now that will need to happen with ICD-10. There is not a grace period once ICD-10 is put into effect. Take advantage of this time and start transitioning, so that on October 1, 2015 your processes are established and understood.

If you would like assistance in performing an assessment of your current practice and establishing ICD-10 processes, contact Pulse RCM. Our RCM Managers and certified professional coders are ICD-10 certified, with the knowledge and expertise to help ensure a successful transition for your practice.

Accuracy of diagnosis

Good clinical documentation starts with a good grasp of understanding documentation requirements and the associated rationale. While some unspecified codes are still acceptable to payers, the increased specificity in ICD-10 codes means that simply saying a patient has uncontrolled diabetes is no longer sufficient. ICD-10 codes will ask for the type, complication, and manifestation, requiring providers to understand and document the difference between diabetes mellitus due to an underlying condition and diabetes induced by drugs or chemicals.

In ICD-9, the fifth digit of diabetes codes not only indicate the type of diabetes but also whether the diabetes is uncontrolled or out of control. In ICD-10, the physician must document that the diabetes is inadequately controlled, out of control, or poorly controlled. You have to code the diabetes by type and add 'with hyperglycemia'.

This is a documentation challenge just as much as a coding challenge. After all, if it isn't written down, then it might as well never have happened. A coder can't code what doesn't exist.









Completeness of documentation

Physicians must be as specific as possible when charting notes. Since ICD-10 takes into account more variables than ICD-9 documentation, it is better for physicians to provide more rather than less.

This information is likely already being shared by the patient during your visit—it's just a matter of recording it for your coding staff. Good documentation will also help reduce the need to follow-up on submitted claims saving you time and money.

Oueries and clarifications

ICD-10 will require coordination and communication.

A busy physician with twenty or thirty patients per day may not remember every detail of his encounter with each patient. As a result the provider is at risk of supplying inaccurate or incomplete information in the event that they need to supplement their documentation after the fact. If physicians don't understand what they need to provide to the coders, the coders will have no choice but to come back to them for specificity.

Understanding the new documentation requirements and documenting them timely will reduce the amount of "after the fact" queries, which could possibly result in timely filing issues and impact the revenue cycle.

Continue to see Clinical **Documentation Requirements** & Examples by Medical Specialty









View by Medical Specialty

Please select a medical specialty below to jump to that section.

Anesthesiology	Cardiovascular	Dermatology
Diagnostic Radiology	Endocrinology	ENT
Family Practice	Gastroenterology	General Surgery
Gynecology	Hematology	Internal Medicine
Mental Health	Nephrology	Neurology
Obstetrics	Ophthalmology	Oncology
Orthopedics	Pathology	Pediatrics
Plastic Surgery	Podiatry	Pulmonary
Radiology	Substance Abuse	Urology







Anesthesiology

Clinical Documentation













Anesthesiology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right, bilateral, multiple locations
- **Status of** + Acute
- **Disease** + Chronic
 - Intermittent
 - ★ Recurrent
- **General** + Detailed locations (Head, Shaft, Proximal, Distal, etc.)
- Injuries
 - + Episode of care (Initial, Subsequent, Sequela)
- **Cause of** Mechanism How it happened (struck by basketball) Injuries
 - ♣ Place of occurrence Where it happened (high school)
 - + Activity What patient was doing (playing basketball)
 - + External cause status Military, Civilian, Work-related, Leisure













Anesthesiology Clinical Scenario

Preop Diagnosis

Intractable back pain which is due to diskogenic pain, L4-L5, L5-S1 as well as facet arthrosis and lumbar spondylosis, status post injury.

Postop Diagnosis

Intractable back pain which is due to diskogenic pain, L4-L5, L5-S1 as well as facet arthrosis and lumbar spondylosis, status post injury.

Procedure Performed

Bilateral L3-L4 medial branches, L5 distal primary ramus, and S1 accessory branch radiofrequency neurotomy.

Findings and Procedure

Following informed consent, the patient was taken to the operating room and placed prone on the fluoroscopy stretcher. The entire back was prepped and draped in sterile surgical fashion. Using a sterile technique, a fluoroscope was brought into

view and the lumbar spine was examined. The superior medial aspect of the transverse processes of bilateral L4 and L5 at the junction of superior articular processes were denoted on the skin. The bilateral sciatic notch as well as the superior medial aspect of the posterior foramen of S1 was equally delineated. These areas were infiltrated with 1% lidocaine using 1-1/2-inch 27-gauge needle. Next, the radiofrequency pulse generator was primed ready and the safe test was completed. A Smith & Nephew device was utilized.

A 22-gauge, 10-mm tip radiofrequency cannula with a bent tip was gently advanced through the anesthetized skin and guided into the respective targets as noted above. Next, the radiofrequency sensory and motor stimulation parameters were then utilized to guide and locate the appropriate targets. The patient demonstrated paresthesia on multifidus muscle stimulation at bilateral S1-L4 as well as L3. She had no significant stimulation or paresthesia on the level of L5 dorsal primary ramus.

Radiofrequency lesion was then created at 80 degrees for 90 seconds at each of the above levels bilaterally. At the end of lesioning, an injection that contained 40 mg of Depo-Medrol and 0.5% bupivacaine was instilled, 1 mL into each level, to prevent post radiofrequency neuritis. The radiofrequency probe was removed and the cannula was dilated and removed. Pressure dressing was applied over all the injection sites. The patient was taken to the recovery area in stable condition.







Cardiovascular

Clinical Documentation







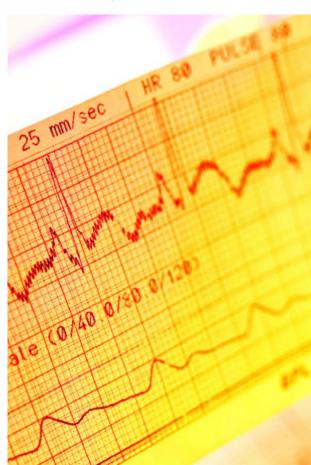






Cardiovascular Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Laterality + Left, right, bilateral, multiple locations

Status of + Acute

Disease + Chronic

Intermittent

Recurrent

+ Transient

Primary

★ Secondary

Diabetes • Type I, Type II or due to other disease / drug

> Link Diabetes to complications

Nervous + Primary versus secondary System

disease and cause

+ Presence of Intractable disease

Nervous + Level and type of paralysis System

System

Circulatory + Acute Myocardial Infarction time period is 4 weeks

> + Link complications to Hypertension

★ Systolic versus diastolic heart failure

+ Left versus right heart failure Rheumatic versus nonrheumatic disease

Traumatic versus nontraumatic cerebral hemorrhage and cause of hemorrhage or infarction

> ♣ Artery blocked or ruptured







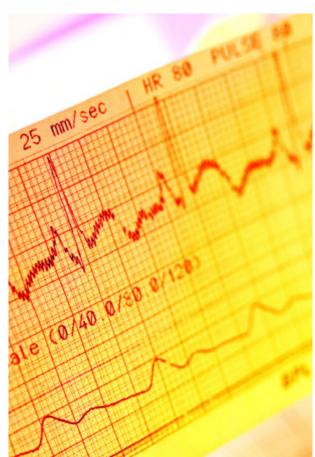






Cardiovascular Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Respiratory + Exacerbation of chronic disease

System + Effects of tobacco use/exposure on respiratory system

Genitourinary + Primary versus secondary disease

◆ Stage of chronic kidney disease

+ Link infectious agent or cause to disease













Cardiovascular Clinical Scenario

Procedures Performed

- 1. Left and Right heart catheterization
- 2. Left ventriculography and coronary angiography
- 3. Intracardiac echocardiography

Indication

- 1. Secundum-type atrioseptal defect.
- 2. Congestive heart failure, chronic, systolic.

Brief History of Present Illness

This is a 63 year old who has chronic dyspnea on exertion consistent with CHF NYHA class III, with most recent echocardiogram on 3/3/2014 ejection fraction rate of 45%. Outpatient evaluation revealed pulmonary hypertension and dilated pulmonary artery. Subsequent noninvasive testing, an echocardiogram, as well as a coronary CT angiography, revealed a large Secundum-type

atrial septal defect. He has been managed with medical therapy and presents today for potential closure of this defect with a percutaneous septal occlude device. Risks/benefits ratio of procedure were explained and informed consent was obtained.

Procedure

On arrival to the lab, the patient was in stable condition. Initially a 5-French sheath was placed in the right common, femoral vein. A 5-French sheath was placed in the left common femoral artery. Hemodynamics was measured using sheath side arms, as well as using a 7-French pulmonary artery Swan-Ganz catheter (after upgrading sheath to 1-French). Intracardiac echocardiography was performed using an AcuNav 10-French intracardiac echocardiography catheter with standard technique.

Complications

None immediate

Hemodynamic Findings

- 1. AC 120/78 (94mm Hg mean)
- 2. LV 120/17mm Hg)
- **3.** RA 16 (12mm Hg mean)
- 4. RV 45/11 mm Hg mean
- **5.** PA 45/17 (32mm Hg mean)
- 6. PCWP 19 mm Hg mean
- 7. Oximetry Run-SVC 71%, RA 84%, PA 88 4%, FA
- **8.** System blood flow 6.14 liters per minute. Pulmonary blood flow 47 liters per minute with Qp/Qs ration 7 69 (assumed hemoglobin of 15.7 gm/dL, assumed oxygen consumption of 258 mL per minute).













Cardiovascular Clinical Scenario

Angiographic Findings

Left Main: Normal. Has a very short left main.

Left Anterior Descending: Normal

Left Circumflex: Left circumflex artery terminates into 3 large CM branches without any significant disease.

Right Coronary Artery: Arising from a slightly anterior position in the right coronary cusp. This vessel has a very large conus branch arising almost in an anomalous fashion right at its origin, and supplies the right ventricle. This has multiple large branches. The main RCA and posterior descending arteries are free of significant disease. A multipurpose 5-French catheter was advanced and initially this wire went to an area outside the right atrial free border. In light of the above, anomalous pulmonary venous drainage was suspected. This multipurpose catheter was advanced and pulmonary vein angiography was performed. This was the right upper pulmonary vein, draining normally into the left atrium and was not anomalous

pulmonary vein. Subsequently, an intracardiac echocardiogram catheter was advanced and parked in the right atrium and detailed interrogation of the interatrial septum was performed using standard technique. There was a large secundum type atrial septal defect. There was no posterior rim detected in the midsegment. The anterior rim was adequate. In light of the above we elected to assess the accurate sizing and flow cessation with a sizing balloon. An Amplatz Super-Stiff wire and subsequently a J-wire were parked in the left atrium, over which a 30mm NMT sizing balloon was advanced and inflated across the interatrial septal. This balloon at 30mm still had some residual minimal shunting on the posterior rim and there was some give with motion. After detailed discussion with Dr. Benway, an interventional cardiologist, we elected not to proceed with any attempts at percutaneous device closure because of the above findings. All equipment was removed, and access site hemostasis was to be achieved when ACT was less than 160 seconds.

Impression

- 1. A large secundum-type atrial septal defect, and not suitable for percutaneous closure.
- 2. Elevated right heart filling pressure with mild pulmonary hypertension and significant left to right shunt at the atrial level (Qp/Qs ration more than 7).
- 3. No significant epicardial coronary artery stenosis.

Plan and Recommendations

This patient's detailed intracardiac echocardiography and the right and left heart catheterization confirm hemodynamically significant secundum-type atrial septal defect. Based on the technical factors delineated above, this will be best served with surgical closure. I will discuss the case with a cardiothoracic surgery colleague, and then proceed further as appropriate. Patient will require close follow up, and I have taken the liberty of adding low-dose ACE inhibitor therapy to optimize his perioperative outcomes from a remodeling standpoint.







Dermatology Clinical Documentation













Dermatology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right, bilateral, multiple locations
- **Status of** + Acute
- **Disease** + Chronic
 - Intermittent
 - Recurrent
 - **+** Transient
 - + Primary
 - **★** Secondary
- **Infections** + Link infective organism and disease process
- **Neoplasms** + Malignant versus benign, primary, secondary, In Situ
 - Detailed locations
 - Overlapping sites versus different, distinct locations

- **Diabetes** + Type I, Type II or due to other disease / drug
 - + Link Diabetes to complications
 - **Skin** + Link infectious agent or cause to disease
 - ♣ Pressure ulcer Detailed site, laterality and stage I – IV
 - ♣ Non-pressure chronic ulcer Site, laterality and:
 - **★** Skin breakdown
 - **★** Fat layer exposed
 - **◆** Necrosis of muscle
 - ♣ Necrosis of bone
 - + Contact dermatitis document reason













Dermatology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Musculoskeletal** + Past infection, past trauma, other disease processes
 - + Link infectious agent or case to disease
 - + Arthritis Rheumatoid versus Osteoarthritis
 - + Primary, post-traumatic, or secondary disease
 - + Pathological Fracture due to osteoporosis, neoplastic disease or other cause

- **General Injuries** + Detailed locations (Head, Shaft, Proximal, Distal, individual body part, etc)
 - + Episode of care (Initial, Subsequent, Sequela)

- **Cause of Injury** Mechanism How it happened (struck by basketball)
 - ♣ Place of occurrence Where it happened (high school)
 - ♣ Activity What patient was doing (playing basketball)
 - + External cause status Military, Civilian, Work-related, Leisure













Dermatology Clinical Scenario

Subjective

Returning 81 year old caucasian female patient seen today after request by Dr. Reynolds at Lakeside nursing home. Patient has been recovering after a fall in her home when she became unbalanced vacuuming her kitchen floor. Patient had complaint of pain on lower back just above buttock. Following up on ulcer last week nurse also requested Dr. Reynolds to examine a lesion that is multicolored with unusual borders on patient's nose that is normally covered up by makeup. Patient had stated she has always had a "beauty mark" there, but had noted it has grown in past few months, as well as changed in color. Last week we had taken a biopsy and now returning to patient with results. I did not take entire lesion last week due to its size. All other systems were negative.

