CPT Category II codes

The What, Why and When for using CPT Category II Codes

- Supplemental tracking codes used for performance measurement that describe clinical components, usually included in E&M or clinical services. Therefore, they do not have a relative value associated with them and are not reimbursable.
- Use is optional and may not be used as a substitute for Category I codes.
- 5-character alpha-numeric codes which always end with the character "F".
- When specific measure criteria have been met, these codes identify opportunities for better clinical outcomes for your patient's care, closes gaps in care more accurately and quickly, which leads to enhanced performance on HEDIS measures for your practice.
- Helps track member screenings to help you monitor care and avoid sending unnecessary reminders.
- Efficient process reduces the need for chart reviews and medical record requests.
- If clinical and documentation requirements are met, there is no limitation on how often these codes can be submitted.

Tips For Implementing CPT Category II Coding into Your Practice

- Work with your system vendor to add these codes into your EMR and Practice Management System.
    - Inquire about automation. Some systems can automatically translate clinical data elements into the appropriate CPT II codes and ensure these codes are included on the claim.
- Develop workflows for clinical office staff, billers, and coders for proper code submission.
- These codes may be submitted on claims with other applicable codes. They are entered in the procedure code field, just like your regular CPT codes are billed.
    - Check payer specific guidelines for submitting Category II codes. Some payers may require a professional service is performed on the date the Category II services are reported.
- Verify the charge amount criteria with your EMR/Practice Management and Clearinghouse vendors. These codes will be entered with either a .00 or .01 charge amount.

CPT Category II Codes			
HEDIS Measure Name and Documentation Guidelines	**CPT II code**	**CPT Category II Code Description**	**Charge Amount**
Controlling High Blood Pressure (CBP) Medical record stating hypertension diagnosis and the following blood pressure screening documentation: •Date and most recent results of the blood pressure reading. •The blood pressure reading must occur on or after the date of the second diagnosis of hypertension. •Documentation must be from provider managing the condition. *Note: Two codes (one from 3074F-3077F and one from 3078F-3080F) must be reported to identify the lowest systolic and lowest diastolic reading to satisfy the CBP measure.*	3074F	Most recent systolic blood pressure <130 mm Hg	.00 or .01
	3075F	Most recent systolic blood pressure 130-139 mm Hg	.00 or .01
	3077F	Most recent systolic blood pressure >/=140 mm Hg	.00 or .01
	3078F	Most recent diastolic blood pressure <80 mm Hg	.00 or .01
	3079F	Most recent diastolic blood pressure 80-89 mm Hg	.00 or .01
	3080F	Most recent diastolic blood pressure >/=90 mm Hg	.00 or .01
Eye Exam for Patients with Diabetes (EED) Medical record stating a confirmed diagnosis of diabetes to include the following retinal eye exam documentation: •A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that a retinal or dilated eye exam was completed by an eye care professional (optometrist or ophthalmologist). •Evidence of bilateral or unilateral eye enucleation anytime during the patient's history through 12/31 of the current calendar year. •A negative retinal or dilated eye exam (negative for retinopathy) by an eye care specialist in the year prior *Note:* *Any provider can report the appropriate CPT Category II code. Report 2022F-2033F with date of eye exam, not the date of service (DOS) when the report was reviewed. Report 3072F with the current year DOS. An eye exam result documented as "unknown" does not meet criteria.*	2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	.00 or .01
	2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	.00 or .01
	2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	.00 or .01
	2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	.00 or .01
	2026F	Eye imaging validation to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy	.00 or .01
	2033F	Eye imaging validation to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy	.00 or .01
	3072F	Low risk for retinopathy (no evidence of retinopathy in prior year)	.00 or .01
Glycemic Status Assessment for Patients with Diabetes (GSD) Medical record stating a confirmed diagnosis of diabetes to include the following HbA1c screening documentation: •Document the date and result(s) or provide a copy of the lab report with the most recent HbA1c control indictor used regardless of data source. *Note: Report CPT Category II code with the date of the A1c test, not the date of the office visit when the test was reviewed.*	3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0%	.00 or .01
	3046F	Most recent hemoglobin A1c level greater than 9.0%	.00 or .01
	3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%	.00 or .01
	3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	.00 or .01
Advanced Care Planning (ACP) Medical record should include the following discussions between a qualified health care professional and the patient: •Discuss the patient's health care wishes if they become unable to make decisions about their care with or without completing legal forms. This may include living wills, instruction directives, health care proxy, health care power of attorney.	1123F	Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record	.00 or .01
	1124F	Advance care planning discussed and documented in the medical record, patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	.00 or .01
	1157F	Advance care plan or similar legal document present in the medical record	.00 or .01

	1158F	Advance care planning discussion documented in the medical record	.00 or .01
Care for Older Adults (COA) Functional Status •Notation that activities of daily living (bathing, dressing, eating, walking, etc.) or instrumental activities of daily living (grocery shopping, driving, meal preparation, laundry, taking medications, etc.) were assessed or documentation of result of assessment using a standardized functional status assessment.	1170F	Functional status assessed	.00 or .01
Care for Older Adults (COA) Medication List	1159F	Medication list documented in medical record	.00 or .01
Care for Older Adults (COA) Medication Review Medication list and evidence of medication review by prescribing practitioner or clinical pharmacist, including date when performed or notation that member in not taking any medication and date when noted, which may include transitional care management services during the same outpatient visit. *Note: Both 1159F and 1160F must be reported to satisfy the medication review component of COA measure.*	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies, and supplements) documented in the medical record	.00 or .01
Prenatal and Postpartum Care (PPC) Stand Alone Prenatal Visits ***See details under CPT Category II Code Description***	0500F	Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP]).	.00 or .01
	0501F	Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit)	.00 or .01
	0502F	Subsequent prenatal care visit [Excludes: patients who are seen for a condition unrelated to pregnancy or prenatal care (e.g., an upper respiratory infection; patients seen for consultation only, not for continuing care)]	.00 or .01
Prenatal and Postpartum Care (PPC) Postpartum Visits	0503F	Postpartum care visit	.00 or .01
Transitions of Care (TRC)-Medication Reconciliation Post-Discharge Medical record should include a medication reconciliation by a qualified health care professional post-discharge in which the discharge medications are reconciled with the most recent medication list in the outpatient medical record. •The medication list may include medication names only or may include medication names, dosages, and frequency, over the counter (OTC) medications and herbal or supplemental therapies. *Notes: The medication reconciliation must be documented on the date of discharge through 30 days after the discharge (31 days total).* *1111F can be reported when the post-discharge medication reconciliation is done during a telephone call or during the transitional care management (TCM).*	1111F	Discharge medications reconciled with the current medication list in outpatient medical record	.00 or .01

Documentation and Coding Tips

Acute Myocardial Infarction

Acute myocardial infarction (AMI), also known as a heart attack, is usually an emergent condition treated as an inpatient encounter, with follow-up and ongoing care provided in the physician office. Office chart audits often indicate the myocardial infarction is older than the four-week time frame or there is no documented date when the myocardial infarction occurred, which may lead to incorrect code assignment. Coding acute myocardial infarction is quite complex, please see specific chapter guidelines for appropriate sequencing and proper code selection.

Acute myocardial infarction:

- Specified as acute or with a stated duration of 4 weeks (28 days) or less from onset.

Subsequent acute myocardial infarction:

- Patient has a new acute myocardial infarction occurring within 4 weeks (28 days) of a previous acute myocardial infarction.

Old Myocardial Infarction:

- After the passage of 4 weeks (28 days) or a healed myocardial infarction, documentation should reflect there is a past myocardial infarction diagnosed by ECG or other investigation but, currently presenting no symptoms.

