ABDOMINAL PAIN—FAMILY PRACTICE SCENARIO ONE

Following are outpatient focused scenarios to illustrate specific ICD-10 documentation and coding nuances related to your specialty. These examples highlight the proper level of detail needed to support the selection of the most appropriate ICD-10 diagnosis codes based on a patient’s health condition and clinical encounter. The following scenarios were natively* coded in ICD-10-CM and ICD-9-CM.

Chief Complaint

“My stomach hurts and I feel full of gas.”

History

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

Exam

• VS: T 99.8°F, otherwise normal.
• Mild jaundice noted.
• Abdomen distended and tender across upper abdomen. Guarding is present.
  Bowel sounds diminished in all four quadrants.
• Oral mucosa dry, chapped lips, decreased skin turgor.

Assessment & Plan

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

2. When addressing alcohol related disorders you should distinguish alcohol use, alcohol abuse, and alcohol dependence. ICD-10-CM has changed the terminology and the parameters for coding substance abuse disorders. In this encounter note, as the acute pancreatitis is suspected, and the patient's alcohol intake status is stated, the associated alcoholism code is listed.

3. Abdominal tenderness may be coded. Ideally the documentation should be include right or left upper quadrant and indicate if there is rebound in order to identify a more specific code. Currently the ICD-10 code would be R10.819, Abdominal tenderness, unspecified site as the documentation is insufficient in laterality and specificity.

**Coding**

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>789.06 Abdominal pain, epigastric</td>
<td>R10.13 Epigastric pain</td>
</tr>
<tr>
<td>789.60 Abdominal tenderness, unspecified site</td>
<td>R10.819 Abdominal tenderness, unspecified site</td>
</tr>
<tr>
<td>782.4 Jaundice NOS</td>
<td>R17 Unspecified jaundice</td>
</tr>
<tr>
<td>276.51 Dehydration</td>
<td>E86.0 Dehydration</td>
</tr>
<tr>
<td>303.90 Other and unspecified alcohol dependence, unspecified</td>
<td>F10.20 Alcohol dependence, uncomplicated</td>
</tr>
</tbody>
</table>

**Other Impacts**

No specific impacts noted.

*Native coding is the term used when patient medical record encounters are coded from “scratch” and codes are assigned from an ICD-10-CM perspective based on the documentation present rather than mapping and converting from ICD-9-CM to ICD-10-CM. As patient history and circumstances will vary, these brief scenarios are illustrative in nature and should not be strictly interpreted or used as documentation and coding guidelines. Each scenario is selectively coded to highlight specific topics; therefore, only a subset of the relevant codes are presented.*
ABDOMINAL PAIN—OTHER SPECIALTY
SCENARIO ONE

Following are outpatient focused scenarios to illustrate specific ICD-10 documentation and coding nuances related to your specialty. These examples highlight the proper level of detail needed to support the selection of the most appropriate ICD-10 diagnosis codes based on a patient’s health condition and clinical encounter. The following scenarios were natively* coded in ICD-10-CM and ICD-9-CM.

Chief Complaint

“My stomach hurts and I feel full of gas.”

History

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

Exam

• VS: T 99.8°F, otherwise normal.
• Mild jaundice noted.
• Abdomen distended and tender across upper abdomen. Guarding is present. Bowel sounds diminished in all four quadrants.
• Oral mucosa dry, chapped lips, decreased skin turgor.

Assessment & Plan

• Dehydration and suspected acute pancreatitis.
• Admit to the hospital. Orders written and sent to on-call hospitalist.
• 1L IV NS started in office. Blood drawn for labs.
• Recommend behavioral health counseling for substance abuse assessment and possible treatment.
• Patient’s wife notified of plan; she will transport to hospital by private vehicle.
1. Describe the pain as specifically as possible based on location.
2. When addressing alcohol related disorders you should distinguish alcohol use, alcohol abuse, and alcohol dependence. ICD-10-CM has changed the terminology and the parameters for coding substance abuse disorders. In this encounter note, as the acute pancreatitis is suspected, and the patient's alcohol intake status is stated, the associated alcoholism code is listed.
3. Abdominal tenderness may be coded. Ideally the documentation should be include right or left upper quadrant and indicate if there is rebound in order to identify a more specific code. Currently the ICD-10 code would be R10.819, Abdominal tenderness, unspecified site as the documentation is insufficient in laterality and specificity.