Objective

Vital signs are found in the back of the chart. Blood pressure ideal at 120/80 and temperature 98.9. Patient's BMI was 20.1.

Assessment

Patient has stage 2 pressure ulcer on sacrum. Skin lesion on nose confirmed malignant melanoma.

Exam

GEN: Patient alert and appears slightly uncomfortable.

CV: No murmur.

RESP: No crackles, rales, or wheezing.

ABD: Patient's abdomen was not tender to palpitation. However, there was pressure ulcer center on sacrum. Fat layer was exposed as patient's skin was quite thin and prone to breakdown. No exposure or necrosis of muscle or bone was observed.

EXT: No edema. No bruising.

FACE: Lesion was observed on patient's nose just to the right of the nasal bridge and above supratip break across the nose to the tear trough of the patient's right side. It is approx. 2.8 cm across with reddish appearance without clear borders.

Plan

- 1. Malignant melanoma on nasal bridge extending to right tear trough of patientperformed removal of lesion with complex closure total of 3.2 cm excised.
- 2. Sacral pressure ulcer stage 2.
- 3. Will follow up with patient next week to check if healing.







Diagnostic Radiology

Clinical Documentation







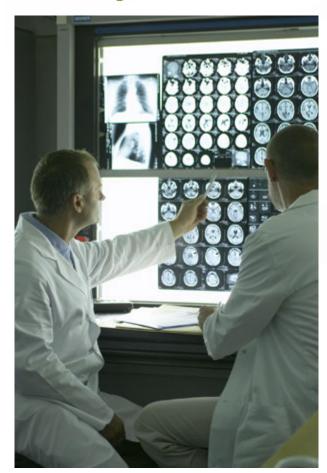






Diagnostic Radiology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Findings + The report should use appropriate anatomic, pathologic, and radiologic terminology to describe the findings

limitations

Potential + The report should, when appropriate, identify factors that may compromise the sensitivity and specificity of the examination

issues

Clinical • The report should address or answer any specific clinical questions. If there are factors that prevent answering the clinical question, this should be stated explicitly

Comparison + studies and reports

Comparison with relevant examinations and reports should be part of the radiologic consultation and report when appropriate and available

- **Impression** + Unless the report is brief each report should contain an "impression" or "conclusion"
 - + A specific diagnosis should be given when possible
 - + A differential diagnosis should be rendered when appropriate













Diagnostic Radiology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Impression** + Follow-up or additional diagnostic studies to clarify or confirm the impression should be suggested when appropriate
 - + Any significant patient reaction should be reported

computergenerated template reports

Standardized • Standardized computer-generated template reports should be designed to satisfy the above criteria













Diagnostic Radiology Clinical Scenario

Referring Physician

John Doe, MD

Indications for Study

- 1. Spinal stenosis.
- 2. Low back pain.
- 3. Bilateral leg numbness.
- 4. Weakness in hands.

Cervical and Lumbar Spine MRI

Due to the patient's body habitus and size, the patient could not be moved further into the coil and visualization of the upper lumbar spine is very limited. The patient's head was also squeezed into the cervical spine coil and was very uncomfortable during the study.

MRI of the Cervical Spine

Sagittal and axial images were obtained. The craniocervical junction is within normal limits. Spinal cord is normal in location and signal

intensity. There is straightening of the normal curvature. Marrow signal within the bony structures is unremarkable.

At C7-T1, there is no focal disk disease.

At C6-7, there is a disk bulge which causes mild flattening of the anterior CSF space and some neural foraminal narrowing, left greater than right.

At C5-6, there is a combination of disk bulge and posterior osteophytes, which narrows the neural foramina and flattens the anterior CSF space, more so than at the C6-7 level.

At C4-5, there is a disk bulge, which flattens the anterior CSF space and causes some bilateral neural foraminal narrowing, left greater than right.

At C3-4, there is a combination of bone and disk, which slightly flattens the anterior CSF space and narrows the neural foramina bilaterally.

Impression

Some mild multilevel disk disease, as described above, with some disk bulges and posterior osteophytes. There is no frank disk herniation

MRI of the Lumbar Spine

Sagittal and axial images were obtained. The upper lumbar spine is not well visualized due to body habitus and positioning within the coil. The conus appears grossly within normal limits, normal in location and signal intensity. The marrow signal appears within normal limits. There is marked narrowing at L5-S1 with some apparent fusion at this level to the left of midline. There is some minimal scoliosis. Marrow signal within the bony structures is unremarkable.













Diagnostic Radiology Clinical Scenario

MRI of the Lumbar Spine

At L5-S1, the nerve roots exit normally. There is some slight right neural foraminal narrowing on one image due to a combination of bone and disk; however, the neural foramina are patent on the next image.

At L4-5, there is a mild disk bulge and posterior facet degenerative changes. Nerve roots are patent.

At L3-4, there are some mild posterior facet degenerative changes, thickening of the ligamentum flavum, and neural foraminal narrowing. On the next image, the nerve roots exit normally.

Impression

- 1. There is some slight trilateral narrowing at L3-4. The nerve roots exit more normally on the next image.
- 2. At L4-5, there is a disk bulge and some posterior facet degenerative changes.
- 3. At L5-S1, there is a bulging disk and narrowing on the right with slight right neural foraminal narrowing on one image. On the next, the neural foraminal are more patent. There is no focal disk herniation.







Endocrinology

Clinical Documentation













Endocrinology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right, bilateral, multiple locations
- **Status of** + Acute
- **Disease** + Chronic
 - Intermittent
 - Recurrent
 - **+** Transient
- **Infections** + Link infective organism and disease process
- **Neoplasms** + Malignant versus benign, primary, secondary, In Situ
 - Detailed locations
 - ♣ Overlapping sites versus different, distinct locations
 - ♣ Leukemia In remission or In. relapse

Diabetes + Type I

- ★ Type II Long term use of Insulin?
- ♣ Due to other disease specify underlying disease
- ♣ Due to drug/chemical specify drug or substance
- ♣ Link Diabetes to complications

- **Nutritional** + Deficiencies specify substance
 - Overweight versus obesity versus morbid obesity
 - **♣** BMI value
 - **+** Malnutrition
 - **◆** With or without complications
 - **★** Mild, moderate or severe













Endocrinology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Diseases

Metabolic + Hypo- and hyper- Do not document A or V

- **Thyroid** Toxic versus non-toxic goiter
- **Disease** With or without crisis or storm
 - ♣ Drug induced specify drug

system

- **Nervous** + Primary versus secondary disease and cause
 - + Presence of intractable disease
 - Level and type of paralysis

- **Eye and Ear** + Upper versus lower eyelid
 - + Cataract as age-related, traumatic or drug induced
 - Primary versus secondary disease
 - Effects of tobacco use / exposure on ear disease

System

- **Circulatory** Acute Myocardial Infarction time period is 4 weeks
 - + Link complications to Hypertension
 - **◆** Systolic versus diastolic heart failure
 - + Left versus right heart failure
 - Rheumatic versus nonrheumatic disease
 - + Atherosclerosis of native artery or vein versus graft
 - + Traumatic versus nontraumatic cerebral hemorrhage and cause of hemorrhage or infarction







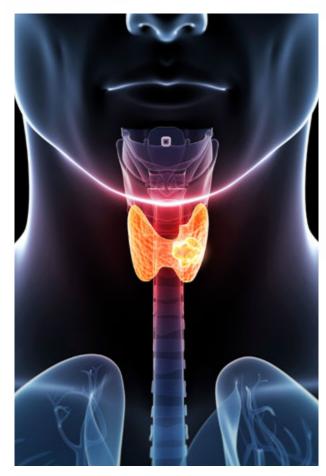






Endocrinology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



System

- **Respiratory** + Exacerbation of chronic disease
 - + Asthma as intermittent versus persistent and mild, moderate or severe

System

- **Digestive** + Links complications to disease
 - **+** Bleeding, fistula, abscess, obstruction, gangrene
 - + Hernia unilateral versus bilateral
 - **◆** Constipation Slow transit or outlet dysfunction
 - **Skin** + Link infectious agent or cause to disease
 - ♣ Pressure ulcer site, laterality and stage

- **Skin** + Non-pressure chronic ulcer site, laterality, plus
 - **♣** Skin breakdown
 - **★** Fat layer exposed
 - ♣ Necrosis of muscle
 - ♣ Necrosis of bone

skeletal

- **Musculo-** Past infection, past trauma, other disease processes
 - + Link infectious agent or cause to disease
 - Arthritis Rheumatoid versus Osteoarthritis
 - + Primary, post-traumatic, or secondary disease
 - + Pathological Fracture due to osteoporosis, neoplastic disease or other cause













Endocrinology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



nary

- **Genitouri-** Primary versus secondary disease
 - + Chronic kidney disease
 - **◆** Document stage
 - **★** Link to Diabetes
 - + Link to infectious agent or cause

Injuries

- **General** + Detailed locations (Head. Shaft, Proximal, Distal, etc)
 - ♣ Type of tendon (Flexor or Extensor)
 - + Episode of care (Initial, Subsequent, Sequela)

Dislocations

- **Fractures &** + Traumatic versus stress
 - **◆** Open versus closed
 - **★** Displaced versus nondisplaced

Fractures & + Dislocations cont.

- Degree of healing
 - **♣** Routine
 - **★** Delayed
 - **♣** Nonunion
 - **★** Malunion
- ♣ A Pathological fracture with Osteoporosis
 - **★** Age-related versus other type

Cause of + Injury

- Mechanism How it happened (struck by basketball)
- Place of occurrence Where it happened (high school)
- Activity What patient was doing (playing basketball)
- External cause status Military, Civilian, Workrelated, Leisure













Endocrinology Clinical Scenario

Subjective

Returning 63 year old female of african descent seen today in the office. Patient noted she has had a goiter for the past 30 years that was not pronounced, however has started swelling in past 2 months. She has had increased weight loss over the past 6 months which was not intentional and unusual as she noted she has actually been eating more in that time period than in the past. She notes that she does not understand how she is constantly sweating and that she is becoming increasingly restless and nervous. All other systems negative.

Objective

Vital signs are found in the back of the chart. Blood pressure was slightly elevated at 136/92 and temperature 99.1. Patient's BMI was 23.1. She had a resting heart rate 132 beats per minute. Labs revealed hyper production of T3 and T4 hormone levels as well as Serum TSH,

however without storm or crisis. I reviewed a Thyroid ultrasound ordered by her PCP which showed the left half of the thyroid as swollen and multi-nodular. Biopsy revealed nodules are non-malignant in nature. Patient's diet revealed patient has been increasing her iodine intake while undertaking extreme "body cleanse" tea and diet.

Assessment

Toxic benign multi-nodular goiter without crisis or storm. Patient has moderate imbalanced food intake without complications at this time.

Exam

GEN: Patient alert and does appear slightly uncomfortable.

CV: No murmur.

RESP: No crackles, rales, or wheezing.

ABD: Patient's abdomen was not tender to palpitation.

EXT: No edema. No bruising.

NECK: Moderate sized goiter with swollen nodule on left side.

Plan

Will schedule patient for surgery to remove left half of the thyroid. Educated patient on proper nutrition and to consult doctor or nutritionist before attempting "cleanse" routines from the internet.













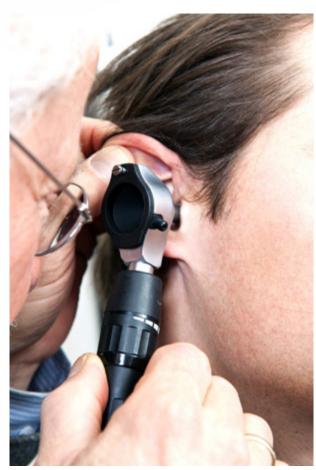






ENT Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right, bilateral, multiple locations
- **Status of** + Acute
- **Disease** + Sub-acute
 - + Chronic
 - Intermittent
 - + Recurrent
 - Transient
 - Primary
 - **★** Secondary
 - **Ears** + Otitis Media
 - **◆** Bleeding, perforation, fistSerous
 - **★** Mucoid
 - **◆** Nonsuppurative
 - ♣ Detailed location of tympanic perforation

- **Ears** + Effects of tobacco use / cont. exposure on ear disease
 - Conductive versus sensorineural hearing loss
- **Noses and** + Specific sinus versus Sinuses pansisnusitis
 - ♣ Allergic versus infective rhinitis
- **Infections** + Link infective organism and disease process
- **Neoplasms** + Malignant versus benign, primary, secondary, In Situ
 - Detailed locations
 - Overlapping sites versus different, distinct locations







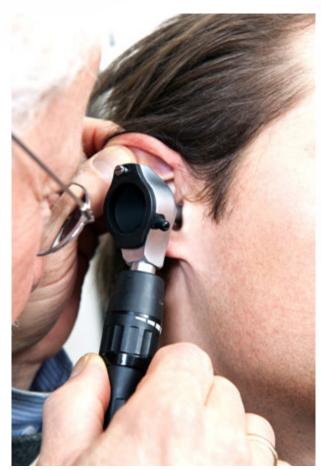






ENT Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Injuries

- **General** + Detailed locations (Head, Shaft, Proximal, Distal, etc.)

 - + Episode of care (Initial, Subsequent, Sequela)

Injury

- **Cause of** ★ Mechanism How it happened (struck by basketball)
 - ♣ Place of occurrence Where it happened (high school)
 - ♣ Activity What patient was doing (playing basketball)
 - + External cause status Military, Civilian, Work-related, Leisure













ENT Clinical Scenario

Referring Physician

John Doe, MD

Reason for Consultation

Left ear pain.