Document the following elements for accurate code assignment of Acute Myocardial Infarction:

- **Date of onset:** Always included the date and if more than one infarction occurs within a 4-week period, include both dates.
- **Type/Subtype:** ST elevation myocardial infarction **(**STEMI) or non-ST elevation myocardial infarction (NSTEMI), Type 1-5.
- **Episode of care:** Initial or subsequent.
- **Artery/Vessel Location/Site:** Left main, left anterior descending, right coronary artery, left circumflex, or anterior/interior wall.
- **Underlying cause, if known:** Atherosclerosis of the coronary arteries, blood clots, sudden severe stress.
- **Workup/treatment plan:** List any medications used specifically for AMI, oxygen therapy, referrals, surgical intervention.

Documentation and Coding Examples:

Acute myocardial infarction: Patient suffered a ST elevation acute myocardial infarction involving the right coronary artery 2 weeks ago and presents to the clinic for post-hospital follow-up. The patient reported no chest pain since discharge and was given refill prescriptions for beta-blocker and anti-platelet agent today.

Assign code: I21.11 ST elevation (STEMI) myocardial infarction involving right coronary artery

Rationale: Office visit is within the 4-week (28 days) or less time frame. Provider clearly documents timelines and site.

Old myocardial infarction: Patient presents for a routine check-up following acute myocardial infarction of the left main coronary artery 3 months ago. Patient is asymptomatic and requires no continued care.

Assign code: I25.2 Old myocardial infarction

.

Rationale: The acute myocardial infarction occurred more than 4-weeks and no longer receiving current care.

Guidance for Appropriate Coding for Wellness and Preventive Encounters

Purpose:

The purpose of this guidance is to provide standardization to properly assign coding (CPT, HCPCS, modifiers and ICD-10) when patients present for wellness/preventive services and other specific problems are addressed during the encounter.

Definitions

Initial Preventive Physical Examination (IPPE) HCPCS Code G0402: Also known as the "Welcome to Medicare Preventive Visit". This visit focuses on health promotion, disease prevention and detection to help beneficiaries stay well. The IPPE service should be provided within the first 12 months of Medicare Part B enrollment and includes but is not limited to the following:

- Review of medical and social history with attention to modifiable risk factors for disease detection;
- Review of potential risk factors for depression or other mood disorders;
- Review of functional ability and level of safety;
- Examination to include specific required elements and other elements as deemed appropriate based on the patient's medical and social history;
- End-of-life planning if patient consents;
- Review current opioid prescriptions;
- Screen for potential substance use disorders;
- Education, counseling, and referral as deemed appropriate based on the review and evaluation performed;
- Counseling and referral to include a written plan provided to the patient for obtaining appropriate screening and other preventive services

Annual Wellness Visit (AWV) and Subsequent Annual Wellness Visits HCPCS Codes G0438, G0439: A personalized prevention plan visit to promote health and disease detection, along with fostering coordination of screening and other preventive services. It is for beneficiaries who are no longer within the first 12 months after the effective date of their first Medicare Part B coverage period and have not received an IPPE or AWV within the past 12 months. The AWV (initial or subsequent) includes but is not limited to the following:

- Review and administration of a health risk assessment;
- Establish/update medical and family history;
- Establish/update list of current providers involved in providing care to the patient;
- Routine measurements including blood pressure, weight (or waist circumference) and other elements as deemed appropriate based on the patient's medical and family history;
- Detection of cognitive impairment;
- Review of potential risk factors for depression;
- Review of functional ability and level of safety;
- Establish/update a written screening schedule;
- Establish/update list of risk factors and conditions and recommendations or interventions that are underway or appropriate;
- Furnish personalized health advice and referral for preventive services as appropriate;
- Provide Advance Care Planning services at patient's discretion;
- Review current opioid prescriptions;
- Screen for potential substance use disorders

Preventive Medicine Evaluation and Management (E/M) Services CPT Codes 99381-99387 (New) or 99391-99397 (Established): Routine evaluation and management preventive services for infants, children, adolescents, and adults. Preventive visits consist of age and gender-appropriate history, examination, counseling, anticipatory guidance, risk factor reduction interventions, and the ordering of laboratory or diagnostic procedures as appropriate.

Problem-Specific Medically Necessary Evaluation and Management (E/M) Services CPT Codes 99202-99205 (New) 99211-99215 (Established): Services provided to patients which can include the following components: history and/or examination, number and complexity of problems addressed at the encounter, medical decision making and total time for the E/M service performed on the date of service, based on the nature of the presenting problem and the patient's and/or family's needs.

Other Preventive Medicine Services: Diagnostic and therapeutic services that are provided to patients in an effort to keep them healthy. These services may have payor-specific requirements such as frequency, and include but are not limited to the following:

- Screening lab tests (cholesterol, lipids, etc.)
- Electrocardiogram
- Age-appropriate vaccines (immunizations, influenza, pneumonia)
- Mammography
- Depression screening
- Pelvic exam and/or Pap test
- Smoking and tobacco use cessation

<u>Coding Guidance</u>

The coding information reported for payment on the claim should represent the services performed and documented, based on the reason(s) the patient presented. When a wellness/preventive service is performed and a significant, separately identifiable medically necessary E/M is also provided, depending on the additional elements performed and documented, it may be appropriate to report both services for payment.

IPPE: If a patient presents for their IPPE only and all of the required elements of the service are performed and documented, assign HCPCS Code G0402. Assign the appropriate wellness diagnosis code(s) and/or all stable or unstable chronic condition diagnosis code(s) if documented by the provider.

AWV: If a patient presents for their AWV only and all the required elements of the service are performed and documented, assign HCPCS Code G0438 or G0439. Assign the appropriate wellness diagnosis code(s) and/or all stable or unstable chronic condition diagnosis codes(s) if documented by the provider.

Preventive Medicine Services: If a patient presents for a wellness/preventive service only and the provider performs and documents an age-appropriate history, examination and provides counseling, anticipatory guidance, risk factor reduction interventions, orders diagnostic services, etc. as appropriate, assign the age-appropriate CPT Code (99381-99397). Assign the appropriate wellness/preventive diagnosis code(s).

IPPE, AWV or Preventive Medicine Service with a Problem-Specific E/M Service: If a patient presents for their IPPE, AWV or Preventive Medicine Service, and also presents with symptom(s) or conditions which require medically necessary history, examination, and medical decision making, assign the appropriate wellness/preventive code (G0402, G0438, G0439 or 99381-99397) in addition to the problem-specific E/M level (99202-99215). Elements considered when selecting the problem-specific E/M level cannot include components of the wellness/preventive service.

Diagnoses: If the patient has a mix of stable and unstable chronic conditions, associate the appropriate wellness diagnosis code and stable chronic condition diagnosis code(s) to the IPPE/AWV/Preventive service. Apply the unstable chronic condition diagnosis code(s) or acute problem-specific diagnosis code(s) to the appropriate level of the problem-specific E/M code.

IPPE or AWV with a Preventive Medicine E/M Service: The required elements of both the IPPE and AWV are similar to the age-appropriate history and risk-factor-reduction components of the Preventive Medicine Service codes. Therefore, reporting both services for one patient encounter could be duplicative. If a comprehensive exam is performed and documented in addition to the IPPE or AWV, the medical necessity should be reflected in the documentation by the nature of the presenting problem(s) and the medical decision making. Performing additional history, exam and listing chronic conditions does not always equate to a separately billable E/M service. The rationale for performing additional elements should be clearly documented in the medical record. In addition, for Medicare beneficiaries there are other separately reportable preventive services, such as Screening Pelvic Examinations (CPT G0101) and Prostate Cancer Digital Rectal Examination (CPT G0102), which would be duplicative of preventive medicine examination components. Therefore, reporting a preventive medicine E/M service in addition to an IPPE or AWV, based solely on the performance of a comprehensive examination, would not be an accurate reflection of the service provided.