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>789.06 Abdominal pain, epigastric</td>
<td>R10.13 Epigastric pain</td>
</tr>
<tr>
<td>789.60 Abdominal tenderness, unspecified site</td>
<td>R10.819 Abdominal tenderness, unspecified site</td>
</tr>
<tr>
<td>782.4 Jaundice NOS</td>
<td>R17 Unspecified jaundice</td>
</tr>
<tr>
<td>276.51 Dehydration</td>
<td>E86.0 Dehydration</td>
</tr>
<tr>
<td>303.90 Other and unspecified alcohol dependence, unspecified</td>
<td>F10.20 Alcohol dependence, uncomplicated</td>
</tr>
</tbody>
</table>

*Native coding is the term used when patient medical record encounters are coded from “scratch” and codes are assigned from an ICD-10-CM perspective based on the documentation present rather than mapping and converting from ICD-9-CM to ICD-10-CM. As patient history and circumstances will vary, these brief scenarios are illustrative in nature and should not be strictly interpreted or used as documentation and coding guidelines. Each scenario is selectively coded to highlight specific topics; therefore, only a subset of the relevant codes are presented.
Chief Complaint

“I’ve found a lump on my left breast and I need my annual GYN exam.”

History

• 47 year old perimenopausal female. G3P3003. LMP December 20, 2013. Last Pap was normal.
• No history of STD. No family history of ovarian or cervical cancer. No significant changes over the last year.
• Positive family history for breast cancer – mother and all three sisters. Sisters are BRCA +.
• Reports finding a small lump in left breast.

Exam

• Pelvic exam is normal. Pap smear performed.
• Left breast examined normal except for 1.5cm mass on left lower/outer quadrant. Mass is tender, easily moveable, firm to touch. Axilla normal, without palpable nodes.
• Right breast normal.

Assessment & Plan

• Normal pelvic exam. Will confirm Pap results with the patient.
• Scheduled fine needle aspiration of left breast mass at the end of this week – with Dr. Smith.
• Scheduled a follow-up visit in 1 week to discuss aspiration results and next steps.
Sample - Go to http://www.roadto10.org for all of the Clinical Scenarios

<table>
<thead>
<tr>
<th>Summary of ICD-10-CM Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Documentation</td>
</tr>
</tbody>
</table>

1. Note whether the encounter is for a specific issue or an annual or “general” exam. There are different diagnosis codes for each. The use of the best code may vary by payor according to what services were rendered and the insurance plan’s reimbursement of a well women’s annual visit versus reimbursement of pelvic and/or clinical breast examinations. As per American Congress of Obstetricians and Gynecologists’ guidelines, a well women’s exam includes both a pelvic exam as well as a clinical breast examination. The rationale for abnormal findings in this encounter is based on the presence of the breast lump.

2. Like ICD-9, family history can be captured in ICD-10-CM. Capture that information as appropriate in your note. As there is a positive family history for breast cancer denoted with the three sisters identified as BRCA positive, the documentation supports the patient’s susceptibility to a malignancy of the breast.

3. ICD-10-CM can now capture the side of the body. There are separate codes for left and right breast diagnoses. As the clinical status for this patient is not known, it does not have right versus left, e.g. solitary cyst of left breast.

4. Using ICD-9 codes, Pap smear coding may vary by payor. In some cases payors reimburse for the retrieval of the Pap smear by the physician, and the screening Pap smear at a specific frequency (e.g. every 2 years). With the new terminology associated with ICD-10-CM codes this point will need to be assessed and confirmed so correct code assignment can occur.

5. It is important to describe the mass in as much detail as possible. Even though it is not possible to definitively diagnose the mass at this visit, the provider can still code for symptoms and thus justify referral and subsequent treatment.

<table>
<thead>
<tr>
<th>Coding</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>611.72 Lump or mass in breast</td>
<td>N63 Unspecified lump in breast, which includes: nodule(s) NOS in breast</td>
</tr>
<tr>
<td>V72.31 Routine gynecologic exam, with or without Pap test</td>
<td>Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings</td>
</tr>
<tr>
<td>V76.2 Routine screening Pap test, intact cervix</td>
<td></td>
</tr>
<tr>
<td>V84.01 Genetic susceptibility, malignant neoplasm breast</td>
<td>Z15.01 Genetic susceptibility to malignant neoplasm of breast</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Impacts</th>
</tr>
</thead>
</table>

- Providing the patient history can justify additional diagnostic tests based on the patient’s risk (such as the fine needle aspiration).
- Capturing the appropriate side of the body is important, as some payers may deny claims without this information.