History of Present Illness

The patient is a pleasant 34 year-old female with lupus, who presents with a 3-week history of left ear pain. She denies any hearing loss, tinnitus, otorrhea or vertigo. She denies any recent history of left ear trauma or swimming. She has not been on any topical or oral antibiotics. She was seen in the emergency department yesterday where she underwent a CT scan of the temporal bone. She denies any recent fevers or chills or history of chronic ear infections.

Past Medical History:

Reviewed, per chart.

Medications

Reviewed, per chart.

Review of Systems

Reviewed, per chart.

Physical Examination

VITAL SIGNS: Temperature 98.6, blood pressure 118/74, respirations 21, pulse 96.

GEN: The patient is a well-nourished, welldeveloped female in no apparent distress.

HEENT: Face symmetric. The patient does have bilateral hyperpigmented malar rashes. Facial strength intact bilaterally. Ears: Right ear: There appeared to be a hyperpigmented rash overlying the external lobule. The external auditory canal was patent without edema or erythema. TMs are pearly gray, mobile and intact. No mastoid tip tenderness. No pain upon manipulation of the right auricle. Left ear: The entire auricle on the left side appeared to be edematous with tenderness

upon manipulation. There was a wick in the distal left external auditory canal, was removed. The external auditory canal appeared to have moist yellow debris with a minimal amount of edema and erythema. The tympanic membrane was mobile and intact. No mastoid tip tenderness appreciated. There was a hyperpigmented rash within the conchal bowl. Nose: No evidence of mass or lesions. Oral cavity/Oropharynx: Moist mucous membranes. No evidence of mass or lesions.

NECK: There is a subcentimeter, palpable, mobile, nontender lymphadenopathy in bilateral submental spaces. Otherwise, no other evidence of lymphadenopathy. No thyromegaly. Trachea midline.

NEUROLOGICAL: Cranial nerves II through XII grossly intact.













ENT Clinical Scenario

Diagnostic Studies

CT scan of the temporal bone was reviewed. There appears to be a minimal amount of edema within the left external auditory canal. Bilateral middle ear and mastoid cavities are aerated, without evidence of bony destruction or opacification.

Impression and Plan

Acute otitis externa and perichondritis of the left ear. There is no evidence of mastoiditis or middle ear infection. We would treat the patient with Ciprodex otic solution 5 drops to the left ear twice a day. The patient should also be placed on oral fluoroquinolone antibiotic for 7 days, which has fairly good cartilage penetration, given the patient's evidence of perichondritis. A left ear culture should be taken. We would like to see her back in one week and have asked her to call the office for an appointment.







Gastroenterology

Clinical Documentation













Gastroenterology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right, bilateral, multiple
 - locations

Status of + Acute

- **Disease** + Chronic
 - Intermittent
 - Recurrent
 - **+** Transient
 - + Primary
 - + Secondary
- **Infections** + Link infective organism and disease process

- **Neoplasms** + Malignant versus benign, primary, secondary, In Situ
 - → Detailed locations
 - Overlapping sites versus different, distinct locations

System

- **Digestive** + Link complications to disease
 - **♣** Bleeding, perforation, fistula, abscess, obstruction, gangrene
 - + Hernia unilateral versus bilateral
 - **◆** Constipation slow transit or outlet dysfunction
 - + Hepatitis cause of disease













Gastroenterology Clinical Scenario

Reason for Visit

Inguinal Hernia.

Allergies

No Known Specific Drug Allergies.

History of Present Illness

Patient is a 65 year old male. Intermittent inquinal swelling on the right side over the past month. No inguinal swelling on the left side. Mild inguinal pain on the right side with the swelling. No inquinal pain on the left side. Here for evaluation and treatment of a right inguinal hernia. This is the first hernia repair patient has ever had. He stated he had no vomiting, no abdominal pain, and no hematochezia. No diarrhea. Patient did complain of having constipation which would be slow transit in nature as there are no signs or symptoms of outlet dysfunction. All other systems negative for signs and symptoms. Reviewed medical history but not significant.

Personal History

BEHAVIORAL: Never a smoker.

Physical Findings

- Vital Signs/Measurements Value Date
- + PR 85 bpm 8/28/2014
- ◆ Blood pressure 135/96 mmHg 8/28/2014
- + Weight 162 lbs 8/28/2014
- ♣ Body mass index 27 kg/m2 8/28/2014
- + Height 65 in 8/28/2014
- Standard Measurements: Value Date
- ◆ Body surface area 1.84 m2 8/28/2014

Exam

GEN: Well-appearing and alert.

EYES: The sclera showed no icterus. Lungs clear to auscultation.

CV: Heart Rate and Rhythm normal.

ABD: Visual inspection: the abdomen was not distended.

PALPATION: The abdomen was soft and nontender.

HERNIA: An inquinal hernia was discovered on the right. No inquinal hernia was discovered on the left.

NEUROLOGICAL: Oriented to time, place, and person.

Assessment

- ♣ Right inguinal hernia with obstruction without gangrene
- Slow transit constipation

Counseling / Education / Plan

- + Pre-op teaching.
- + Set patient up with Surgeon to have hernia repair.
- + Advised on change of eating habits to include more fiber into diet.







General Surgery

Clinical Documentation













General Surgery Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right, bilateral, multiple locations
- **Status of** + Acute
- **Disease** + Chronic
 - Intermittent
 - ★ Recurrent
- Injuries
- **General** + Detailed locations (Head, Shaft, Proximal, Distal, etc.)

 - **★** Episode of care (Initial, Subsequent, Sequela)
- Injuries
- **Cause of** Mechanism How it happened (struck by basketball)
 - ♣ Place of occurrence Where it happened (high school)
 - + Activity What patient was doing (playing basketball)
 - + External cause status Military, Civilian, Work-related, Leisure













General Surgery Clinical Scenario

Indication for the Procedure

The patient is a young woman that sustained an open fracture at the distal phalanx while playing soccer in a park with friends, and developed bony mallet finger to the left index finger. The patient is the team goalie and stated she tried to block a shot and the ball, wet from rain and traveling excessively fast, only caught her index finger. It was determined she would need irrigation and debridement of the open fracture in the distal phalanx in the left index finger, as well as open treatment and internal fixation of the left distal phalangeal index bony mallet finger. Patient was advised of the risks of the surgery including but not limited to infection, anesthetic complications, deep vein thrombosis, pulmonary embolism, and even death. Patient wished to proceed with the operation.

Procedure Description

The patient's left index finger was confirmed and marked prior to the operation. The patient was taken to the operative suite and placed in the supine position with the hand table in place. An incision was made over the area of the open wound in the dorsal aspect of the distal phalanx proximal to the distal phalangeal joint. We thoroughly irrigated and debrided the wound itself in the area of the bony mallet in the open fracture site and irrigated it thoroughly. Normal saline was used in the joint space as well. The extensor tendon was noted as completely disrupted, as well as small fleck of bone in the open fracture itself. It was determined to perform an open treatment and internal fixation with the use of a 0.062 K-wire into the distal phalanx and into the middle phalanx deformity. Fluoroscopy was done on the hand and wrist on the left side throughout the procedure, as well as post procedure to confirm appropriate

procedure placement of the pin and the alignment of the digit. The patient was transported to the recovery room in stable condition with a splint in place as a short arm right Gauntlet splint. The block was performed on the right upper extremity for postoperative pain separate from the general anesthetic procedure itself and done by general anesthesia services for post-op pain.







Hematology Clinical Documentation







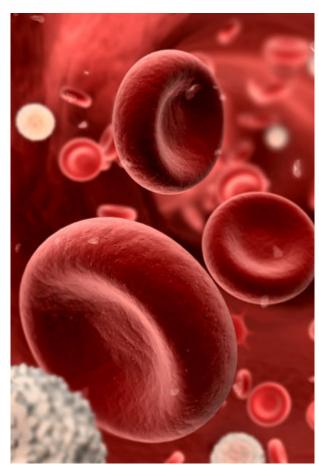






Hematology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Laterality + Left, right, bilateral, multiple locations

Disease + Chronic

Status of + Acute

Intermittent

Recurrent

+ Transient

Primary

+ Secondary

Infections + Link infective organism and disease process

Neoplasms + Benign versus malignant, primary, secondary, In Situ

+ Detailed locations

 Overlapping sites versus different, distinct locations

Neoplasms + Leukemia:

cont.

★ In remission or in relapse

o Adult versus juvenile

+ Lymphoma:

+ Hodgkin:

o Nodular lymphocytic predominant

o Nodular sclerosis classical

o Mixed cellularity classical

o Lymphociticdepleted classical

o Lymphocitic-rich classical







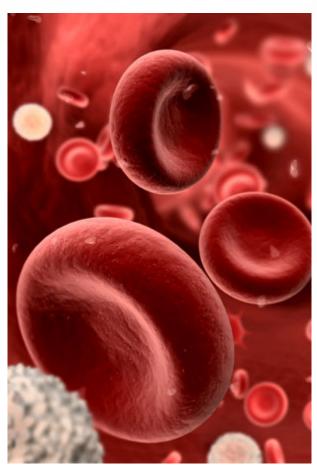






Hematology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Neoplasms cont.

- **+** Follicular:
 - o Grade I IIIb
 - o Diffuse follicle center
 - o Cutaneous follicle center
- ♣ Non-follicular:
 - o Small cell B-cell
 - o Mantle cell
 - o Diffuse large B-cell
 - o Lymphoblastic
 - o Burkitt
- ♣ Mature T/NK-Cell
 - o Mycosis fungoides
 - o Sezary disease
 - o Peripheral T-cell
 - o Anaplastic large cell, ALK+
 - o Anaplastic large cell, ALK-
 - o Cutaneous T-cell

cont.

- **Neoplasms** + Current disease, if still under treatment
 - + History of disease, if treatment complete

Bloosd & + Anemia: Blood-**Forming Organs**

- **★** Iron, B12, folate or other nutritional deficiency
- **◆** Type of Sickle cell, with or without crisis
- + Acquired versus hereditary hemolytic anemia
- **◆** Cause of aplastic anemia
- **★** In chronic, neoplastic or kidney disease













Hematology Clinical Scenario

Subjective

28 year old male patient seen today after nosebleed that would not stop for over an hour. He was referred to us by Dr. Weston, patient's PCP. Patient is well nourished. Patient noted that he has become easy to bruise and that they seem to not fade in timely manner. Has had persistent pain in joints, night sweats, and general weakness for the past several months. All other systems were negative.

Objective

Vital signs are found in the back of the chart. Blood pressure ideal at 120/80 and temperature 98.9. Patient's BMI was 32.1.

Exam

GEN: Patient alert and comfortable

CV: No murmur

RESP: No crackles, rales, or wheezing

NECK: Lymph nodes were swollen

ABD: Patient's abdomen was tender to palpitation

EXT: No edema. Bruising on both legs

Assessment

Reviewed labs and found patient with extreme levels of white blood cells at 10.9 cpl while platelet count was greatly diminished at 90k/cmm. Hemoglobin reduced at 6 millimoles/liter. Blood sugar test showed a level of 82.

1. Patient current Acute Myeloblastic Leukemia the involving lymph nodes of face and neck.

Plan

- 1. I counseled patient on therapies and prognosis.
- 2. Anemia secondary to the patient's leukemia and chemotherapy.
- 3. Will follow up with patient next month.







Internal Medicine & Family Practice

Clinical Documentation













Internal Medicine & Family Practice Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right, bilateral, multiple locations
- **Status of** + Acute **Disease** + Chronic

 - Intermittent
 - Recurrent
 - **+** Transient
 - Primary
 - **★** Secondary
- **Infections** + Link infective organism and disease process
- **Nervous** + Primary versus secondary **System** disease and cause
 - + Presence of Intractable disease
 - Level and type of paralysis

- **Neoplasms** + Malignant versus benign, primary, secondary, In Situ
 - + Detailed locations
 - Overlapping sites versus different, distinct locations
 - + Leukemia In remission or in relapse

Diabetes + Type I

- **★** Type II Long term use of Insulin?
- Due to other disease specify underlying disease
- ♣ Due to drug/chemical specify drug or substance
- + Link Diabetes to complications













Internal Medicine & Family Practice Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Eye & Ear** + Upper versus lower eyelid
 - + Cataract as age-related, traumatic or drug induced
 - Primary versus secondary disease
 - + Effects of tobacco use / exposure on ear disease

System

- **Respiratory** + Exacerbation of chronic disease
 - + Asthma as intermittent versus persistent and mild, moderate or severe

System

- **Digestive** + Link complications to disease
 - **♣** Bleeding, perforation, fistula, abscess, obstruction, gangrene
 - + Hernia unilateral versus bilateral
 - ♣ Constipation slow transit or outlet dysfunction

System

- **Circulatory** + Acute Myocardial Infarction time period is 4 weeks
 - + Link complications to Hypertension
 - **★** Systolic versus diastolic heart failure
 - + Left versus right heart failure
 - Rheumatic versus nonrheumatic disease
 - + Atherosclerosis of native artery or vein versus of a graft
 - + Traumatic versus nontraumatic cerebral hemorrhage and cause of hemorrhage or infarction
 - ♣ Artery blocked or ruptured













Internal Medicine & Family Practice Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Skin** + Link infectious agent or cause to disease
 - ♣ Pressure ulcer site, laterality and stage
 - ♣ Non-pressure chronic ulcer site, laterality and
 - **★** Skin breakdown
 - **★** Fat layer exposed
 - ♣ Necrosis of muscle
 - **♣** Necrosis of bone

skeletal

- **Musculo-** Past infection, past trauma, other disease processes
 - Link infectious agent or cause to disease
 - + Primary, post-traumatic, or secondary disease
 - + Pathological Fracture due to osteoporosis, neoplastic disease or other cause

nary

- **Genitouri-** Primary versus secondary disease
 - Stage of chronic kidney disease
 - + Link infectious agent or cause to disease

Injuries

- **General** + Detailed locations (Head, Shaft, Proximal, Distal, etc)
 - ♣ Type of tendon (Flexor or Extensor)
 - + Episode of care (Initial, Subsequent, Sequela)













Internal Medicine & Family Practice Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Dislocations

- **Fractures &** + Traumatic versus stress
 - **◆** Open versus closed
 - **◆** Displaced versus nondisplaced
 - + Degree of healing
 - **★** Routine
 - **★** Delayed
 - **♣** Nonunion
 - **★** Malunion
 - ♣ Pathological fracture with Osteoporosis
 - ♣ Age related versus other type

- **Cause of** Mechanism How it happened (struck by basketball)
 - **Injury** + Place of occurrence Where it happened (high school)
 - Activity What patient was doing (playing basketball)
 - + External cause status Military, Civilian, Work-related, Leisure













Internal Medicine & Family Practice Clinical Scenario

Subjective

79 year old caucasian female patient seen today in emergency department of hospital. Patient experienced a fall in her home while she became unbalanced mopping her kitchen floor. Patient had pain in back immediately following fall. She stated there was sharp pain from between shoulder blades that has not faded. She has history of Osteoporosis, as well as diabetes type 1. All other systems were negative.