Diagnoses: Apply the appropriate wellness diagnosis code and stable chronic condition diagnosis code(s) to the IPPE or AWV CPT Code and the age-appropriate Preventive Medicine CPT Code.

Important Notes

- If payors have specific reporting requirements for coding, those guidelines should be followed. However, payor specific coverage should not influence performing or reporting additional E/M services. The services reported should be based on the reason(s) the patient presented and what was medically necessary for the provider to perform on that particular date of service.
- Documentation for chronic conditions assessed during wellness/preventive visits need to be evaluated to identify what the provider did on the specific date of service to manage/treat the condition(s). Noting conditions to capture risk burden, HCCs etc. does not automatically equate to a reportable problem-specific E/M service.
- If the patient is already under the care of a provider for acute or chronic conditions listed in the documentation, determine what is being done at this specific encounter for management of the condition(s) when considering the appropriate CPT/HCPCS code(s) to report.
- Ensure elements are not counted more than once toward any Evaluation and Management Service. If an element is required for the AWV, it may not also be counted toward a Preventive Medicine Service or a problem-specific E/M service.
- Documentation guidelines for office and other outpatient services, CPT codes 99202-99215, changed as of January 1, 2021.

Documentation Examples

IPPE or AWV with a Problem-Specific E/M Visit:

A patient presents for an IPPE or AWV visit and is being followed for their morbid obesity, depression, hypothyroidism, and type 2 diabetes mellitus. All required elements of the IPPE or AWV have been documented. Labs today show the patient has an elevated blood sugar of 538. Metformin is increased to 1000 mg BID. The patient is morbidly obese with a BMI of 49.64. The patient is encouraged to increase exercise and modify their diet and received a referral to the bariatric clinic. The patient's moderate, recurrent major depression is worse, with decreased concentration and energy, and increased anxiety. Xanax is increased to 1 mg to 3 times daily. Their hypothyroidism is stable, TSH is normal.

CPT Code: IPPE G0402 or AWV G0438/G0439

Diagnosis Code(s): Z00.01-Encounter for general adult medical examination with abnormal findings, E03.9-Hypothyroidism, unspecified.

CPT Code: Problem-specific E/M code with modifier 25 (components used to support E/M may not include elements included in IPPE or AWV)

Diagnosis Code(s): E11.65-Type 2 diabetes mellitus with hyperglycemia, E66.01-Morbid (severe) obesity due to excess calories, Z68.42-Body mass index (BMI) 45.0-49.9 adult, F33.1-Major depressive disorder, recurrent, moderate.

For example, when reporting an AWV or IPPE in addition to a problem-specific 99213 E/M service, the documentation would include a medically appropriate history and/or examination, which is determined by the treating physician or other qualified health professional reporting the service, and low-level medical decision making. If using time for code selection, 20-29 minutes of documented time is required for the 99213 problem-specific E/M service. Time spent performing the AWV or IPPE could not be considered/counted to support the problem-specific E/M code.

Annual Wellness Visit or IPPE Only:

A 65-year-old patient presents for their IPPE or AWV. All required elements of the IPPE/AWV have been performed and documented. Chronic medical problems include knee arthritis, a history of squamous cell cancer of the skin, GERD, and anxiety. The assessment and plan include, "chronic issues are stable" and prescriptions are refilled for Pantoprazole, Sertraline, and Naproxen. The documentation includes questions about falls and counseling regarding sunscreen use with documentation supporting this. This would not warrant a problem-specific E/M service as these conditions were not addressed in sufficient fashion to warrant a separate problem-specific E/M. Falls and sunscreen counselling are components of the IPPE/AWV. Elements considered for a separate, problem-specific E/M must be beyond what would be included in the AWV or IPPE. In this case, medically appropriate history and exam for the chronic conditions were not documented. Only prescription refills were documented, therefore an additional E/M is not supported.

CPT Code: IPPE G0402 or AWV G0438/G0439

Diagnosis Code(s): Z00.00-Encounter for general adult medical exam without abnormal findings, plus stable chronic conditions as appropriate

Documentation and Coding Tips

Atherosclerosis of Aorta

St. Luke's Health Partner's is committed to helping providers accurately document and code their patient's health records.

Atherosclerosis of the aorta is a common, chronic condition in the elderly and is often noted incidentally on a chest x-ray, abdominal imaging, imaging of major vessels, spinal imaging, and angiography.

When documenting and coding atherosclerosis of the aorta, it's important to follow these critical tips for compliant code selection.

Documentation Tips:

- Define in your note whether you are addressing the valve or the vessel.
    - Many EMR systems default to "aortic" atherosclerosis.
    - "Aorta" refers to the vessel.
    - "Aortic" refers to the valve.
- Where possible and known, document the section of the aorta for further clarity (i.e., atherosclerosis of the abdominal aorta).
- Indicate any clinical significance of the condition and impact on other conditions.
- Note your treatment plan with any current medications, follow up or lifestyle changes.

Documentation & Coding Examples

Non-specific documentation example:

HPI: Patient seen today for AWV. Discussed his aortic atherosclerosis.
Assessment and Plan: Aortic atherosclerosis-stable, follow up in one year.

Rationale: Coding cannot take place where there is conflicting information such as "aortic" in the short description and no further clarification if the vessel or the valve was addressed.

Specific documentation example:

Assessment and Plan: Patient with atherosclerosis of aorta noted on CT abdomen dated 3-15-2015. Stable-continue Simvastatin.

Rationale: Documentation addresses the location of aorta. Correct code selection is I70.0 Atherosclerosis of aorta.

Documentation and Coding Tips

Overweight, Obesity & BMI

Follow these best practices for capturing accurate documentation for Overweight, Obesity and BMI visits:

- BMI may be documented by any clinical staff or provider but, an associated diagnosis of overweight, obesity or morbid obesity must be documented by the patient's provider.
- BMI diagnosis codes should only be reported when the associated diagnosis is documented:
  - E66.01-Morbid (severe) obesity, due to excess calories
  - E66.09-Other obesity due to excess calories E66.1-Drug induced obesity
  - E66.2-Morbid (severe) obesity with alveolar hypoventilation
  - E66.3-Overweight
  - E66.8-Other obesity
  - E66.811-Obesity, Class 1
  - E66.812-Obesity, Class 2
  - E66.813-Obesity, Class 3
  - E66.9-Obesity, unspecified
- The explicit provider diagnosis determines the weight-related ICD.10 obesity code, not the documented BMI.
- Morbid obesity may be reported for patients with a BMI of 35 or greater when associated comorbid condition(s) is also documented.

Specify When Documenting:

- **Type:** Overweight, obesity, morbid obesity, morbid obesity with alveolar hypoventilation
- **Cause:** Due to excess calories, drug-induced obesity (specify drug)
- **Comorbidities/complication factors**: Cancer, cardiovascular diseases, diabetes, sleep apnea, etc.
- **Treatment:** Evidence-based diet, behavioral counseling, bariatric surgery

Documentation and Coding Examples:

Documentation Examples

72-year-old male patient seen today, concerned he has gained 20 pounds over the last year and his struggle with obesity. Recommend he lose weight through diet and exercise before prescribing any medication.
Assign code: E66.9, Obesity, unspecified.

68-year-old female patient presents today for Class 3 obesity. She admits to overeating and is morbidly obese. Her BMI today is 49.07. Discussed plan for healthy eating habits and exercise.
Assign code: E66.813, Obesity, Class 3. Z68.42 BMI 45.0-49.9.
Note: If both Morbid Obesity & Class 3 Obesity are documented, only a code for Class 3 Obesity should be assigned as it is more specific.