*Native coding is the term used when patient medical record encounters are coded from “scratch” and codes are assigned from an ICD-10-CM perspective based on the documentation present rather than mapping and converting from ICD-9-CM to ICD-10-CM. As patient history and circumstances will vary, these brief scenarios are illustrative in nature and should not be strictly interpreted or used as documentation and coding guidelines. Each scenario is selectively coded to highlight specific topics; therefore, only a subset of the relevant codes are presented.
DIARRHEA, FEVER, AND VOMITING—PEDIATRICS
SCENARIO ONE

Following are outpatient focused scenarios to illustrate specific ICD-10 documentation and coding nuances related to your specialty. These examples highlight the proper level of detail needed to support the selection of the most appropriate ICD-10 diagnosis codes based on a patient's health condition and clinical encounter. The following scenarios were natively* coded in ICD-10-CM and ICD-9-CM.

Chief Complaint
Watery diarrhea, fever, and vomiting for two days.

History
• 33 month old female presents as new patient with severe dehydration after two days of watery diarrhea, fever, and vomiting with no indication of nausea. Child holds onto stomach and is crying but makes no tears. Child unimmunized for all vaccines per mother. Child noted to have reduced urine output per mother. Symptoms started after a visit to the pool with her cousins. Mother thinks daughter swallowed pool water multiple times.

Exam
• Apparent acute distress. Appears dehydrated. Child is holding her upper abdomen.
• Mild jaundice noted.
• Vitals: T 100.1°F, R 36, P 135 BP 90/55. BS hyperactive times four quadrants. The abdomen is distended and diffusely tender to palpation. No rebound tenderness, masses, or organomegaly.
• Dry mouth and tongue, membranes pale. Skin dry with poor skin turgor. Capillary refill is >3 seconds.

Assessment & Plan
• Unvaccinated status a concern. Will address with family after this acute episode is over.
• Rotavirus likely. Order rotavirus with EIA and RT-PCR, electrolyte panel.
• Patient requires IV hydration. Send to hospital for IV fluids and observation. Admission orders called in.
Summary of ICD–10–CM Impacts

Clinical Documentation

1. Code the symptoms of diarrhea, fever, dehydration, dry mouth, and vomiting. Determine if the patient has nausea and document accordingly since there are codes to differentiate nausea and vomiting, and/or if there is the presence of vomiting without nausea.

2. Determine why the patient is not vaccinated and document accordingly. It is important to identify the reason(s) since there are multiple codes available to explain why immunizations haven't been administered. Because this is a significant public health issue, ICD-10-CM has addressed the collection of this information by providing multiple coding explanations as to why a child has not been immunized. In this scenario, Z28.3 Under-immunization status is the most appropriate code as it represents delinquent in immunizations.

<table>
<thead>
<tr>
<th>Coding</th>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>787.91 Diarrhea</td>
<td>R19.7 Diarrhea, unspecified</td>
<td></td>
</tr>
<tr>
<td>780.60 Fever, unspecified</td>
<td>R50.9 Fever, unspecified</td>
<td></td>
</tr>
<tr>
<td>787.03 Vomiting alone</td>
<td>R11.11 Vomiting without nausea</td>
<td></td>
</tr>
<tr>
<td>276.51 Dehydration</td>
<td>E86.0 Dehydration</td>
<td></td>
</tr>
<tr>
<td>789.67 Abdominal tenderness, generalized</td>
<td>R10.817 Generalized abdominal tenderness</td>
<td></td>
</tr>
<tr>
<td>V64.ØØ No vaccination, not otherwise specified</td>
<td>Z28.3 Under-immunization status</td>
<td></td>
</tr>
</tbody>
</table>

Other Impacts

No specific impacts noted.

*Native coding is the term used when patient medical record encounters are coded from “scratch” and codes are assigned from an ICD-10-CM perspective based on the documentation present rather than mapping and converting from ICD-9-CM to ICD-10-CM. As patient history and circumstances will vary, these brief scenarios are illustrative in nature and should not be strictly interpreted or used as documentation and coding guidelines. Each scenario is selectively coded to highlight specific topics; therefore, only a subset of the relevant codes are presented.*
EPIGASTRIC PAIN—INTERNAL MEDICINE
SCENARIO TWO

Following are outpatient focused scenarios to illustrate specific ICD-10 documentation and coding nuances related to your specialty. These examples highlight the proper level of detail needed to support the selection of the most appropriate ICD-10 diagnosis codes based on a patient’s health condition and clinical encounter. The following scenarios were natively* coded in ICD-10-CM and ICD-9-CM.