Objective

Blood pressure within reason at 128/90 and temperature 98.1. Patient's BMI was 21.8. Reviewed patient's X-Ray which was ordered upon admission. Patient appears to have compression fracture of T-6 vertebrae. Judging by apparent thickness of surrounding vertebra, this is a pathologic fracture due to patient's Osteoporosis. Patient has no loss of sensation of lower body or thorax from the fracture.

Exam

GEN: Patient alert and does appear greatly uncomfortable

CV: No murmur

RESP: No crackles, rales, or wheezing

ABD: Patient's abdomen was not tender to palpitation

EXT: No edema. No bruising. She has full feeling in her feet and on both sides.

Assessment

Patient has pathological fracture of T-6 vertebrae due to postmenopausal Osteoporosis, as well as having Diabetes type 1 without complications.

Plan

Recommend bed rest for patient and will admit to supportive care for recovery. I will refer patient to Orthopedic doctor for care.







Mental Health & Substance Abuse Treatment

Clinical Documentation













Mental Health & Substance Abuse Treatment Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Status of + Acute

- **Disease** + Chronic
 - Intermittent
 - Recurrent
 - Persistent
 - **+** Transient
 - Major

Mental and **Behavioral** disorders

- + Source of dementia or delirium
- ♣ Alcohol or drug use, abuse or dependence
 - **♣** With intoxication
 - ♣ With withdrawal
 - **♦** With alcohol or drug-induced disorders
- ♣ Type of schizophrenia or schizoaffective disorder
- ♣ Type of anxiety disorder

Mental and + **Behavioral** disorders cont.

disorder **♣** Partial or full remission

Depressive, manic or bipolar

- **★** Mild, moderate, severe
- ◆ Most recent episode depressed, manic or mixed
- Intellectual Disabilities
 - **★** Mild, moderate, severe, profound
- ♣ Type of speech or language disorder
- **◆** Type of attention-deficit hyperactivity disorder













Mental Health & Substance Abuse Treatment Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Nervous** + Primary versus secondary disease and cause
- **System** Drug name or type on drug-induced disorders
 - Specific type of epilepsy
 - **★** Seizure disorder = Epilepsy
 - ♣ Seizure = single event or yet-to-be diagnosed
 - **★** Type of migraine and with or without aura
 - Presence of intractable disease
 - Level and type of paralysis
 - ♣ Type of hydrocephalus













Mental Health & Substance Abuse Treatment Clinical Scenario

Chief Complaint

"I got a lot of stress and I have suicidal thoughts."

History of Present Illness

Male patient had been seeing his primary care physician for anxiety and depression since 2001. This began with job related stress; he was a supervisor and was on 24-hour call. The patient became increasingly depressed and began isolating himself and staying in bed on his day off. The patient has depressive symptoms of crying, insomnia, anorexia with recent 20-pound weight loss, decreased concentration, psychomotor retardation, and suicidal ideation with plan. In addition, the patient has auditory hallucinations and hears vague voices talking to him. He will sometimes hear his wife call him when she is not. At the current time, the patient has been taking Wellbutrin 150 milligrams daily, Lexapro 20 milligrams daily, and Xanax 1 milligram three times a day. He also uses a Combivent inhaler. He has been to the emergency room on several occasions for panic and anxiety attacks and he was treated symptomatically and released.

Past Psychiatric History

See above. There is no evidence of physical, emotional, or sexual abuse as a child and there is no evidence of substance abuse. He denies any family history of emotional illness.

Medical & Surgical History

At work, the patient was moving a chlorine tank, which ruptured, and he inhaled chlorine gas and was hospitalized for a week. He also has asthma and sinus problems.

Family History

His wife has bipolar disorder. One son has problems with anger management and is currently disabled because of this.

Social History

The patient has a high school education. He worked for 38 years before he was disabled. He feels that he gets along well with people. His marriage is solid but his wife's mental problems, which have been going on for five to seven years, cause him stress.

Exam

HEENT: Non-contributory

CARDIORESPIRATORY: Patient has shortness of

breath

GASTROINTESTINAL: Non-contributory

GENITOURINARY: Non-contributory

MUSCULOSKELETAL: Non-contributory













Mental Health & Substance Abuse Treatment Clinical Scenario

Mental Status Exam

Patient is well-nourished, well-developed white man in moderate to marked distress. He is tearful during initial interview. His mood is depressed and his affect is appropriate for the situation. Stream of mental activity is unremarkable; there is no evidence of delusions or ideas of reference. He does have auditory hallucinations. He appears to be of average intellectual functioning. His memory is good for remote and recent events. His general knowledge is good. Insight and judgment are fair.

Inventory of Strengths & Weaknesses

Patient's primary strength is his recognition of illness and willingness to accept help. Weaknesses include difficulty in dealing with stressful situations and difficulty in controlling impulses at times.

Diagnosis: Axis I

- 1. Major depressive illness, recurrent with suicidal ideation and plan and psychotic features.
- 2. Panic/Anxiety disorder without agoraphobia.

Treatment Plan

Patient will have individual and group therapy. His Wellbutrin will be increased and he will be started on low doses of Seroquel, which will be increased if psychotic symptoms are not abated.

Problem Summaries & Recommendations

This 58-year-old married white male is admitted for treatment of depression with suicidal ideation and psychotic features secondary to multiple stressors as noted in history and physical.

Prognosis

Fair to Good

Estimated Length of Stay

7 to 10 Days

Discharge Criteria

Resolution of depression, suicidal ideation and auditory hallucinations, follow-up treatment plan in place.







Nephrology Clinical Documentation













Nephrology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Status of** + Acute **Disease** + Chronic

 - Intermittent
 - Recurrent
 - Persistent
 - **+** Transient
- **Infections** + Link infective organism and disease process
- **Neoplasms** + Malignant versus benign, primary, secondary, In Situ
 - + Detailed locations, including left, right or bilateral
 - Overlapping sites versus different, distinct locations
 - + Leukemia in remission or in relapse

Diabetes + Type I

- ◆ Type II Long term use of insulin?
- Due to other disease specify underlying disease
- ♣ Due to drug/chemical specify drug or substance
- ♣ Link Diabetes to eye disease

- **Nutritional** + Deficiencies specify substance
 - ♣ Overweight versus obesity versus morbid obesity
 - **♣** BMI value
 - Malnutrition
 - ♣ With or without complications
 - **♣** Mild, moderate or severe













Nephrology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Diseases

Metabolic + Hypo- and hyper - Do not document A or V

System

- **Circulatory** + Acute Myocardial Infarction time period is 4 weeks
 - + Link complications to Hypertension
 - **◆** Systolic versus diastolic heart failure
 - + Left versus right heart failure
 - + Rheumatic versus nonrheumatic disease
 - Atherosclerosis of native artery or vein versus graft
 - ♣ Traumatic versus non-traumatic cerebral hemorrhage and cause of hemorrhage or infarction

- **Skin** + Link infectious agent or cause to disease
 - ♣ Pressure ulcer site, laterality and stage
 - ♣ Non-pressure chronic ulcer site, laterality plus
 - **◆** Skin breakdown
 - **★** Fat layer exposed
 - ♣ Necrosis of muscle
 - ♣ Necrosis of bone

- **Diabetes** + Primary versus secondary disease
 - + Chronic kidney disease
 - **★** Document stage
 - **♣** Link to Diabetes
 - + Link infectious agent or cause to disease













Nephrology Clinical Scenario

History

The patient was seen in the clinic today. She is a 46-year-old woman with a history of sacral pain radiating to both buttocks, posterolateral thighs, and into the left foot. She also gets lower back pain. She has numbness in the right buttock and right thigh intermittently. She also describes weakness in the left leg. She has perineal pain in the right groin. She also describes bowel dysfunction with episodes of incontinence. Her sacral pain is made worse by sitting and made better by lying down. Her sacral pain is such that she cannot sit for more than 5 minutes comfortably. She constantly squirms when she does sit and she avoids sitting related activities. Neurontin, Motrin, and prior L5-S1 decompression have not helped.

Past Surgical History

Hysterectomy and spinal decompression.

Illnesses

Hypothyroidism.

Medications

Synthroid, Neurontin, Ambien, Motrin, and estrogen patch.

Allergies

Tylenol.

Family History

Hypertension, and Lung cancer.

Social History

No history of alcohol or tobacco abuse.

Review of Systems

Sacral pain, difficulty sitting, sleeping problems, numbness and tingling, headaches, dizziness, bowel problems, weight change, burning feet, paralysis. Other systems are negative.

Physical Examination

NEUROLOGIC: She is awake, alert, and oriented. Her speech is fluent. Pupils are 3 mm and reactive. Extraocular movements are full. Face is symmetric. Tongue is midline. She has full strength in all extremities. She has decreased sensation over the left anterolateral and posterior thigh and on the bottoms of both feet. Cerebellar function is intact. Deep tendon reflexes are symmetrically absent. Her toes are equivocal. There is no clonus.

RADIOGRAPHIC FINDINGS: I reviewed the patient's lumbar MRI. This study reveals multiple small perineural/Tarlov cysts in the foramina. These do not appear to be causing any significant neural element compression. However, I cannot assess the sacrum, which would be important given the patient's sacral related symptoms.













Nephrology Clinical Scenario

Impression

The patient is a 46-year-old woman with sacral, buttock, lower extremity, perineal, and bowel symptoms. The patient has an MRI of the lumbar spine, but the sacrum has not been assessed.

Plan

I would like to further evaluate the patient with an MRI of the sacrum. She should also undergo flexion and extension X-rays of the lumbar spine to rule out any spondylolisthesis that might be present. The patient underwent a recent EMG and nerve conduction study, which I would also like to see the results from. I will await the above.







Neurology Clinical Documentation







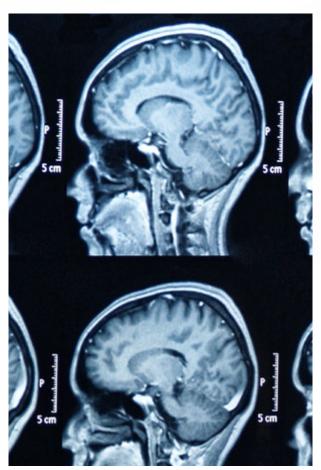






Neurology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- + Document location with greater specificity occluded vessel, location of stenosis, spinal level, bleeding vessel
- ◆ Document comorbidities with detail that will show their impact on patient condition even if it is not the primary problem
- + Document the clinical findings/indicators to support the diagnosis documented
- + Document a clear LINK between underlying condition and related, secondary or causal illness whenever appropriate

Headaches/Migraines: Frequency, Complications, Characteristics

- **Identify** + Vascular
- **the type** Associated with sexual activity
 - + Primary cough
 - **+** Exertion
 - + Stabbing

tension, or hemicranias

- **Cluster,** Specify when episodic or chronic
- paroxysmal + State if acute or chronic
 - + Include information regarding any post-concussion syndrome
 - + Drug-induced







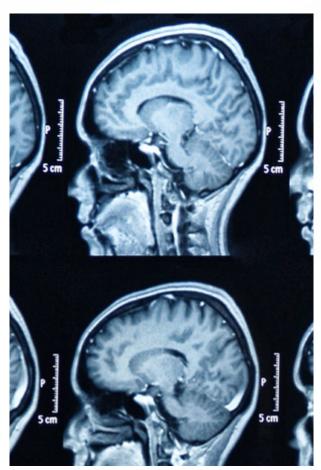






Neurology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Indicate the type of migraine

- + Hemiplegic, ophthalmoplegic, menstrual, cyclical vomiting, periodic headache syndrome, etc.
- + Specify when the migraine is intractable (e.g., poorly controlled, pharmacoresistant, treatment-resistant, refractory)
- **★** Clarify the presence or absence of:
- + An aura
 - **★** Status migrainosus
 - ♣ Cerebral infarction

Documenting sequela of a neurovascular event requires more precise documentation

- 1. Seguela is identified as a result of:
 - + Infarct, non-traumatic hemorrhage, or other neurovascular disease must be identified
- 2. Conditions to identify
 - + Hemiplegia, hemiparesis, monoparesis, other paralytic syndrome
 - + Location of limb involvement
- 3. Speech and language deficits must be identified as: Aphasia, dysphagia, dysarthria, fluency disorder













Neurology Clinical Scenario

The patient is a 50-year-old right-handed woman with a history of chronic headaches who complains of acute onset of double vision and right eyelid droopiness three days ago.