Patient seen today for weight loss counseling. The patient has a BMI of 36 and is morbidly obese. Patient also has comorbidities related to obesity, which are hypertension and obstructive sleep apnea.
Assign code: E66.01, Morbid obesity due to excess calories. I10 Hypertension. G47.33 Obstructive sleep apnea. Z68.36 BMI 36.0-36.9. Z71.3 Dietary counseling and surveillance.

Documentation and Coding Tips

Cancer Coding: Active vs History Of

Clear provider documentation is essential for accurate and complete coding of cancer.

Active cancer is when:

- The patient is actively and currently being treated and managed for cancer with chemotherapy or radiation.
- The patient has refused therapeutic treatment for cancer or is on watchful waiting.

History of cancer is when:

- The cancer was successfully treated, excised or eradicated and no further treatment is needed.
- The patient had cancer and is coming back for surveillance of recurrence.

Adjuvant hormonal therapy for breast or prostate cancer can be coded as active or history of if:

- The patient is taking medication to treat the cancer (even after it's been removed), document this as active cancer treatment and code as active cancer.
- The patient is taking medication for prophylactic purposes to ensure the treated cancer does not come back, document this as prophylactic treatment and code as history of.

Document the following for accurate and specific assignment of the correct ICD.10 code(s):

- **Type of cancer:**
  - Document the primary malignancy and all secondary metastases.
  - Use the words "to" and "from" to clarify the origin of the cancer.
- **Location of cancer:**
  - Document the specific body part or tissue type.
  - Include laterality, if applicable.
- **Status of cancer:**
  - Document if the cancer is currently active, historical, in remission, not achieved remission or is recurrent.
- **Current treatment plan for cancer:**
  - Document all treatment plans (surgery, chemotherapy, radiation, adjuvant hormonal therapy, prophylactic treatment, patient refusal of treatment, watchful waiting) and any complications.

Documentation and Coding Examples:

Active cancer: Female patient with ongoing chemotherapy after right mastectomy for breast cancer.
Assign code: C50.911 Malignant neoplasm of unspecified site of right female breast; Z90.11 Acquired absence of right breast and nipple

Even though the breast has been removed, the breast cancer is still being treated with chemotherapy and still coded as active cancer rather than personal history.

History of cancer: Female patient with metastatic bone cancer originating from breast cancer that was eradicated 3 years ago, and is no longer receiving treatment, is seen today for ongoing radiation treatment for bone cancer.
Assign code: C79.51 Secondary malignant neoplasm of bone; Z85.3 Personal history of malignant neoplasm of breast.

Where the breast cancer was eradicated 3 years ago, you would code the active metastatic bone cancer and code the breast cancer as history of.

Documentation and Coding Tips

Chronic Kidney Disease

A review of the patient's diagnostic studies, pertinent clinical findings and the stage of CKD must be documented to code the condition.

Specify When Documenting:

- **Underlying cause, if known.**
- **Stage and severity (include the GFR results, if available):**
  - Stage I, N18.1-Normal or slightly increased GFR (>/= to 90)
  - Stage II, N18.2-Mild kidney disease decreased GFR (60-89)
  - Stage III, N18.30-Moderate kidney disease, unspecified decreased GFR (30-59)
  - Stage III, N18.31-Moderate kidney disease 3a decreased GFR (45-59)
  - Stage III, N18.32-Moderate kidney disease 3b decreased GFR (30-44)
  - Stage IV, N18.4-Severe kidney disease decreased GFR (15-29)
  - Stage V, N18.5-Kidney failure GFR <15 (note acute or chronic and cause, if known), & End-Stage Renal Disease, N18.6

  Note-If both a stage and ESRD are documented, assign code N18.6 only.

  Do not assign CKD codes based on GFR results alone.

  Assign N18.9 Chronic kidney disease, unspecified, if the stage of CKD is not documented.
- **Presence/Complications:**
  - AV fistula or shunt for dialysis
  - Complication due to renal dialysis access device, implant or graft (i.e. embolism, hemorrhage, infection, occlusion, pain)
- **Associated diagnoses/conditions:**
  - Document any additional or secondary conditions that may be present
  - Document any cause and effect relationship between CKD and other conditions
- **Treatment:**
  - Dialysis dependence
  - Acute or chronic hemodialysis or peritoneal dialysis
  - Transplant status
  - Use of immunosuppressants

Documentation & Coding Examples

Non-specific documentation example:

Patient seen today for CKD follow up. Repeated CMP today to ensure stability.

Assign code: N18.9 Chronic kidney disease, unspecified.

Specific documentation example:

Patient has five-year history of CKD Stage 3 but, based on trending GFR's, is now diagnosed with Stage 4 CKD. I am referring her to a nephrologist.

Assign code: N18.4 Chronic kidney disease, stage 4.

Documentation and Coding Tips

Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is often used as an umbrella term to describe emphysema, chronic bronchitis, and chronic asthma. If a patient predominately exhibits features of one specific disease over another, this should be documented rather than the less specific term of COPD. Document to the highest specificity to code accurately. Coding these conditions requires a solid understanding of the current ICD.10 coding guidelines.

Specify When Documenting:

- **Type:** Emphysema, chronic bronchitis, chronic asthma
- **Severity:** Acute, chronic, intermittent, acute exacerbation, asthmatic, obstructive
- **Describe severity as:** Mild, moderate, persistent, or severe
- **Comorbidities:** Cardiac disease, diabetes, pulmonary artery disease, etc.
- **Cause:** Any known lower respiratory infections and the infectious agent
- **Clinical signs and symptoms:** Coughing, shortness of breath, sputum production, wheezing, etc.
- **Tobacco abuse, dependence, past history, or exposure (environmental or occupational)**
- **Any additional lung disease due to external agent and specify agent (gases, organic dust, vapor, etc.)**
- **Report any hypoxia, hypercapnia, hypoxemia, polycythemia, or chronic respiratory failure.**
- **Note any diagnostic tests:** ABG's (arterial blood gas), PFT (pulmonary function test), chest x-ray, etc.
- **Treatment:** Bronchodilators, tobacco counseling, dependence on ventilator, oxygen, steroids, tracheostomy, etc.

Documentation and Coding Examples

Non-specific documentation example:

Patient seen today for follow up of his COPD.

Assign code: J44.9 COPD, unspecified.

Specific documentation examples:

Patient has decompensated COPD with continuous home oxygen.

Assign code: J44.1 COPD with (acute) exacerbation. Z99.81 dependence on supplemental oxygen.

Patient with emphysema presents due to moderate persistent asthma and COPD.

Assign code: J43.9 Emphysema, unspecified. J45.40 Moderate persistent asthma, uncomplicated.
Note: Emphysema is a form of COPD so, you would not need an additional code to represent unspecified COPD.

Documentation and Coding Tips

Congestive Heart Failure

Proper documentation of the precise type of heart failure is important to adequately describe the severity of the patient's illness and for accurate coding. If a provider does not specify "failure" in their documentation, a code from I50.X would not be assigned. Merely stating congestive heart failure, congestive heart disease, or heart failure without further description, is only supportive of code I50.9 heart failure, unspecified. Don't miss out by leaving off specific details in your documentation.

Specify When Documenting:

- **Type:**
  - Diastolic (congestive) heart failure with preserved ejection fraction (HFpEF)
  - Systolic (congestive) heart failure with reduced ejection fraction (HFrEF)
  - Combined diastolic/systolic (congestive) heart failure
- **Severity:**
  - Acute
  - Chronic
  - Acute on chronic
- **Disease status:**
  - Stable
  - Improved
  - Worsening
  - Acute exacerbation
  - Decompensation
- **Underlying cause, if known (i.e. cardiomyopathy, hypertension)**
- **Workup/treatment plan:**
  - Testing
  - Current/new medications
  - Lifestyle changes

Documentation & Coding Examples

Non-specific documentation example:

Patient seen today for congestive heart failure. Continue diuretics and use of wedge pillow while sleeping.