Chief Complaint

“My chest has been burning for three days.”

History

- 83 year old female with history of chronic left-sided congestive heart failure, well controlled, CAD, mild intermittent asthma, depression, type II diabetes, and GERD.

- Patient experiencing burning to center of chest and throat with some occasional nausea. She generally avoids spicy foods but ate Mexican meal with her friends three days ago. Took a friend’s nitroglycerin SL tablet, but symptoms did not improve. Has been taking over-the-counter antacids to relieve symptoms.

- She finds that sleeping on three pillows lessons burning symptoms; symptoms worsen when sleeping on left side. Denies SOB or worsening of CHF symptoms. Notes bitter taste in mouth at times.

- Diabetes is well controlled with subcutaneous insulin. Patient reports blood glucose is between 90 and 110.

- Intermittent asthma is well controlled, unaffected by presenting symptoms.

Exam

- Chest clear. Heart sounds normal.

- EKG shows no changes from prior, does show left ventricular hypertrophy.

- CXR is unchanged from previous.

- Abdomen is soft, non-tender to exam except to epigastric area. No guarding.

- Vitals: BP is 112/60, HR is 65, O2 saturation is 99% on room air. No fever noted.

Assessment & Plan

- GERD

- Modify diet to avoid spicy foods, alcohol. Avoid eating three hours before bedtime. Continue sleeping with head of bed elevated until symptoms subside.

- Continue OTC antacid per label instructions to control symptoms

- Begin esomeprazole 20 mg PO daily x 4 weeks.

- Follow up in four weeks if symptoms not improved.
**Summary of ICD–10–CM Impacts**

**Clinical Documentation**

1. Document the acuity (i.e. chronic, acute, acute on chronic) and type (i.e. systolic, diastolic or both) of heart failure, as there are discrete ICD-10-CM codes for each type.

2. Document the type of diabetes and if appropriate, any effects due to the disease (e.g. a foot ulcer, diabetic retinopathy, etc.).

3. In ICD-10-CM, gastroesophageal reflux disease is differentiated by noting “with esophagitis” (K21.0) versus “without esophagitis” (K21.9). As there is no documentation under the physical exam noting that esophagitis was evident gastroesophageal reflux disease without esophagitis is coded.

4. If asthma symptoms were present, then the provider should note whether or not the asthma is persistent, triggers (if known) how many attacks per day, week or month are typically experienced, and the functional impact. ICD-10 does not include the concept of extrinsic or intrinsic as represented in ICD-9-CM. In ICD-10-CM one must document whether asthma is mild intermittent, persistent, or moderate and severe persistent. Furthermore, ICD-10-CM guidelines now require the use of an additional code to indicate if a patient is exposed to tobacco smoke.

**Coding**

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>530.81 Esophageal reflux</td>
<td>K21.9 Gastroesophageal reflux disease without esophagitis</td>
</tr>
<tr>
<td>428.1 Left heart failure</td>
<td>I50.1 Left ventricular failure</td>
</tr>
<tr>
<td>250.00 Diabetes mellitus type II without complications not stated as uncontrolled</td>
<td>E11.9 Type 2 diabetes mellitus without complications</td>
</tr>
<tr>
<td>V58.67 Long-term use of insulin</td>
<td>Z79.4 Long-term (current) use of insulin</td>
</tr>
<tr>
<td>493.10 Intrinsic asthma, unspecified</td>
<td>J45.20 Mild intermittent asthma, uncomplicated</td>
</tr>
</tbody>
</table>

**Other Impacts**

Management of chronic conditions such as diabetes, asthma or heart failure should be described in the record. The documentation of the clinical management may lead to increased reimbursement via clinical quality measures, or quality improvement pay-for-performance physician incentives, regardless of clinical presentation/complications.

*Native coding is the term used when patient medical record encounters are coded from “scratch” and codes are assigned from an ICD-10-CM perspective based on the documentation present rather than mapping and converting from ICD-9-CM to ICD-10-CM. As patient history and circumstances will vary, these brief scenarios are illustrative in nature and should not be strictly interpreted or used as documentation and coding guidelines. Each scenario is selectively coded to highlight specific topics; therefore, only a subset of the relevant codes are presented.*
Chief Complaint
First follow-up visit post fracture to left femur.