History of Present Illness

Mrs. Smith states that on Sunday evening (7/14/03) about 20 minutes after sitting down to work at her computer, she developed blurred vision, which she describes as the words on the computer looking fuzzy and seeming to run into each other. When she looked up at the clock on the wall, she had a hard time making out the numbers. At the same time, she also noted a strange sensation in her right eyelid. She went to bed and upon awakening the following morning, she was unable to open her right eye. When she lifted the right eyelid with her fingers, she had double vision with the objects appearing side by side. The double vision was most prominent when she looked to the left, but was also present when she looked straight ahead, up, down, and to the right, and went away when she closed either of her eyes. She

also noted that she had pain in both of her eyes that increased if she moved her eyes around, especially on looking to the left. She was seen in the Alton Memorial Hospital ER and subsequently transferred to BJH by ambulance.

Mrs. Smith also notes that for the past two to three weeks, she has been having intermittent pounding bifrontal headaches that worsen with straining, such as when coughing or having a bowel movement. The headaches are not positional and are not worse at any particular time of day. She rates the pain as 7 or 8 on a scale of 1 to 10, with 10 being the worst possible headache. The pain lessened somewhat when she took Vicodin that she had lying around. She denies associated nausea, vomiting, photophobia, loss of vision, seeing flashing lights or zigzag lines, numbness, weakness, language difficulties, and gait abnormalities. Her recent headaches differ from her "typical migraines," which have occurred about 4-6 times per year since she was a teenager and consist of seeing shimmering white stars move horizontally

across her vision for a couple minutes followed by a pounding headache behind one or the other eye, photophobia, phonophobia, and nausea and vomiting lasting several hours to two days. She has never taken anything for these headaches other than ibuprofen or Vicodin, both of which are partially effective. The last headache of that type was two months ago.

Her visual symptoms have not changed since the initial presentation. She denies previous episodes of transient or permanent visual or neurologic changes. She denies head trauma, recent illness, fever, tinnitus or other neurologic symptoms. She is not aware of a change in her appearance, but her husband notes that her right eye seems to protrude; he thinks that this is a change in the last few days.













Neurology Clinical Scenario

Past medical history:

- 1. Migraine headaches, as described in HPI.
- 2. Depression. There is no history of diabetes or hypertension.

Medications:

- ♣ Zoloft 50 mg daily, ibuprofen 600 mg a few times per week.
- + Vicodin a few times per week.

Allergies

None.

Social history

The patient lives with her husband and 16-year-old daughter in a 2-story single-family house and has worked as a medical receptionist for 25 years. She denies tobacco or illicit drug use and rarely drinks a glass of wine.

Family history

Her mother had migraines and died at the age of 70 after a heart attack. Her maternal grandfather had a stroke at age 69. There is no other family history of stroke or vascular disease, but she has no information about her father's side of the family.

Review of systems

She states that she had an upper respiratory infection with rhinorrhea, congestion, sore throat, and cough about 6 weeks ago. She denies fever, chills, malaise, weight loss, neck stiffness, chest pain, dyspnea, abdominal pain, diarrhea, constipation, urinary symptoms, joint pain, or back pain. Neurologic complaints as per HPI.

General physical examination

The patient is obese but well-appearing. Temperature is 37.6, blood pressure is 128/78, and pulse is 85. There is no tenderness over the scalp or neck and no bruits over the eyes or at the neck. There is no proptosis, eyelid swelling, conjunctival injection, or chemosis. Cardiac exam shows a regular rate and no murmur.

Neurologic examination

Mental Status: The patient is alert, attentive, and oriented. Speech is clear and fluent with good repetition, comprehension, and naming. She recalls 3/3 objects at 5 minutes.

Cranial nerves

CN II: Visual fields are full to confrontation. Fundoscopic exam is normal with sharp discs and no vascular changes. Venous pulsations are present bilaterally. Pupils are 4 mm and briskly reactive to light. Visual acuity is 20/20 bilaterally.

CN III, IV, VI: At primary gaze, there is no eye deviation. When the patient is looking to the left, the right eye does not adduct. When the patient is looking up, the right eye does not move up as well as the left. She develops horizontal diplopia in all directions of gaze especially when looking to the left. There is ptosis of the right eye. Convergence is impaired.













Neurology Clinical Scenario

CN V: Facial sensation is intact to pinprick in all 3 divisions bilaterally. Corneal responses are intact.

CN VII: Face is symmetric with normal eye closure and smile.

CN VII: Hearing is normal to rubbing fingers.

CN IX, X: Palate elevates symmetrically. Phonation is normal.

CN XI: Head turning and shoulder shrug are intact.

CN XII: Tongue is midline with normal movements and no atrophy.

MOTOR: There is no pronator drift of outstretched arms. Muscle bulk and tone are normal. Strength is full bilaterally.

REFLEXES: Reflexes are 2+ and symmetric at the biceps, triceps, knees, and ankles. Plantar responses are flexor.

SENSORY: Light touch, pinprick, position sense, and vibration sense are intact in fingers and toes.

COORDINATION: Rapid alternating movements and fine finger movements are intact. There is no dysmetria on finger-to-nose and heel-knee-shin. There are no abnormal or extraneous movements. Romberg is absent.

GAIT/STANCE: Posture is normal. Gait is steady with normal steps, base, arm swing, and turning. Heel and toe walking are normal. Tandem gait is normal when the patient closes one of her eyes.

Laboratory Data:

CT (non-contrast) 7/17: no abnormalities. Orbits not well seen.

MRI 7/18: Multi-focal areas of increased signal on T2 and FLAIR in the deep white matter bilaterally. These range in size from 1 to 10 mm and do not enhance after administration of gadolinium. There are no signal abnormalities in the brain stem or in the corpus callosum. No abnormalities in orbits, sinuses, or venous structures.

Assessment:

In summary, the patient is a 50-year-old woman with longstanding headaches who has had an

acute onset of pupil-sparing partial third nerve palsy on the right (involving levator palpabrae, superior rectus, and medial rectus) associated with a bifrontal headache. Because this is an isolated third nerve palsy without involvement of other cranial nerves or orbital abnormalities, the lesion is localized to the nerve itself, e.g. in the subarachnoid space. Ophthalmoplegic migraine remains a likely diagnosis given the history of migraine with aura, even though the current headache is different in character from her usual headaches and is not associated with visual aura, nausea/vomiting, or photophobia. However, other potentially serious causes of third nerve palsy must be excluded. If a third nerve palsy is due to a compressive lesion, the pupillary fibers will generally become involved within about one week of the onset of symptoms. So the fact that her pupil is normal in size and reactive to light weighs against the diagnosis of a compressive lesion such as an aneurysm or tumor, but does not eliminate the possibility.













Neurology Clinical Scenario

The MRI does not show evidence of a mass lesion, but an aneurysm cannot be completely excluded without an angiogram. Another potentially serious cause of the third nerve palsy is meningitis. The patient is afebrile, has no meningeal signs, is wellappearing, and has been stable over three days, making bacterial meningitis highly unlikely, but atypical meningitis including fungal, Lyme, sarcoid or carcinomatous meningitis are possibilities. Finally, the patient may have a vascular lesion of the third nerve due to unrecognized diabetes.

The appearance of the MRI abnormalities is nonspecific. The lesions are potentially explainable by migraines, but are also consistent with hypertension or a vasculopathy. The patient denies a history of hypertension, is not currently hypertensive, and has no risk factors for vascular disease, but the possibility of a genetic disorder such as CADASIL cannot be excluded given the lack of paternal history.

Plan

1. R IIIrd nerve palsy.

The patient will undergo a cerebral angiogram to evaluate for an aneurysm, particularly a posterior communicating aneurysm. Patient has been informed of risks and benefits of this procedure and it is scheduled for AM. She will be kept NPO for the procedure.

A lumbar puncture will be performed with opening pressure assessed and CSF sent for cell count and differential, protein, glucose, cultures and cytology. She will have her glucose and hemoglobin A1C drawn to evaluate for diabetes.

She will have close observation for possible neurologic worsening including neuro checks every 4 hours for first 24 hours.

She will be given an eye patch for comfort to eliminate the diplopia.

2. Headache.

She will be given a trial of naprosyn 400 mg po bid; if this is ineffective, she may require narcotic analgesia while her evaluation is being completed. If the cerebral angiogram and lumbar puncture are negative and her headache does not improve, she may be a candidate for IV dihydroergotamine treatment. Despite the infrequency of her migraines, the occurrence of a debilitating migraine with neurological deficits warrants the use of a prophylactic agent. A tricyclic antidepressant would be a good choice given her history of depression.

3. Depression.

The patient denies current symptoms and will continue Zoloft at current dose.

4. Obesity.

The patient requests referral to a dietician.







Obstetrics & Gynecology

Clinical Documentation













Obstetrics & Gynecology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right, bilateral, multiple locations
- Status of + Acute
- **Disease** + Sub-Acute
 - + Chronic
 - Intermittent
 - ♣ Recurrent
 - Transient
- **Infections** + Link infective organism and disease process
- **Nutritional** + Deficiencies specify substance
 - Overweight versus obesity versus morbid obesity
 - Malnutrition
 - **★** With or without complications
 - **★** Mild, moderate or severe

- **Neoplasms** + Malignant versus benign,
 - primary, secondary, In Situ + Detailed locations, including
 - left, right or bilateral
 - Overlapping sites versus different, distinct location
 - **Diabetes** + Type I, Type II, or due to other disease/drug
 - **◆** Specify underlying disease
 - + Link Diabetes to complications
 - **★** Gestational versus prepregnancy
- **Metabolic** + Hypo- and hyper- do not Disease document A or V













Obstetrics & Gynecology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Skin** + Link infectious agent or cause to disease
- **Genitourinary** + Primary versus secondary disease
 - **◆** State of chronic kidney disease
 - **+** Document stage
 - **★** Link to diabetes
 - + Link infectious agent or cause to disease
- Reproductive
- **Female** + Location and extent of prolapse
 - **★** Midline, lateral
 - **★** Incomplete, complete
 - **★** Source of infertility

- **Obstetrics** + Reason for C-Section as principal diagnosis
 - + Trimester when complication began
 - + Abortion
 - ♣ Incomplete, complete, failed attempted
 - **★** Associated complications
 - + High risk pregnancy
 - **★** Hx of infertility, ectopic or molar pregnancy
 - + Gestational versus preexisting condition
 - **★** If gestational diabetes is in control
 - Multiples
 - **★** Number of fetuses
 - **★** Identify the fetus with complication













Obstetrics & Gynecology Clinical Scenario

Preoperative Diagnosis

Retained intrauterine device

Postoperative Diagnosis

Retained intrauterine device

Operation

- 1. Evaluation under anesthesia.
- 2. Removal of intrauterine device.

Anesthesia

Laryngeal mask airway (LMA)

Findings

Normal ParaGard intrauterine device (IUD), not sent to pathology.

Indication for Procedure

The patient is a 32-year-old female with a ParaGard intrauterine device IUD placed approximately 10 years ago. She presented to the office for a removal recently. Upon attempts in the office, the IUD

string detached from the IUD. Multiple attempts in the office utilizing polyp forceps and ultrasound guidance were unsuccessful in removing the IUD. Decision was made to bring the patient back for evaluation under anesthesia and removal.

Description of Operation

Complications: None.

Disposition: Stable.

Estimated blood loss: Less than 10 mL.

After informed consent was obtained, the patient was brought back to the operative suite where adequate general anesthesia was obtained. The patient was then placed in dorsal lithotomy position and prepped and draped in a sterile fashion. A weighted speculum was placed inside the vagina, and the anterior lip of the cervix was grasped with a long Allis clamp. Upon examination after relaxation, it was noted that the IUD was in the lower uterine segment. Utilizing polyp forceps, the IUD was able to be grasped at its base and removed from the uterus. Minimal bleeding

occurred. No hysteroscopy was necessary. Vaginal instruments were then removed.

The patient was then awakened from the general anesthesia and transferred to the recovery room in stable condition.







Ophthalmology

Clinical Documentation







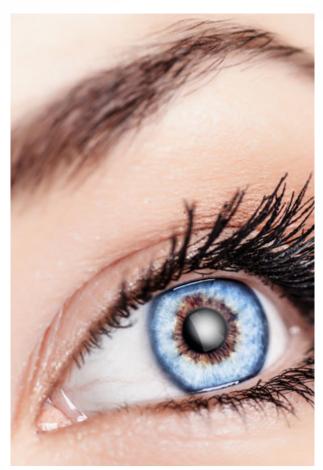






Ophthalmology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right, bilateral, multiple locations
- **Status of** + Acute
- **Disease** + Chronic
 - Intermittent
 - ★ Recurrent
 - Primary
 - **★** Secondary
- **Infections** + Link infective organism and disease process
- **Neoplasms** + Benign versus malignant, primary, secondary
 - Detailed locations
 - Overlapping sites versus different, distinct locations

Diabetes + Type I

- ♣ Type II Long term use of insulin?
- ♣ Due to other disease specify underlying disease
- ♣ Due to drug/chemical specify drug or substance
- ♣ Link Diabetes to eye disease

Eye Injuries + Detailed locations (specific orbital bone, eyelid, eyeball)

- + Laceration (penetrating, with prolapse, avulsion)
- + Episode of care (Initial, Subsequent, Sequela)







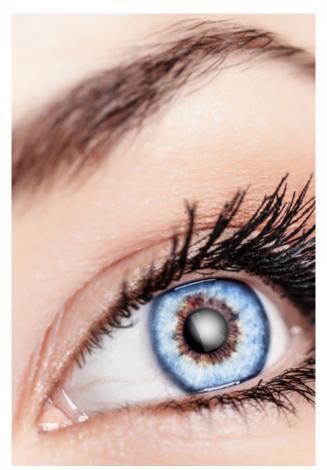






Ophthalmology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Cause of + Mechanism – How it happened (struck by basketball)

- ♣ Place of occurrence Where it happened (high school)
- + Activity What patient was doing (playing basketball)
- + External cause status Military, Civilian, Work-related, Leisure

Eye + Upper versus lower eyelid

- **Disease** + Ectropion and Entropion
 - ♣ Cicatricial, mechanical, senile, spastic, trichiasis
 - + Type and location of corneal ulcer
 - + Cataract as age-related, traumatic or drug induced
 - ♣ Anterior versus posterior
 - **★** Complicated versus uncomplicated













Ophthalmology Clinical Scenario

Preop Diagnosis

Ptosis

Postop Diagnosis:

Ptosis

Procedure

Mullerectomy

Anesthesia

MAC

Complications

none

Indications

The patient had been complaining of a progressive drooping of the eyelid which was interfering with their ability to see to watch TV and read. By holding her eyelid up she can see better. Visual field testing was performed which demonstrated a loss of the superior visual field. By taping the eyelid up into

its proper anatomic position there was a marked improvement in the field. Neosynephrine 10% instilled into the eye resulted in a good elevation of the eyelid.