Assign code: I50.9 heart failure, unspecified

Specific documentation example:

Patient with hypertensive heart disease with end-stage heart failure in acute on chronic diastolic and systolic heart failure with mild decompensation. I increased diuretics and patient is now on full-time supplemental oxygen for chronic hypoxemic respiratory failure.

Assign codes: I50.84 End-stage heart failure, I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure, J96.11 Chronic respiratory failure with hypoxia, I11.0 Hypertensive heart disease with heart failure.

Documentation and Coding Tips

CVA/Stroke: After Initial Acute Care Episode

One of the most common coding errors seen in HCC chart auditing is the assignment of an acute stroke code in an outpatient office setting. Typically, office visits are directed at follow up care and address patient's residual deficits.

Use these documentation and coding tips for accurate and specific assignment of the correct codes:

- Acute stroke is only coded during the initial episode of care.
- Once the patient is discharged from the hospital, the condition should be coded as one of the following scenarios:
    - Personal history of CVA/Stroke without residual effects (Z86.73)
        - Use this code if the patient recovers with no lingering problems related to the stroke.
        - Do not assign codes from category I69 with this code.
    - All sequalae (late effect) of stroke (Subcategory I69.3_ _)
        - Use this code range if the patient presents with deficits after the discharge from the initial care episode.
            - Document underlying cause (i.e. previous CVA, due to stroke)
            - Document type of late effect (i.e. aphasia, dysphagia, hemiparesis, hemiplegia)
            - Document body side affected (i.e. right dominant, right non-dominant)
        - Category I69 is to be used to indicate conditions in I60-I67 as the cause of sequelae. The "sequelae" include conditions specified as such or as residuals which may occur at any time after the onset of the causal condition.

Documentation and Coding Examples:

Patient was recently hospitalized for stroke two weeks ago and returns for a follow-up visit. He has no residual effects from the initial stroke.

Assign code:
Z86.73 Personal history of CVA/Stroke without residual effects.

Patient presents for follow-up visit from acute stroke on May 21, 2022. He is experiencing left dominant hemiplegia and aphasia due to the stroke.

Assign codes:
I69.352 Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side.
I69.320 Aphasia following cerebral infarction.

Documentation and Coding Tips

Depressive Disorders

Documentation of depressive disorders is important to adequately describe the severity of the patient's illness and for accurate coding.

Specify When Documenting:

Include the required specific information below for accurate coding of depressive disorders. In the absence of key documentation elements, our default codes are: F32.9-Major depressive disorder, single episode, unspecified or F32.A-Depression, unspecified (Depression NOS, Depressive disorder NOS).

- **Episode:** Single or recurrent
  - Single-A patient experiences only one single depressive episode during their lifetime.
  - Recurrent-Considered recurrent when there is an interval of at least two consecutive months between separate episodes during which criteria are not met for a major depressive episode.
- **Severity:** Mild, moderate, severe, with or without psychotic features
- **Clinical Status:** Partial or full remission
  - In remission-With appropriate treatment, the patient's depression symptoms may be controlled, in which case they are considered "in remission". They still carry the diagnosis of major depression.
  - Partial-Occasional symptoms from a previous major depressive episode without meeting full criteria or a hiatus lasting less than two months without any significant symptoms.
  - Full-No significant signs or symptoms of the disturbance present during the past two months.
- **Underlying cause of depression, if known**
- **Any comorbidities, if known**
- **Treatment Plan/Results:** Screening, testing, medication, counseling/therapy, referrals

Documentation & Coding Examples

Non-specific Documentation Example:

65-year old male seen today for depression. He is responding well to citalopram.

Assign Code: F32.A Depression, unspecified.

Specific Documentation Example:

72-year old female with prior known episodes of major depressive disorder, severe without psychosis. Her symptoms are worsening with increased loss of interest in activities, sadness and she is tearful today. Denies self-harm. We will increase her Lexapro dosage to 20 mg and will see her for follow up appointment in 2 weeks.

Assign Code: F33.2 Major depressive disorder, recurrent, severe without psychotic features.

Documentation and Coding Tips

Diabetes Mellitus with Chronic Complications

With expanded combination codes for diabetes, providers can report specific clinical details concerning diabetic complications. To promote quality and continuity of care, it is crucial to report all documented conditions to the highest specificity. ICD-10-CM assumes a link with diabetes and multiple common conditions. Familiarize yourself with these conditions in the index of your ICD-10-CM book for correct coding.

When documenting Diabetes Mellitus with Chronic Complications, specify the following:

- Follow guidance from the general Diabetes Mellitus coding tip and document: Type, degree of control, use of insulin and oral hypoglycemic drugs, and treatment plan.
- Document and use as many codes as required to describe all complications of diabetes.
- Use terms such as: Due to, associated with, secondary to, as this will establish the causal relationship between the two conditions.
- Document all body system(s) affected and complication(s) affecting the body system(s).
- Document when a complication or manifestation is NOT due to diabetes.
- For diabetes mellitus with ***other specified*** complications, document what the ***other specified*** complication is and its relation to diabetes mellitus. You will also need to include the additional ICD.10 code to identify the specific complication. (See the specific documentation example below for diabetes mellitus with hyperlipidemia).

Documentation and Coding Examples

Specific documentation example:

Patient presents today for follow-up on his hyperlipidemia due to type 2 diabetes mellitus. He was started on Lipitor at his visit 6 months ago. Fasting labs show lipids are at goal. His A1C is up slightly to 7.0.

Assign code: E11.69 Type II diabetes mellitus with other specified condition. E78.5 Hyperlipidemia.

Specific documentation example:

Patient seen today for diabetic chronic kidney disease, stage 3. The patient has type 2 diabetes and is taking insulin daily. UA and Renal Function Panel ordered today.

Assign code: E11.22 Type II diabetes mellitus with diabetic chronic kidney disease. N18.3 Chronic kidney disease, stage 3 (moderate). Z79.4 Long term (current) use of insulin.

Specific documentation example:

Patient has type 2 diabetes mellitus with neuropathy. She experiences mostly burning and tingling but, no numbness in her feet. Gabapentin 600 mg at night provides some relief. She has not been routinely checking her blood sugars. Glycohemoglobin A1C ordered today.

Assign code: E11.40 Type II diabetes mellitus with neuropathy.

Documentation and Coding Tips

Diabetes Mellitus

Address diabetes in every encounter with a diabetic patient, as it will always affect outcomes and care.

When documenting Diabetes Mellitus, specify the following:

- **Type:**
  - E08-Diabetes mellitus due to underlying condition
  - E09-Diabetes mellitus drug or chemical induced
  - E10-Type I diabetes mellitus
  - E11-Type II diabetes mellitus
  - E13-Other specified form of diabetes mellitus

  Note-If the type is not documented, report codes from category E11-diabetes mellitus Type II.
- **Complications or manifestations:**
  - Use as many codes as required to describe all documented complications of diabetes.
  - Use terms such as: due to, associated with, secondary to, as this will establish the relationship between the two conditions.
  - Document when a complication or manifestation is NOT due to diabetes.
  - Document all body system(s) affected and complication(s) affecting the body system(s).
- **Degree of control:**
  - Terms controlled and uncontrolled are no longer used for diabetes mellitus in ICD.10.
  - Document whether hyperglycemic or hypoglycemic.
  - Inadequate control, out of control, or poorly controlled is reported as hyperglycemia.
- **Use of insulin and oral hypoglycemic drugs:**
  - Z79.4 is assigned for diabetes mellitus Type II when insulin is prescribed for long term use.
  - Z79.4 is not assigned when insulin is given temporarily to bring blood sugars under control.
  - Z79.84 is assigned for long term (current) use of oral hypoglycemic drugs.
  - When both oral hypoglycemic drugs and insulin are prescribed, only code for the long term (current) use of insulin.
- **Treatment:**
  - Document whether diabetes is controlled by diet, exercise, anti-diabetic medications, insulin or a combination of these modalities.
  - Document referrals for dietetic counseling, foot care, or other therapies.