History
- 85 year old retired male sustained a crush injury to his left femur from a forklift accident while he was a consumer in a building store. The forklift hit his left leg and crushed it.
- Patient sustained an open, displaced, transverse fracture of his left middle femur shaft. There was a 2-3 cm skin avulsion and moderate surrounding tissue damage to his left lateral thigh approximately five inches above the knee. Gustilo Class II fracture.
- S/P ORIF of left femur two weeks prior to today's visit. Received tetanus vaccine while in hospital.
- Patient has been receiving daily PT at home since he left the hospital one week ago. Patient is non-weight bearing on the LLE.

Exam
- X-ray today of left femur compared to surgical films show good healing. All surgical plates and screws intact. No signs of infection at the surgical site.
- Patient reports that pain is decreasing daily. Able to bend left knee 45º, with full ROM to left ankle and toes. Mild pedal edema noted. Circulation to left foot is excellent with palpable pedal pulses and brisk capillary refill <2 sec.
- Physical therapy reports patient is progressing well and is compliant with ROM instructions. Gait steady with LLE in hinged knee brace and crutches.

Assessment & Plan
- Left femur fracture is healing appropriately.
- Discontinue home PT. Patient to begin daily rehab at PT Center tomorrow. Continue to increase PT exercises. Updated orders sent to PT office and discussed with patient.
- See patient in office in 4 weeks for repeat films, evaluation of surgical site, and PT progression.
### Summary of ICD-10-CM Impacts

**Clinical Documentation**

1. Describes circumstances of injury. With ICD-10-CM, you must re-document or reference extensive details surrounding the circumstances of injury to ensure correct coding and proper claims processing. This includes timeframe, etiology, episode of care, injury site, cause, and place of occurrence. According to the ICD-10-CM guidelines, place of occurrence, activity and work status codes are only coded on the first visit. Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequelae) for each encounter for which the injury or condition is being treated. As this is a subsequent encounter, this information is reflected in the 7th character of the ICD-10-CM code (e.g., V83.7xxD for V83.7xxD, Person on outside of special industrial vehicle injured in nontraffic accident).

Note that per the guidelines there is no national requirement for mandatory ICD-10-CM external cause code reporting. You may be required to report them based on a state based external cause code mandate (for example, for a trauma registry) or as required by a particular payor. Providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and may assist in claims processing/insurance coordination of benefits.

2. Describes the fracture/injury - With ICD-10-CM, you need to document specifics about the type of fracture injury to ensure correct coding. Include information on the side, location (make reference to the appropriate anatomical landmarks) and classification. The fracture description above is well defined and includes description that supports the necessary items such as traumatic, open, displaced, middle of femur shaft, subsequent encounter, routine healing, and fracture classification Gustilo class II. This information is reflected in 7th character of the ICD-10-CM code (e.g. S72.322E).

3. Note the presence of infection (if any). Documenting whether there are signs of infection will support if additional surgical intervention is necessary and if additional adverse sequelae develop.

### Coding

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>821.11 Open fracture of shaft of femur</td>
<td>S72.322E Displaced transverse fracture of shaft of left femur, subsequent encounter for open fracture type I or II with routine healing</td>
</tr>
<tr>
<td>E919.2 Accidents caused by lifting machines and appliances</td>
<td>W23.0xxD Caught, crushed, jammed, or pinched between moving objects subsequent encounter</td>
</tr>
<tr>
<td>N/A</td>
<td>V83.7xxD Person on outside of special industrial vehicle injured in nontraffic accident</td>
</tr>
</tbody>
</table>

### Other Impacts

- Correctly coding the fracture ensures the provider will be reimbursed for appropriate follow-up visits and that the patient can receive appropriate outpatient (i.e. PT, imaging, etc.) services. Uncomplicated follow-up visits may be bundled by a payor.
- The circumstances of injury such as where and how it occurred are important for claims processing and coordination of benefits.

*Native coding is the term used when patient medical record encounters are coded from “scratch” and codes are assigned from an ICD-10-CM perspective based on the documentation present rather than mapping and converting from ICD-9-CM to ICD-10-CM. As patient history and circumstances will vary, these brief scenarios are illustrative in nature and should not be strictly interpreted or used as documentation and coding guidelines. Each scenario is selectively coded to highlight specific topics; therefore, only a subset of the relevant codes are presented.*
Chief Complaint

“Dr. Smith asked that you check my hypertension prior to my surgery.”