Procedure Description

After informed consent was obtained, the patient was brought to the operating room. A supraorbital block of local anesthetic consisting of a 50/50 mixture of Xylocaine 1% with epinephrine mixed with Marcaine. 75% with epinephrine. The face was then prepped and draped in the usual sterile fashion. The eyelid was then everted over a Desmarres retractor. The superior border of the tarsus was then marked with a marking pen. Another line was then marked on the conjunctiva 8 mm superior to this. The conjunctiva and Mueller's muscle were the freed up from the underlying levator muscle by pulling on these tissues with an Arson forceps. A Mullerectomy clamp was then placed on the two previously marked lines. The clamp was shut to enclose the 8 mm of Muller's muscle and conjunctiva. A 6-0 plain suture was then

run along the underside of the clamp. The clamp and its tissues were then excised by running a #15 Barde Parker blade along the underside of the clamp. The 6-0 plain suture was then run once along the length of the wound to close the edge of tarsus to the conjunctiva. The suture was buried temporarily. The patient tolerated the procedure well and left the operating room in good condition.







Oncology Clinical Documentation













Oncology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Chronic Disease

- **Anemia in** + Document the chronic disease and link it to the anemic:
 - **★** Anemic due to chronic kidney disease
 - ♣ Anemic due to colon cancer

Antemia

- **Blood Loss** + Document, when appropriate:
 - ♣ Anemia due to acute blood loss
 - **★** Anemia due to chronic blood loss
 - + If acute blood loss anemia is due to blood loss during surgery:
 - **◆** Documentation of postoperative anemia is not enough

Blood Loss Antemia cont.

- ♣ Document instead postoperative anemia due to acute blood loss
- ♣ When it is your clinical judgment that the surgery resulted in a expected amount of blood loss, no diagnosis of acute blood loss is needed

Anemia

- **Nutritional** + Document Iron deficiency anemia by type:
 - Sideropenic iron deficiency anemia
 - + Iron deficiency due to inadequate dietary iron intake













Oncology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Anemia cont.

- **Nutritional** + Document vitamin B12 type, such as:
 - **♣** Due to intrinsic factor deficiency
 - **◆** Vitamin B12 malabsorption
 - ♣ Document folate deficiency type, such as:
 - **♣** Due to diet
 - ♣ Drug induced
 - + Document other nutritional types, such as:
 - ♣ Protein deficiency
 - ♣ Other Drug Induced **Blood Disorders**

Anemia cont.

- **Nutritional** + Document cause and effect. for example:
 - **♣** Agranulocytosis due to sulfasalazine
 - ♣ Pancytopenia due to chemotherapy

Underdosing

- **Drug** + Document type:
 - ♣ Intentional versus
 - **◆** Unintentional
 - + Document reason for underdosing, such as:
 - **★** Financial hardship or
 - **★** Age related dementia













Oncology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Leukemia + Document:

- - **♣** Acute
 - **◆** Chronic
- ♣ Document specific type, for example:
 - **★** Acute lymphoblastic
 - **◆** Chronic lymphocytic of B-cell type
 - **★** rolymphocytic of B-cell type
 - **♣** Hairy cell
 - **★** Adult T-cell
- ♣ Document remission-relapse status for each patient visit:
 - ♣ Not having achieved remission
 - **★** In remission
 - ♣ In relapse

- **Neoplasms** + Document specific site
 - **→** Document laterality:
 - ♣ Right
 - **+** Left
 - ♣ Bilateral
 - + Detail when a patient has presented for a specific treatment related to the neoplasm
 - **◆** Surgical removal
 - **◆** Chemotherapy
 - **★** Immunotherapy
 - **★** Radiation therapy
 - **→** Document morphology:
 - **★** Malignant
 - ♣ Benign
 - ♣ In situ
 - ♣ Uncertain behavior
 - **◆** Unspecified behavior













Oncology Clinical Scenario

Procedure Description

Aplastic anemia. After several bone marrow biopsies, she was diagnosed with aplastic anemia. She started cyclosporine and prednisone.

Chief Complaint

Aplastic anemia.

History Of Present Illness

This is a very pleasant 72-year-old woman, who I have been following for her pancytopenia. After several bone marrow biopsies, she was diagnosed with aplastic anemia. She started cyclosporine and prednisone on 03/30/10. She was admitted to the hospital from 07/11/10 to 07/14/10 with acute kidney injury. Her cyclosporine level was 555. It was thought that her acute kidney injury was due to cyclosporine toxicity and therefore that was held.

Overall, she tells me that now she feels guite well since leaving the hospital. She was transfused

2 units of packed red blood cells while in the hospital. Repeat CBC from 07/26/10 showed white blood cell count of 3.4 with a hemoglobin of 10.7 and platelet count of 49,000.

Current Medications

Folic acid, Aciphex, MiraLax, trazodone, prednisone for 5 days every 4 weeks, Bactrim double strength 1 tablet b.i.d. on Mondays, Wednesdays and Fridays.

Allergies

No known drug allergies.

Review Of Systems

As per the HPI, otherwise negative.

Past Medical History

- 1. Hypertension.
- 2. GFRD.
- 3. Osteoarthritis.
- 4. Status post tonsillectomy.

- **5.** Status post hysterectomy.
- **6.** Status post bilateral cataract surgery.
- 7. Esophageal stricture status post dilatation approximately four times.

Social History

She has no tobacco use. She has rare alcohol use. She has three children and is a widow. Her husband died after they were married only eight years. She is retired.

Family History

Her sister had breast cancer.

Physical Exam

VIT: Height 167 cm, weight 66 kg, blood pressure 122/70, pulse 84, and temperature is 98.9.

GEN: She is nontoxic, noncachectic appearing.

HEAD: Examined and normal.

EYES: Anicteric.













Oncology Clinical Scenario

ENT: No oropharyngeal lesions.

LYMPH: No cervical, supraclavicular, or axillary lymphadenopathy.

HEART: Regular S1, S2; no murmurs, rubs, or gallops.

LUNGS: Clear to auscultation bilaterally.

ABDOMEN: Nontender, nondistended; normal bowel sounds; no hepatosplenomegaly.

EXT: Reveal no edema.

Assessment / Plan

Aplastic anemia. I am going to repeat her CMP today to assess her kidney function. It is possible that I may resume the cyclosporine, but at 50% dose reduction. She was supratherapeutic when her cyclosporine level was drawn in the hospital. Her values were 555 and the trough should be 100 to 400. We will continue with monthly CBCs for now and I will see her again in one month.







Orthopedics Clinical Documentation













Orthopedics Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right bilateral, multiple locations
- **Underlying** + Past infection Cause of Past trauma musculoskeletal

 - **disease** + Other disease process
 - Disease
 - **Status of** + Acute
 - + Chronic
 - + Intermittent
 - + Recurrent

 - **Arthritis** + Rheumatoid versus osteoarthritis
 - Primary, post-traumatic or secondary disease
 - **★** Generalized or particular joints

Injuries

- **General** + Detailed locations (Head, Shaft, Proximal, Distal, etc.)
 - ♣ Type of tendon (Flexor or Extensor)
 - + Episode of care (Initial, Subsequent, Sequela)

Dislocations

- **Fractures &** + Traumatic versus stress
 - **♣** Open versus closed
 - **♣** Displaced versus non-displaced
 - + Degree of healing
 - **♣** Routine
 - **♣** Delayed
 - **♣** Nonunion
 - **♣** Malunion













Orthopedics Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Fractures & • Pathological fracture with Osteoporosis

Dislocations Age related versus other type

Arthritis + Rheumatoid versus osteoarthritis

+ Primary, post-traumatic or secondary disease

♣ Generalized or particular joints













Orthopedics Clinical Scenario

Subjective

The patient is a 53-year-old seen for right shoulder pain. He has had a rather insidious onset of pain a month ago. He complains of pain with the ends of forward flexion and abduction. He has noticed a loss of motion. He has had difficulty reaching overhead. He has had problems sleeping. He had no particular injury that he can recall. He complains of pain over the lateral deltoid area primarily. He rates the pain as 7/10 today.

Objective

The patient is a well-appearing gentleman. He is 5 feet 8 inches, 204 pounds. He is walking with a normal gait. He has full symmetrical motion of his neck and a straight spine. He has no pain to palpation of his neck. No pain to palpation about his posterior shoulder musculature. No atrophy noted about the shoulder girdle. His range of motion is limited significantly. Abduction is only about 70 degrees actively. Passively, I can get him to about 90, significant pain with that. Forward flexion is about 110-130 with moderate pain. Internal rotation limited to his belt. He is able to do a lift-off. His left side is 5/5. His external rotation and supraspinatus are 5/5 bilaterally; although, he has significant pain with both, particularly supraspinatus, on the right. Speed's test causes him some mild pain. AC joint is prominent but nontender. He is neurovascularly intact distally. No swelling of his arm noted.

X-rays obtained today show some significant degenerative arthritis of the AC joint. Type II acromion. Well-maintained glenohumeral and subacromial spaces.

Assessment and Plan

Rotator cuff tendinopathy and nascent adhesive capsulitis. He is having rather significant pain. He is unable to take NSAIDs because of the Coumadin. We talked about doing a corticosteroid injection today. We talked about the risks of bleed in

conjunction with his INR of 3.3. His other risks, including but not limited to steroid flare and infection, were discussed as well. He requested that the injection be done. The risk of the bleed was minimal. The posterior aspect of the right shoulder was prepped sterilely with Betadine and alcohol. Posterior portal site was used to enter the subacromial space under sterile technique with a 22 gauge needle injecting 60 mg of Kenalog, 1.5 mL of lidocaine. The patient tolerated it well. I am going to see the patient back in 6-8 weeks' time. Gave him a home program to get working in terms of motion. We talked about a formal physical therapy consult. The patient would rather work on his own for now I will see him back in 6-8 weeks.







Pathology Clinical Documentation













Pathology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- ★ Was a separate service performed?
- ★ Which specific service was performed?
- ♣ What specimen(s) does the service(s) relate to and
- ♣ How many times was the service performed with each specimen?
- + Document the stain that was used and its results.

- specimen
- **Type of** + TUR bladder
 - ♣ Cervical "cone"
 - + Sterilization
 - + Biopsy
 - + Resection
 - ♣ Partial/wedge ode in a charge audit.

dependent on

- **Level** + Neoplastic or non-neoplastic,
- ♣ Skin cyst vs skin lesion or location and diagnosis
 - + Lipoma vs soft tissue mass.

If multiple specimens and/or blocks are stained, document which specimens and/or blocks the stains were performed on and the results.

+ If a special stain didn't yield a diagnosis, do not use words like "normal" or "noncontributory." This tends to mean that the service was not medically necessary. Rather "GMS stain negative for H. pylori" or "Iron stores confirmed by Iron stain."













Pathology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- + Be sure to specify the technique or approach used to obtain a diagnostic result. Is it an IHC stain, in situ hybridization study, etc. Was the approach qualitative, quantitative or semi-quantitative and if it was manual or computer-assisted.
- + Don't assume when a bone specimen is submitted, a decalcification is reported. Document decalcification in the report.
- + Clearly document for intraoperative consultations.
- + Patient name and identification number
- ♣ Name of laboratory
- ♣ Name of physician or practitioner ordering the test
- + Date and time of the collected specimen, and date and time of receipt
- + Reason for an unsatisfactory specimen, if applicable
- + Test or evaluation performed
- + Result
- ♣ Date and time of report













Pathology Clinical Scenario

Description

Specimen labeled "right ovarian cyst" is received fresh for frozen section.

Gross Description

Specimen labeled "right ovarian cyst" is received fresh for frozen section. It consists of a smoothwalled, clear fluid filled cyst measuring 13x12x7 cm and weighing 1351 grams with fluid. Both surfaces of the wall are pink-tan, smooth and grossly unremarkable. No firm or thick areas or papillary structures are noted on the cyst wall externally or internally. After removal the fluid, the cyst weight 68 grams. The fluid is transparent and slightly mucoid. A frozen section is submitted.

Diagnosis

Right Benign cystic ovary.