Documentation and Coding Examples

Non-specific documentation example:
Patient here today for follow up of his diabetes.

Assign code: E11.9 Type II diabetes without complications.

Specific documentation example:
Patient has limited ambulation due to peripheral neuropathy. His diabetes is poorly controlled, today's A1C was 12.4.

Assign code: E11.40 Type II diabetes with diabetic neuropathy, unspecified. E11.65 diabetes with hyperglycemia.

Documentation and Coding Tips

General Physician Documentation

Follow these simple charting tips and examples to address common coding and compliance shortcomings that can lead to appropriate risk scores.

- Review and update problem lists. Lists should reflect active medical problems.
  - Type 2 diabetes mellitus
  - Chronic obstructive pulmonary disease
- Document conditions that **coexist** at the time of the encounter/visit and that require or affect patient care, treatment, or management.
  - PCP Example: COPD managed by patient's Pulmonologist. Stable, continue current regimen on Proair HFA 90 mcg/inhaler.
  - Specialist Example: Patient with CKD, stage 4 seen today in nephrology for review of recent GFR results. Longstanding history of diabetes and hypertension, which are stable and managed by his PCP.
- Review and update medication lists. Lists should reflect currently prescribed medications and the condition prescribed for.
  - Gabapentin 100 mg capsule by mouth 3 times daily for type 2 diabetes mellitus with neuropathy
- Document your Assessment and Plan in a format that clearly aligns each diagnosis to a treatment plan.
  - Assessment and Plan: Type 2 diabetes mellitus-Metformin, 500 mg bid; draw A1C in 3 months
- Identify any complications and document what caused the complication.
  - Chronic kidney disease, stage 4 due to type 2 diabetes mellitus
- Use linking language for related conditions.
  - Aphagia due to CVA rather than Aphagia and CVA
- Acknowledge pertinent laboratory or radiology results in the body of the documentation.
  - Chronic kidney disease (CKD) stage 3a, GFR of 47
- Always code status conditions when present.
  - Amputation, dialysis, ostomy, transplant, etc.
- In an outpatient environment, do not code diagnoses as "consistent with", "likely" "probable", "questionable", "rule-out" or "suspected". Document and code the signs and symptoms if you do nothave a definitive diagnosis.
- Avoid copy and paste to ensure documentation is unique to each encounter. Each note stands alone.
- Documentation must have MEAT for each diagnosis.
  - **Only one of the four elements of MEAT is needed for each documented condition**

MEAT	Support	Disease Example	Documentation Example
Monitor	Signs, symptoms, disease progression/regression	Congestive heart failure	Congestive heart failure is stable. Will continuesame dose of Lasix.
Evaluate	Test results, medication effectiveness, response to treatment	Type 2 diabetes mellitus	Blood sugar log and A1C results reviewed withthe patient.
Assess/Address	Order tests, discuss tests, review records, counseling, status/level of condition	Peripheral neuropathy	Decreased sensation of BLE by monofilament test.
Treat	Prescribe medications/therapies, surgical/therapeutic interventions, referral to specialist	New diagnosis of Chronic kidney disease, Stage 3	Referred to nephrology clinic.

Documentation and Coding Tips

Pathological fractures (non-traumatic)

Pathological fractures describe a fracture that is a result of a medical condition rather than trauma. Fractures in patients with known disease whose injury (i.e. minor fall) would not usually break a normal, healthy bone should not be classified with a traumatic injury code. Upon compliance review, providers often consider these types of fractures to be traumatic when selecting their diagnoses.

When documenting Pathological Fractures, specify the following:

- **Episode of care:**
  - A-Initial encounter for fracture
    - Initial is when the patient is receiving active treatment
  - D-Subsequent encounter for fracture with routine healing
  - G-Subsequent encounter for fracture with delayed healing
  - K-Subsequent encounter for fracture with nonunion
  - P-Subsequent encounter for fracture with malunion
    - Subsequent is after the patient has completed active treatment and is receiving routine care during the healing or recovery phase
  - S-Sequela
    - Late effects of the fracture
- **Identify location and laterality**
- **Specify the type:**
  - Age-related osteoporosis
  - Neoplastic disease
  - Other (i.e. Long-term use of prednisone, menopause, Cushing's syndrome)
- **Diagnostic Tools/Treatment:**
  - List diagnostic procedures and services (i.e. CT scan, DEXA, MRI, x-ray)
  - List therapeutic procedures and services (i.e. physical therapy, restricted activity, and rest)
  - List any medications prescribed

Documentation and Coding Examples

Non-specific documentation example:

Patient presented today after experiencing back pain for two days with no known injury. X-ray revealed compression fractures, T8-T10.

Assign code: M54.9 Back pain NOS. A compression fracture can be pathological, nontraumatic NOS or traumatic. Without more detailed fracture information, the coder cannot report a fracture specific diagnosis.

Specific documentation example:

A patient with age-related osteoporosis suffers a pathological fracture to her right hip after falling off a stool. She is being seen for this new fracture today.

Assign code: M80.051A Age-related osteoporosis with current pathological fracture, right femur.
W08.XXXA Fall from stool.

Documentation and Coding Tips

Pulmonary Embolism and Deep Vein Thrombosis

Document to the highest specificity for accurate and complete coding of pulmonary embolus (PE) and deep vein thrombosis (DVT). There are no specific coding guidelines for when a PE/DVT are considered acute or chronic. Provider documentation is key for proper code assignment.

Acute embolism/thrombosis is when:

- A new and often symptomatic embolism/thrombosis is discovered, and the patient is starting anticoagulation therapy.

Chronic embolism/thrombosis is when:

- An old or established embolism/thrombosis requires ongoing anticoagulation therapy.

History of embolism/thrombosis is when:

- The patient no longer has an embolism/thrombosis but is taking anticoagulation medication prophylactically.

Clearly document the following for the accurate and specific assignment of the correct ICD.10 code(s) for PE/DVT:

- **Severity:** Acute, chronic, historical
- **Type:** Saddle, septic, single/multiple subsegmental, other
  - With or without acute cor pulmonale
- **Laterality:** Left, right, bilateral
- **Vein:** Femoral, iliac, peroneal, popliteal, tibial, etc.
- **Location:** Upper extremity, lower extremity
- **Treatment:** List medication and length of treatment. Also include compression stockings, imaging, lab tests, surgical removal, vena cava filter, etc.
  - *Use additional code, if applicable, for associated long-term (current) use of anticoagulants (Z79.01)*

Documentation and Coding Examples:

Acute deep vein thrombosis: Male patient with an acute DVT of right lower leg. Starting Coumadin treatment.
Assign code: I82.401 Acute embolism and thrombosis of unspecified deep veins of right lower extremity.

Rationale: Documentation specifies laterality, and the patient is starting Coumadin treatment.

Chronic deep vein thrombosis: 70-year-old female patient seen today for follow-up of an old, chronic deep vein thrombosis of the right femoral vein. Patient is on anticoagulation therapy.
Assign code: I82.511 Chronic embolism and thrombosis of right femoral vein. Z79.01 Long-term (current) use of anticoagulants.