History

- 81 year old male scheduled for a TURP in 5 days. Dr. Smith requested evaluation for hypertension and cardiac clearance assessment for surgery.
- Inferior wall MI one year ago, received thrombolytic therapy and experienced complete resolution of his symptoms. Last EF (last month) was 50%.
- Regular physical activity includes walking, swimming, and golfing. He denies SOB with exertion.
- No history of cerebrovascular disease. No DM, CHF, renal failure, or angina.
- Has history of essential hypertension and was prescribed metoprolol succinate once daily by PCP, but patient is not taking as he cannot afford it.

Exam

- Patient is an 81 year old male in no acute distress. Height and weight are appropriate for age.
- Vitals taken; BP is elevated at 157/92.
- Chest is clear. Physical exam is normal. No pedal edema.
- EKG shows nonspecific T-wave changes.
- Labs show creatinine at 1.5, a slight increase from his baseline and possibly indicating early renal insufficiency.

Assessment & Plan

- Will have PCP monitor BUN and creatinine for renal function and nephrology referral if necessary.
- HTN is due to patient’s noncompliance with metoprolol succinate. Will coordinate with Dr. Smith as unclear if he was aware of financial situation. Change to propranolol 20 mg, 2 tabs PO daily, first dose administered in office. Provided 30 day supply of free propranolol samples.
- Reevaluate HTN in 3 days; if improving then clear for surgery.
### Summary of ICD-10-CM Impacts

#### Clinical Documentation

1. Documenting why the encounter is taking place is important, as the coder will assign a different code for a routine visit vs. a surgery clearance vs. an initial visit.

2. If known, it is important to document whether or not patients are compliant with their medications. “Underdosing” is a new concept in ICD-10-CM and can be captured along with the diagnoses, such as this case for metoprolol succinate. When an issue with underdosing is noted, document if the matter is new or has been recurrent. The ICD-10-CM terms provide new detail as compared to the ICD-9-CM code V15.81, history of past noncompliance. In this case there was no noted history of noncompliance.

3. Documentation indicates that lab results reveal “a slight increase in his baseline and possibly indicating early renal insufficiency.” Guidelines allow the reporting of additional diagnosis to support the abnormal test result.

4. In ICD-10-CM coders are provided the “Use Additional Code” note under the hypertensive diseases (I10-I15) block. If known, document whether or not the patients have the following: exposure to environmental tobacco smoke, history of tobacco use, occupational exposure to environmental tobacco smoke, tobacco dependence, and or tobacco use. In this case there was no noted history of the above.

#### Coding

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>401.9 Unspecified essential hypertension</td>
<td>I10 Essential (primary) hypertension</td>
</tr>
<tr>
<td>794.31 Nonspecific abnormal electrocardiogram [ECG] [EKG]</td>
<td>R94.31 Abnormal electrocardiogram [ECG] [EKG]</td>
</tr>
<tr>
<td>794.4 Nonspecific abnormal results of function study of kidney</td>
<td>R94.4 Abnormal results of kidney function studies</td>
</tr>
<tr>
<td>412 Old myocardial infarctions</td>
<td>I25.2 Old myocardial infarction</td>
</tr>
<tr>
<td>N/A</td>
<td>T46.5X6A Underdosing of other antihypertensive drugs, [initial encounter]</td>
</tr>
<tr>
<td>N/A</td>
<td>Z91.120 Patient’s intentional underdosing of medication regimen due to financial hardship</td>
</tr>
<tr>
<td>V72.81 Pre-operative cardiovascular examination</td>
<td>Z01.810 Encounter for pre-procedural cardiovascular examination</td>
</tr>
</tbody>
</table>

#### Other Impacts

For hierarchical condition categories (HCC) used in Medicare Advantage Risk Adjustment plans, certain diagnosis codes are used as to determine severity of illness, risk, and resource utilization. HCC impacts are often overlooked in the ICD-9-CM to ICD-10-CM conversion. The physician should examine the patient each year and complantly document the status of all chronic and acute conditions. HCC codes are payment multipliers.

*Native coding is the term used when patient medical record encounters are coded from “scratch” and codes are assigned from an ICD-10-CM perspective based on the documentation present rather than mapping and converting from ICD-9-CM to ICD-10-CM. As patient history and circumstances will vary, these brief scenarios are illustrative in nature and should not be strictly interpreted or used as documentation and coding guidelines. Each scenario is selectively coded to highlight specific topics; therefore, only a subset of the relevant codes are presented.*