Pediatrics

Clinical Documentation













Pediatrics Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right bilateral, multiple locations
- **Status of** + Acute **Disease** + Chronic
 - Intermittent
 - Recurrent
 - **+** Transient
- **Newborns** Special series of codes for newborn conditions- not coded to same codes as over 28 days of life
 - + Affected by, or suspected to be affected by, maternal conditions- specify condition

Anomalies

- **Congenital** + Syndromes-Document additional anomalies if not part of standard definition
 - ♣ Document "history of" as if repaired
- **Infections** + Link infective organism and disease process

- **Neoplasms** + Malignant versus benign, primary, secondary, In Situ
 - + Detailed locations
 - Overlapping sites versus different, distinct locations
 - + Leukemia- In remission or relapse













Pediatrics Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Diabetes** + Type I, Type II, or Due to disease or drug
 - Link Diabetes to complications
- System
- **Nervous** + Primary versus secondary disease and cause
 - ♣ Drug name or type on drug-induced disorders
 - Specific type of epilepsy
 - **★** Seizure disorder = epilepsy
 - ♣ Seizure = single event or yet to be diagnosed
 - + Type of migraine and with or without an aura
 - ♣ Presence of intractable disease
 - ♣ Level and type of paralysis
 - ♣ Type of hydrocephalus

- **Eye and Ear** + Upper versus lower eyelid
 - + Cataract as age-related, traumatic or drug induced
 - Primary versus secondary disease
 - + Effects of tobacco use / exposure on ear disease

System

Circulatory + Rheumatic versus nonrheumatic disease

Respiratory + Exacerbation chronic disease

System Asthma as intermittent versus persistent and mild, moderate or severe













Pediatrics Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



System

- **Digestive** + Link complications to disease
 - **♣** Bleeding, perforation, gangrene, fistula, abscess, obstruction
 - Hernia Unilateral versus bilateral
 - ♣ Constipation Slow transit or outlet dysfunction
 - **Skin** + Link infectious agent or cause to disease

- **Genitourinary** Primary versus secondary disease
 - + Link infectious agent or cause to disease

skeletal

- **Musculo-** Past infection, past trauma, other disease processes
 - + Link infectious agent or cause to disease
 - + Arthritis Rheumatoid versus Osteoarthritis
 - + Primary, post-traumatic, or secondary disease

Inquiries

- **General** + Detailed locations (Head, Shaft, Proximal, Distal, etc.)
 - + Episode of care (Initial, Subsequent, Sequela)













Pediatrics Clinical Scenario

Chief Complaint

The patient is a 9 - year old female who presents with her mother with a complaint of cold symptoms. States she had a fever last week. Now she has a sore throat and difficulty swallowing foods. She also has a headache and stuffy nose:

HPI: Congestion, fever, nasal discharge and sore throat. Denies cough. Fever: Temperature reported to be 101.8 on Sunday, per mom. Sore throat: Described as scratchy. Exposed to cigarette smoke. Reports associated loss of appetite, diarrhea and nausea but declines associated vomiting and pain in mid abdomen.

ROS: Constitutional: Denies chills and fever today. ENMT: Reports ear pain/fullness, reports sinus congestion and nasal discharge. Respiratory: Reports cough, but denies wheezing. Skin: Denies rashes. Allergy/Immunology: Denies environmental or seasonal allergies.

Current Medications

None Reported.

Allergies

NKDA

Past Medical History

Last well child visit one year ago.

Family History

Father is a smoker, on disability due to work related arm injury, Mother - unremarkable. MGM is remarkable for Congestive Heart Failure, Hypercholesterolemia, and Hypertension.

Social History

The child lives 50/50 share with the mother and father. The patient also has brother and sister. Both parents are very involved in the care of all of the children. The fathers home is not smoke free. The mother's home has a cat and dog.

Physical Exam

BP: 108/72, Pulse: 72, Temp: 98.4, Resp: 18, Ht: 55.75", Wt.: 86lbs. BMI: 19.5.

CONST: Ill appearing child and mildly dehydrated.

ENMT: Auditory canals are patent. Tympanic membranes have normal landmarks, no fluid or erythema bilaterally. Nasal mucosa shows congestion, moistness and normal with no clear discharge. Oral mucosa: pink, smooth and moist and dry. Tongue appears pink and dry with no abnormalities. Posterior pharynx shows injection and irritation, but no exudates. Tonsils appear normal.

NECK: symmetric and supple. Palpation reveals no swelling or tenderness.













Pediatrics Clinical Scenario

RESP: Chest expansion is adequate bilaterally. Respiration rate is normal. No wheezing. Lungs are clear bilaterally.

CV: Rate is regular. No heart murmur appreciated. Lymph: No visible or palpable lymphadenopathy in the neck. Skin warm and dry, no rash.

Assessment

Pharyngitis, Acute.

Plan

Push fluids and rest. Rx is given for Amoxicillin 400mg, 1 0.m. tid x 10days. If nausea persists, follow up.







Plastic Surgery

Clinical Documentation













Plastic Surgery Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Wound

- **Open** + Laterality
- ♣ With/Without Nail Damage Finger/Toe
 - With/Without Foreign Body
 - ♣ With/Without Tendon Involvement
 - Type
 - **★** Laceration
 - **♣** Puncture
 - **♣** Open Bite
 - + With Amputation
 - **Encounter**
 - **♣** Initial
 - **♣** Subsequent
 - **♣** Sequela
 - Size of Wound Closure (if done)

Wound Finger/Toe

cont.

- **Open** + Type of Wound Repair
- **♣** Simple
 - **★** Intermediate
 - **♣** Complex
- **Other Open** With/Without Foreign Body
 - Wounds With/Without Tendon Involvement
 - + Laterality
 - + Encounter
 - **♣** Initial
 - **♣** Subsequent
 - **♣** Sequel
 - **◆** Type
 - **♣** Laceration
 - ♣ Puncture
 - **♣** Open Bite













Plastic Surgery Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Other Open** + Size of Wound Closure (if done)
 - cont.
 - **Wounds** + Type of Wound Repair
 - **♣** Simple
 - **★** Intermediate
 - **♣** Complex

 - **Cause of** → Mechanism How it happened (struck by basketball)
 - ♣ Place of Occurrence Where it happened (high school)
 - ♣ Activity What was happening (playing basketball)
 - + External Cause Status -Military, Civilian, Work-related, Leisure













Plastic Surgery Clinical Scenario

Description

Quad blepharoplasty for blepharochalasia and lower lid large primary and secondary bagging.

Preoperative Diagnoses

- 1. Blepharochalasia.
- 2. Lower lid large primary and secondary bagging.

Postoperative Diagnoses

- 1. Blepharochalasia.
- 2. Lower lid large primary and secondary bagging.

PROCEDURE: Quad blepharoplasty.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: Minimal.

CONDITION: The patient did well.

Procedure

The patient had marks and measurements prior to surgery. Additional marks and measurements were made at the time of surgery; these were again checked. At this point, the area was injected with 0.5% lidocaine with 1:200,000 epinephrine. Appropriate time waited for the anesthetic and epinephrine effect.

Beginning on the left upper lid, the skin excision was completed. The muscle was opened, herniated, adipose tissue pad in the middle and medial aspect was brought forward, crossclamped, excised, cauterized, and allowed to retract. The eyes were kept irrigated and protected throughout the procedure. Attention was turned to the opposite side. Procedure was carried out in the similar manner.

At the completion, the wounds were then closed with a running 6-0 Prolene, skin adhesives, and Steri-Strips. Attention was turned to the right

lower lid. A lash line incision was made. A skin flap was elevated and the muscle was opened. Large herniated adipose tissue pads were present in each of the three compartments. They were individually elevated, cross-clamped, excised, cauterized, and allowed to retract.

At the completion, a gentle tension was placed on the facial skin and several millimeters of the skin excised. Attention was turned to he opposite side. The procedure was carried out as just described. The contralateral side was reexamined and irrigated. Hemostasis was good and it was closed with a running 6-0 Prolene. The opposite side was closed in a similar manner.

Skin adhesives and Steri-Strips were applied. The eyes were again irrigated and cool Swiss Eye compresses applied. At the completion of the case, the patient was extubated in the operating room, breathing on her own, doing well, and transferred in good condition from operating room to recovering room.







Podiatry Clinical Documentation













Podiatry Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- Type of + Closed or open
- **fracture** Open fractures require the Gustilo classification to be marked on the superbill and documented in the notes
 - ♣ Grade I, Grade II, Grade III, Grade IIIA, Grade IIIB, or Grade IIIC
- **Bone** Displaced or nondisplace alignment
- anatomical site and laterality
- **The specific** + Name of the exact bone and the specific location including the right or left side of the body when appropriate
 - + Ex: Fracture of 2nd Metatarsal bone, right foot
 - **Result** + Healing, routine, delayed, malunion, or nonunion

- **Result** + Document at each encounter
- **Episode** + Initial encounter, subsequent of care encounter, or sequela
 - ◆ Document at each encounter.
- Injuries + External Cause -You will need to provide "how" the injury occurred.
 - Place of occurrence Where did the injury take place?
 - + Activity code -What was the patient doing that caused the injury?
 - External cause status Indicate if the injury was related to another source (military, work, etc.)













Podiatry Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Diabetes** + Type of Diabetes
- **Mellitus** Complication or manifestation
 - + Body system affected
 - + If type 2 diabetes, long-term insulin use
 - **Ulcer** + Location
 - + Size
 - + Depth
 - **+** Base
 - + Tunneling
 - **→** Odor
 - + Infection presence
 - + Classification













Podiatry Clinical Scenario

Subjective

An 83-year-old diabetic female presents today stating that she would like diabetic foot care.

Objective

On examination, the lateral aspect of her left great toenail is deeply ingrown. Her toenails are thick and opaque. Vibratory sensation appears to be intact. Dorsal pedal pulses are 1/4. There is no hair growth seen on her toes, feet or lower legs. Her feet are warm to the touch. All of her toenails are hypertrophic, opaque, elongated and discolored.

Assessment

- 1. Onychocryptosis.
- 2. Onychomycosis.
- 3. Difficulty in walking. The patients' toenails have made wearing shoe gear painful.

Plan

Aseptic technique was used and the lateral aspect of the left great toenail was excised. Blood loss was minimal. Hemostasis was achieved. Her left great toe was dressed with Neosporin ointment and absorbent dressing. Her remaining toenails required manual as well as electric debridement. Follow-up is every three months or whenever she needs to come in.







Pulmonary Clinical Documentation













Pulmonary Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Asthma** + Intractable asthma attack
 - Severe
 - ♣ Intractable wheezing
 - Severe prolonged asthma attack
- **Respiratory** + Acute
 - Failure + Chronic
 - + Acute and/on chronic
 - + Unspecified
 - + Hypercapnia
 - Нурохіа
 - **Sepsis** + Document underlying local infection
 - **◆** Specify causal relationship to local

- **Sepsis** Infection and/or procedure Identify causative organism
 - **→** Staphylococcus
 - **★** MSSA
 - **♣** MRSA
 - **◆** Other specified
 - **♣** Unspecified
 - **◆** Streptococcus
 - **♣** Group A
 - **♣** Group B
 - **♣** Pneumonia
 - **♣** Other
 - **◆** Unspecified
 - ◆ Other gram negative
 - Anaerobes
 - + Any associated
 - ♣ Organ dysfunction or failure













Pulmonary Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Sepsis** Severe sepsis **cont.** • Septic shock
 - **◆** SIRS is only applicable for non-infectious
 - Process
- **Pneumonia** + Identify any associated
 - **+** Influenza
 - + Lung abscess

Virus:

- Adenoviral
- + Human metapneumovirus
- ♣ Parainfluenza
- ♣ Respiratory syncytial virus
- SARS-associated coronavirus
- Other virus

Pneumonia Bacteria:

cont.

- + E. Coli
- + H. influenza
- + Klebsiella pneumonia
- **★** MRSA
- MSSA
- ♣ Mycoplasma pneumoniae
- + Pseudomonas
- **◆** Streptococcal pneumoniae
- ◆ Streptococcus, Group B
- + Other
- ♣ Aerobic Gram-negative













Pulmonary Clinical Scenario

History of Present Illness

Past medical history reviewed, family history reviewed, and surgical history reviewed.

The patient is presenting today for persistent asthma. Patient has had coughing, wheezing, shortness of breath, and chest tightness. The symptoms have been manifesting on a daily basis. He has been waking up at least once a week but not nightly due to cough. He uses rescue inhaler daily. It has had some limitation but not extremely limited his daily activities.

Reviewed social history

Current medication: Medication list reviewed.

Allergies: No Known Drug Allergies.

Review of systems

Pulmonary: Shortness of breath. Non-productive cough and slight wheezing. Psychological: Sleep disturbances. Allergic and Immunologic: No complaint of recurrent infections. All other

systems negative.

Physical findings

Oropharynx: Mallampati class 4 airway. Lungs: Abnormal breath sounds/voice sounds were heard decreased breath sounds were heard. Musculoskeletal, skin, Cardiovascular, digestive systems were all normal.

Tests

Labs: Lung function FEV1 72%

Assessment

Intrinsic asthma without exacerbation

Plan

I will prescribe Spiriva for asthma treatment. Followup visit, 1 Year and as needed.







Radiology Clinical Documentation













Radiology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



Findings + The report should use appropriate anatomic, pathologic, and radiologic terminology to describe the findings.

limitations

Potential + The report should, when appropriate, identify factors that may compromise the sensitivity and specificity of the examination.

issues

Clinical • The report should address or answer any specific clinical questions. If there are factors that prevent answering the clinical question, this should be stated explicitly.

Comparison + studies and reports

Comparison with relevant examinations and reports should be part of the radiologic consultation and report when appropriate and available.

- **Impression** + Unless the report is brief each report should contain an "impression" or "conclusion."
 - + A specific diagnosis should be given when possible
 - + A differential diagnosis should be rendered when appropriate.













Radiology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Impression** + Follow-up or additional diagnostic studies to clarify or confirm the impression should be suggested when appropriate.
 - + Any significant patient reaction should be reported.

computergenerated template reports

Standardized • Standardized computer-generated template reports should be designed to satisfy the above criteria.













Radiology Clinical Scenario

Referring Physician

John Doe, MD

Indications for Study

- 1. Spinal stenosis.
- 2. Low back pain.
- 3. Bilateral leg numbness.
- 4. Weakness in hands.

Cervical and Lumbar Spine MRI

Due to the patient's body habitus and size, the patient could not be moved further into the coil and visualization of the upper lumbar spine is very limited. The patient's head was also squeezed into the cervical spine coil and was very uncomfortable during the study.

MRI of the Cervical Spine

Sagittal and axial images were obtained. The craniocervical junction is within normal limits. Spinal cord is normal in location and signal

intensity. There is straightening of the normal curvature. Marrow signal within the bony structures is unremarkable.

At C7-T1, there is no focal disk disease.