Rationale: The provider documented the severity, laterality, and vein of the of the deep vein thrombosis and notes the use of anticoagulants.

History of pulmonary embolism: 75-year-old patient seen today in follow-up for a pulmonary embolism she had 6 months ago. No evidence of embolism on ultrasound and is now taking Xarelto prophylactically.
Assign code: Z86.711 Personal history of pulmonary embolism. Z79.01 Long-term (current) use of anticoagulants.

Rationale: Since the provider documented no evidence of embolism and the patient is taking Xarelto prophylactically, this means the patient has a history of having this diagnosis.

Documentation and Coding Tips

Respiratory Failure

Respiratory failure is never a single diagnosis; it always has an associated cause. Clinical documentation of cause and sequence of events is fundamental for correct code assignment.

Specify When Documenting:

- **Severity:**
  - Acute
  - Chronic
  - Acute and chronic
  - Postprocedural
    - **Do not** document and code respiratory failure when a patient is maintained on a ventilator following surgery when the ventilator is a routine aspect of the surgery.
    - **Do** document and code respiratory failure if there is a complication or chronic condition that requires an extension of ventilator support.

- **Type:**
  - Hypoxemia
  - Hypercapnia
  - Both hypoxemia and hypercapnia

- **Cause:** Any underlying conditions, such as pulmonary embolism, pulmonary hypertension, COPD, fibrosis, injury, pneumonia, surgery

- **Clinical results:** Such as exam findings, arterial blood gas, pulse oximetry, chest x-ray

- **Treatment plan:** Such as oxygen dependence, medication, pulmonary rehabilitation

Note: Include any related tobacco use, abuse, dependence, past history, or smoke exposure (i.e. second hand, occupational)

Documentation and Coding Examples

Non-specific documentation example:

60-year-old female with chronic respiratory failure. She is dependent upon home O2, good saturation today.

Assign code: J96.10-Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia. Z99.81-Oxygen dependence (long-term, supplemental).

Specific documentation example:

85-year-old male with acute on chronic respiratory failure due to end-stage pan-lobular emphysema with hypoxia and hypercapnia. He required mechanical ventilation. The patient has a history of tobacco dependence.

Assign code: J96.21-Acute and chronic respiratory failure with hypoxia, J96.22-Acute and chronic respiratory failure with hypercapnia, J43.1-Panlobular emphysema, Z99.11-Dependence on respiratory (ventilator) status, Z87.891-Personal history of nicotine dependence.

Documentation and Coding Tips

Rheumatoid Arthritis

Rheumatology documentation and coding rules require very complex and specific details. Capture these essential elements to ensure accurate documentation and quality patient care for managing rheumatoid arthritis and your patient's comorbid conditions.

Specify When Documenting:

- **Type:** Adult onset (>16 years) or juvenile onset
  - If an adult patient has rheumatoid arthritis that originated in childhood, document juvenile rheumatoid arthritis. The age of onset determines whether the patient has rheumatoid arthritis or juvenile rheumatoid arthritis.
- **Anatomical site:** List specific joint(s) involved
  - For categories where no "multiple site" codes are provided, and more than one joint is involved, multiple codes should be used to represent the different sites involved
- **Laterality:** Left, right or bilateral
  - There is no available code to report bilateral rheumatoid arthritis of any joint. If the condition is bilateral, report two codes
- **Complications/manifestations:** Organ or system involvement, bursitis, myopathy, polyneuropathy, etc.
- **Symptoms:** Joint pain, swelling in joints, etc. in the absence of a confirmed diagnosis
- **Testing/treatment plan:** Blood test results, imaging results, medications, injections, joint replacement, referrals for rheumatology consultations and name of current rheumatologist, etc.
  - Document in the note the negative or positive results for rheumatoid factor
- **Immunosuppressant drugs:**
  - ICD-10-CM does not provide a specific code to identify long-term use of immunosuppressant drugs. Assign code Z79.899, other long-term (current) drug therapy, to report long-term use of immunosuppressant drugs.
  - Do not assign a code for an immunocompromised state caused by drug treatment of rheumatoid arthritis. Immunosuppressant drugs are commonly used in the treatment of autoimmune diseases such as rheumatoid arthritis for the specific purpose of suppressing the immune system.

Documentation and Coding Examples

Non-specific documentation example:

Patient presents today for follow-up of worsening rheumatoid arthritis.

Assign code: M06.9 Rheumatoid arthritis, unspecified.

Specific documentation example:

A 65-year-old patient has been complaining of stiffness and pain in her fingers in both hands first thing in the morning. Exam is performed, X-ray of the hands and rheumatoid factor blood test are ordered. The X-ray reveals the characteristics of early joint damage, and the rheumatoid factor is positive. She is diagnosed with rheumatoid arthritis.

Assign code: M05.841 Other rheumatoid arthritis with rheumatoid factor of right hand. M05.842 Other rheumatoid arthritis with rheumatoid factor of left hand.

Social Determinants of Health (SDoH) Z Codes

Z55-Problems related to Education and Literacy	
ICD.10 Z Code Description	ICD.10 Z Code
Illiteracy and low-level literacy	Z55.0
Schooling unavailable and unattainable	Z55.1
Failed school examinations	Z55.2
Underachievement in school	Z55.3
Educational maladjustment and discord with teachers and classmates	Z55.4
Less than a high school diploma • No general equivalence degree (GED)	Z55.5
Problems related to health literacy • Difficulty understanding health related information • Difficulty understanding medication instructions • Problem completing medical forms	Z55.6
Other problems related to education and literacy • Problems related to inadequate teaching	Z55.8
Problems related to education and literacy, unspecified • Academic problems	Z55.9
Z56-Problems related to Employment and Unemployment	
Unemployment, unspecified	Z56.0
Change of job	Z56.1
Threat of job loss	Z56.2
Stressful work schedule	Z56.3
Discord with boss and workmates	Z56.4
Uncongenial work environment • Difficult condtions at work	Z56.5
Other physical and mental strain related to work	Z56.6
Other problems related to employment	See 5th digit codes below
Sexual harassment on the job	Z56.81
Military deployment status • Individual (civilian or military) currently deployed in theater or in support of military war, peacekeeping, and humanitarian operations	Z56.82
Other problems related to employment	Z56.89
Unspecified problems related to employment • Occupational problems NOS	Z56.9
Z57-Occupational exposure to risk factors	
Occupational exposure to noise	Z57.0
Occupational exposure to radiation	Z57.1
Occupational exposure to dust	Z57.2
Occupational exposure to other air contaminants	See 5th digit codes below
Occupational exposure to environmental tobacco smoke	Z57.31
Occupational exposure to other air contaminants	Z57.39
Occupational exposure to toxic agents in agriculture • Occupational exposure to solids, liquids, gases, or vapors in agriculture	Z57.4