At C6-7, there is a disk bulge which causes mild flattening of the anterior CSF space and some neural foraminal narrowing, left greater than right.

At C5-6, there is a combination of disk bulge and posterior osteophytes, which narrows the neural foramina and flattens the anterior CSF space, more so than at the C6-7 level.

At C4-5, there is a disk bulge, which flattens the anterior CSF space and causes some bilateral neural foraminal narrowing, left greater than right.

At C3-4, there is a combination of bone and disk, which slightly flattens the anterior CSF space and narrows the neural foramina bilaterally.

Impression

Some mild multilevel disk disease, as described above, with some disk bulges and posterior osteophytes. There is no frank disk herniation

MRI of the Lumbar Spine

Sagittal and axial images were obtained. The upper lumbar spine is not well visualized due to body habitus and positioning within the coil. The conus appears grossly within normal limits, normal in location and signal intensity. The marrow signal appears within normal limits. There is marked narrowing at L5-S1 with some apparent fusion at this level to the left of midline. There is some minimal scoliosis. Marrow signal within the bony structures is unremarkable.













Radiology Clinical Scenario

MRI of the Lumbar Spine

At L5-S1, the nerve roots exit normally. There is some slight right neural foraminal narrowing on one image due to a combination of bone and disk; however, the neural foramina are patent on the next image.

At L4-5, there is a mild disk bulge and posterior facet degenerative changes. Nerve roots are patent.

At L3-4, there are some mild posterior facet degenerative changes, thickening of the ligamentum flavum, and neural foraminal narrowing. On the next image, the nerve roots exit normally.

Impression

- 1. There is some slight trilateral narrowing at L3-4. The nerve roots exit more normally on the next image.
- 2. At L4-5, there is a disk bulge and some posterior facet degenerative changes.
- 3. At L5-S1, there is a bulging disk and narrowing on the right with slight right neural foraminal narrowing on one image. On the next, the neural foraminal are more patent. There is no focal disk herniation.







Urology Clinical Documentation













Urology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- **Laterality** + Left, right, bilateral, multiple locations
- **Status of** + Acute **Disease** + Chronic

 - Intermittent
 - Recurrent
 - Persistent
 - Transient
- **Infections** + Link infective organism and disease process
- **Neoplasms** + Malignant versus benign, primary, secondary, In Situ
 - + Detailed locations, including left, right or bilateral
 - ♣ Overlapping sites versus different, distinct locations
 - + Leukemia In remission or In relapse

Diabetes + Type I

- ◆ Type II Long term use of insulin?
- **→** Due to other disease specify underlying disease
- ♣ Link Diabetes to eye disease

Nutritional + Deficiencies – specify substance

- Overweight versus obesity versus morbid obesity
 - **★** BMI value
- Malnutrition
 - **→** With or without complications
 - **★** Mild, moderate or severe







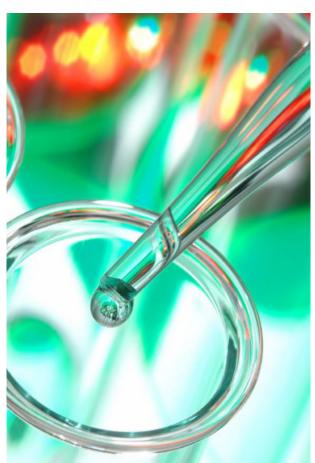






Urology Requirements

The following items should be documented as appropriate to allow complete coding under ICD-10



- Diseases
- **Metabolic** + Hypo- and hyper **Do not** document A or V

System

- **Circulatory** + Acute Myocardial Infarction time period is 4 weeks
 - + Link complications to Hypertension
 - **◆** Systolic versus diastolic heart failure
 - + Left versus right heart failure
 - + Rheumatic versus nonrheumatic disease
 - Atherosclerosis of native artery or vein versus graft
 - ♣ Traumatic versus non-traumatic cerebral hemorrhage and cause of hemorrhage or infarction

- **Skin** + Link infectious agent or cause to disease
 - ♣ Pressure ulcer site, laterality and stage
 - ♣ Non-pressure chronic ulcer site, laterality plus
 - **★** Skin breakdown
 - **◆** Fat layer exposed
 - ♣ Necrosis of muscle
 - ♣ Necrosis of bone

- **Diabetes** + Primary versus secondary disease
 - + Chronic kidney disease
 - **★** Document stage
 - **★** Link to Diabetes
 - + Link infectious agent or cause to disease













Urology Clinical Scenario

Subjective

The patient is a 26-year-old female who presents for follow up of left sided renal calculi. The patient was originally seen in the emergency room down state for left sided flank pain. She was found to have an obstructing renal calculi with CT stone protocol per the results. A culture was also done at her visit last week and grew beta hemolytic strep greater than 100,000 organisms. In the office today the patient continues to have colicky left sided flank pain, continued chills, nausea, and loss of appetite. She has no documented fevers and no vomiting. She has 8 days left of Ciprofloxacin. The patient is out of Vicodin.

Objective

Blood pressure is 140/70, weight is 101.36 kilograms. Heart regular rate and rhythm, no murmurs. Lungs are clear to auscultation bilaterally. Abdomen has positive bowel sounds time 4 quadrants. There is CVA tenderness and left lower

quadrant pain on palpation. There is no quarding and no rebound tenderness. Skin is clean without rashes, erythema, or jaundice.

Assessment

- 1. Urinary tract infection with beta hemolytic strep.
- 2. Elevated blood pressure secondary to pain.

Plan

The patient will stop her Ciprofloxacin. A prescription for amoxicillin 850 mg p.o. b.i.d. times 7 days was given to her today. Vicodin 5/500 1 to 2 p.o. every 4 hours p.r.n. pain, #60 were given with no refills. The patient was encouraged to strain her urine. She was also given encouragement to drink plently of water.









ICD-10 is not simply a change in the code set.

Moving from 14,000 ICD-9 codes to the expected 68,000 plus codes in ICD-10 is significant. In addition to the new clinical documentation requirements that ensure accurate assignment of these codes, there are still other significant areas of your practice that will be impacted by the implementation of ICD-10.

ICD-10 is expected to impact the revenue cycle. This impact can be significant to any sized practice unless you have performed a thorough assessment and implemented new workflows to address any potential impacts.

This guide will help you identify practice areas that should be assessed and suggestions for processes that will help you address any potential impact of ICD-10.

ICD-10 should remain an absolute priority for your practice to ensure timely and thorough preparation. Take advantage of this extension and use it to become educated, focused, and prepared, in order to have a smooth transition in 2015!

This ebook also contains significant areas of impact that should be evaluated in each practice. As all practices are unique, this guide may not cover all areas and workflows, but should enable you to fully understand what areas ICD-10 will influence in your practice.







Your Implementation Team. Gather your experts now!

Begin by assembling and educating your ICD-10 Implementation Team. This team should include one top resource from each area in the office. This person should be someone who understands in detail the workflows associated with their individual departments, and where/ how ICD-10 will impact each of these areas. Make sure to include your clinical staff! Their understanding of the daily use of ICD-9 will be valuable knowledge in your assessment and processes.

Consider the following with each department:

- impacts?
- ★ Will changes need to be made because of ICD-10?
- ♣ What changes need to happen?
- + How long will it take to make these changes?
- ♣ Are additional internal resources needed to make these changes?
- + Are there outside resources available to us?

- ★ Who needs additional education?
- ♣ How am I going to assess the impact of these changes?

All of these items should be considered and discussed regularly during your Implementation Team meetings. Reporting wins and anything hindering progress should be the primary focus to stay on schedule for a successful implementation.







Authorizations Department

Your scheduling or authorizations departments utilize the ICD-9 code set to obtain referrals or authorizations. Knowledge of the ICD-10 codes for medical necessity is must-have knowledge in these departments. A good rule of thumb is if an ICD-9 code affects pricing, coordination of benefits, or if it required a pre-authorization, the new code will require the same.

Paper Superbill

With the new code set, new superbills will need to be implemented. If your office utilizes a paper superbill, these are THE source document for accurate coding, billing, and reimbursement. You will need to evaluate your current ICD-9 codes being utilized and then convert these codes to ICD-10. Remember that some payers will still require ICD-9 codes to be utilized so these will still need to be available. Be prepared, based upon your specialty, to expand your superbill. Don't

underestimate the gravity of this task. If there are customized superbills per provider, then this can be a very time consuming task.

As well as superbills, the ABN (Advanced Beneficiary Notice) is used to communicate pricing of a non-covered procedure to the patient and is a guarantee of payment from the patient if the service(s) are denied as non-covered. Understanding ICD-10 code set and the covered diagnosis for the procedures requiring these forms will be must-have knowledge as well.

E-Charge

If you are utilizing E-charge, these encounter forms will need to be updated as well. Staff will need to be aware of any changes that are made to the forms.

Assess Impact Post Implementation

Monitor your front office, scheduling departments, and the provider's utilization of the new forms by auditing insurance denials. Look for medical necessity, authorization not on file, and invalid codes as denial reasons. Re-evaluate the workflow efficiency of new forms or revised forms if needed. Monitor your Medicare denials closely. Look for non-covered procedure denials to ensure proper utilization of the ABN form.









Coding Department

Coding staff will need strong ICD-9 and ICD-10 coding skills to perform forward and backward mapping of the code set. Coders will be dual coding for non-HIPAA covered payers, such as Auto Liability and Workman's Comp. Coders need to understand the new coding logic, coding rules, documentation requirements, and anatomy and physiology. Ensuring that your coding staff has adequate resources and education of the new code set should be a priority.

Assess Impact Post Implementation

Understand what your coding denials are NOW. What are your denials for coding post October 1, 2015? Be sure to look for Clearinghouse rejects indicating incorrect coding, missing digits, invalid primary diagnosis, etc. For Payers, look for LCD's, NCD's, non-covered, and unspecified code denials. If you are seeing an increased amount in these denials post implementation, this would be a good indicator of additional training needed in the coding department.













Billing Department

The billing department will need to understand the new code set to understand how to correct rejections and denials. The amount of denials will likely increase due to the specificity requirements in ICD-10. In addition, working these denials will probably take more time due to unfamiliarity with the changes in EOB's and new denial reasons. All of these items could slow down the payment posting process.

Assess Impact Post Implementation

Monitor productivity reports now and post implementation. Understanding the volume the department generates now and post implementation will help determine the need for additional education or staffing resources. Monitor your average amounts for charges entered, claims generated, and payments posted. You should allow for a moderate drop of 10-15% of productivity for a limited amount of time.









Appeals Department

Appeals department staff will need a strong knowledge in ICD-10 codes and documentation requirements in order to file disputes for underpayment or denials. If they are unfamiliar with the changes in clinical documentation, they will not be able to justify the appeal.

Assess Impact Post Implementation

Monitor your appeals department by reviewing the number of appeals overturned. Has this amount decreased since implementation? If so, additional training and guidance would be needed to increase the success of your appeals.











Contract Negotiations Department

ICD-10 may open provider contracts not originally slated to open for renegotiation. This is an opportunity for providers to renegotiate contracts and hopefully take steps to recoup some of the implementation cost for ICD-10.

Assess Impact Post Implementation

Monitor your contracted rate compared to your contractual write off amounts.

> texhem ni enollisoq pnibasi avli pnii reamwork and cooperation between all the members of company provides success

> > CONTRACT







Collections Department

The amount of uncollected dollars transferred to private pay is going to increase due to coding errors, billing errors, or insurance limitations. The granular level of coding may spark pre-existing conditions, insurance limitations, and unpaid claims due to diagnosis codes that indicate a cosmetic service and/or non-covered diagnosis. As a result, patient balances may increase. By ensuring that you have accurate patient demographics and welldefined financial policies, you can increase your likelihood of collecting these balances.

Assess Impact Post Implementation

Have your self pay balances increased since implementation? Are these balances due to denials from payers? What are the denials?









Clinical Documentation Department

Documentation will be significantly impacted by ICD-10 implementation. The changes in the documentation requirements to allow for the granular level of coding required by the new code set must be properly documented in order for the coder to assign the correct code set to the record. Repeated inquiries to the physician to clarify documentation will slow down the revenue cycle. Educating the clinicians on the new documentation requirements is essential to a successful ICD-10 implementation. Consider these suggestions to evaluate and monitor your documentation improvement initiative:

- ♣ Assess documentation for ICD-10 readiness. Take a sampling of current records and analyze the documentation as to whether it meets the requirements for the ICD-10 code. If the documentation states only "fracture of the right patella" it would be missing five other documentation requirements required for a proper code assignment.
- ♣ Implement early clinician education. If the clinician begins documenting the record with the new requirements now, impact will be greatly reduced.

Post Implementation Assessment

Establish a concurrent documentation review program. Closely monitor claims being denied due to incomplete documentation and implement a process for an audit and feedback to the providers.









Are you ready?

The best way to prepare for ICD-10 is to pretend it is here today. Start utilizing workflows now that will need to happen with ICD-10. There is not a grace period once ICD-10 is put into effect. Take advantage of this time and start transitioning now, so that on October 1, 2015 your processes are established and understood.

If you would like assistance in performing an assessment of your current practice and establishing ICD-10 processes, contact Pulse RCM. Our RCM Managers and certified professional coders are ICD-10 certified, with the knowledge and expertise to help ensure your successful transition.







Resources

- 1. AAMC ICD-10 Implementation Guide https://www.aamc.org/download/270020/data/icd10implementationguide.pdf
- 2. CMS Education, Downloads, GEMS http://www.cms.gov/Medicare/Coding/ICD10/Index.html
- 3. Pulse Systems, Inc. https://www.pulseinc.com/
 - ★ http://www.pulseinc.com/icd-10-mu2/pulse-systems-icd-10-readiness
 - → Webinars, ICD-9 to ICD-10 Code Conversion Charts, Implementation Checklists, White Paper, Vendor Questionnaire
 - + http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
 - + Implementation guides, videos, documentation readiness