Occupational exposure to toxic agents in other industries • Occupational exposure to solids, liquids, gases, or vapors in other industries	Z57.5
Occupational exposure to extreme temperature	Z57.6
Occupational exposure to vibration	Z57.7
Occupational exposure to other risk factors	Z57.8
Occupational exposure to unspecified risk factor	Z57.9
Z58-Problems related to physical environment	
Inadequate drinking-water supply • Lack of safe drinking water	Z58.6
Other problems related to physical environment	See 5th digit codes below
Basic services unavailable in physical environment • Unable to obtain internet service, due to unavailability in geographic area • Unable to obtain telephone service, due to unavailability in geographic area • Unable to obtain utilities, due to inadequate physical environment	Z58.81
Other problems related to physical environment	Z58.89
Z59-Problems related to housing and economic circumstances	
Homelessness	See 5th digit codes below
Homelessness unspecified	Z59.00
Sheltered homelessness • Doubled up • Living in a shelter such as: motel, scattered site housing, temporary or transitional living situation	Z59.01
Unsheltered homelessness • Residing in place not meant for human habitation such as: abandoned buildings, cars, parks, sidewalk • Residing on the street	Z59.02
Inadequate housing	See 5th digit codes below
Inadequate housing, unspecified	Z59.10
Inadequate housing environmental temperature • Lack of air conditioning • Lack of heating	Z59.11
Inadequate housing utilities • Lack of electricity services • Lack of gas services • Lack of oil services • Lack of water services	Z59.12
Other inadequate housing • Pest infestation • Restriction of space • Technical defects in home preventing adequate care • Unsatisfactory surroundings	Z59.19
Discord with neighbors, lodgers, and landlord	Z59.2
Problems related to living in residential institution • Boarding-school resident	Z59.3
Lack of adequate food	See 5th digit codes below
Food insecurity	Z59.41
Other specified lack of adequate food	Z59.48

• Inadequate food • Lack of food	
Extreme poverty	Z59.5
Low income	Z59.6
Insufficient social insurance and welfare support	Z59.7
Other problems related to housing and economic circumstances	See 5th and 6th digit codes below
Housing instability, housed • Foreclosure on home loan • Past due on rent or mortgage • Unwanted multiple moves in the last 12 months	Z59.81
○ Housing instability, housed, with risk of homelessness ▪ Imminent risk of homelessness	Z59.811
○ Housing instability, housed, homelessness in past 12 months	Z59.812
○ Housing instability, housed unspecified	Z59.819
Transportation insecurity • Excessive transportation time • Inaccessible transportation • Inadequate transportation • Lack of transportation • Unaffordable transportation • Unreliable transportation • Unsafe transportation	Z59.82
Financial insecurity • Bankruptcy • Burdensome debt • Economic strain • Financial strain • Money problems • Running out of money • Unable to make ends meet	Z59.86
Material hardship due to limited financial resources, not elsewhere classified • Material deprivation due to limited financial resources • Unable to obtain adequate childcare due to limited financial resources • Unable to obtain adequate clothing due to limited financial resources • Unable to obtain adequate utilities due to limited financial resources • Unable to obtain basic needs due to limited financial resources	Z59.87
Other problems related to housing and economic circumstances • Foreclosure on home • Isolated dwelling • Problems with creditors	Z59.89
Problems related to housing and economic circumstances, unspecified	Z59.9
Z60-Problems related to social environment	
Problems of adjustment to life-cycle transitions • Empty nest syndrome • Phase of life problem • Problem with adjustment to retirement [pension]	Z60.0
Problems related to living alone	Z60.2
Acculturation difficulty • Problem with migration • Problem with social transplantation	Z60.3

○ DEF: Problem adapting to a different culture or environment not based on any coexisting medical disorder	
Social exclusion and rejection • Exclusion and rejection on the basis of personal characteristics, such as unusual physical appearance, illness or behavior • Social isolation	Z60.4
Target of (perceived) adverse discrimination and persecution	Z60.5
Other problems related to social environment • Inadequate social support • Lack of emotional support	Z60.8
Problem related to social environment, unspecified	Z60.9
Z62-Problems related to upbringing	
Inadequate parental supervision and control	Z62.0
Parental overprotection	Z62.1
Upbringing away from parents	See 5th digit codes below
Child in welfare custody • Child in foster care • Child in welfare guardianship	Z62.21
Institutional upbringing • Child living in group home • Child living in orphanage	Z62.22
Child in custody of non-parental relative • Child in care of non-parental family member • Child in custody of grandparent • Child in kinship care • Guardianship by non-parental relative	Z62.23
Child in custody of non-relative guardian	Z62.24
Other upbringing away from parents	Z62.29
Hostility towards and scapegoating of child	Z62.3
Inappropriate (excessive) parental pressure	Z62.6
Other specified problems related to upbringing	See 5th and 6th digit codes below
Personal history of abuse in childhood • Personal history of abuse in adolescence	Z62.81
Personal history of physical and sexual abuse in childhood	Z62.810
Personal history of psychological abuse in childhood	Z62.811
Personal history of neglect in childhood	Z62.812
Personal history of forced labor or sexual exploitation in childhood	Z62.813
Personal history of child financial abuse	Z62.814
Personal history of intimate partner abuse in childhood	Z62.815
Personal history of unspecified abuse in childhood	Z62.819
Parent-child conflict	See 6th digit codes below
Parent-biological child conflict • Parent-child problem NOS	Z62.820
Parent-adopted child conflict	Z62.821
Parent-foster child conflict	Z62.822
Parent-step child conflict	Z62.823
Non-parental relative or guardian-child conflict	See 6th digit codes below

Non-parental relative-child conflict • Grandparent-child conflict • Kinship-care child conflict • Non-parental relative legal guardian-child conflict • Other relative-child conflict	Z62.831
Non-relative guardian-child conflict	Z62.832
Group home staff-child conflict	Z62.833
Other specified problems related to upbringing	See 6th digit codes below
Parent-child estrangement NEC	Z62.890
Sibling rivalry	Z62.891
Runaway (from current living environment) • Child leaving living situation without permission	Z62.892
Other specified problems related to upbringing	Z62.898
Problems related to upbringing, unspecified	Z62.9
Z63-Other problems related to primary support group, including family circumstances	
Problems in relationship with spouse or partner • Relationship distress with spouse or intimate partner	Z63.0
Problems in relationship with in-laws	Z63.1
Absence of family member	See 5th digit codes below
Absence of family member due to military deployment • Individual or family affected by other family member being on military deployment	Z63.31
Other absence of family member	Z63.32
Disappearance and death of family member • Assumed death of family member • Bereavement	Z63.4
Disruption of family by separation and divorce • Marital estrangement	Z63.5
Dependent relative needing care at home	Z63.6
Other stressful life events affecting family and household	See 5th digit codes below
Stress on family due to return of family member from military deployment • Individual or family affected by family member having returned from military deployment (current or past conflict)	Z63.71
Alcoholism and drug addiction in family	Z63.72
Other stressful life events affecting family and household • Anxiety (normal) about sick person in family • Health problems within family • Ill or disturbed family member • Isolated family	Z63.79
Other specified problems related to primary support group • Family discord NOS • Family estrangement NOS • High expressed emotional level within family • Inadequate family support NOS • Inadequate or distorted communication within family	Z63.8
Problem related to primary support group, unspecified • Relationship disorder NOS	Z63.9
Z64-Problems related to certain psychosocial circumstances	
Problems related to unwanted pregnancy	Z64.0

Problems related to multiparity	Z64.1
Discord with counselors • Discord with probation officer • Discord with social worker	Z64.4
Z65-Problems related to other psychosocial circumstances	
Conviction in civil and criminal proceedings without imprisonment	Z65.0
Imprisonment and other incarceration	Z65.1
Problems related to release from prison	Z65.2
Problems related to other legal circumstances • Arrest • Child custody or support proceedings • Litigation • Prosecution	Z65.3
Victim of crime and terrorism • Victim of torture	Z65.4
Exposure to disaster, war, and other hostilities	Z65.5
Other specified problems related to psychosocial circumstances • At risk for feeling loneliness • Religious or spiritual problem	Z65.8
Problem related to unspecified psychosocial circumstances	Z65.9

Documentation and Coding Tips

Social Determinants of Health (SDoH) and Z Diagnosis Coding

The Journey to Better Patient-Centered Outcomes…Code It and Track Patient Needs!

- There are socioeconomic factors that can affect a person's health, including both environmental and societal conditions such as education and literacy, employment, health behaviors, housing, lack of adequate food or water, occupational exposure to risk factors, social support, transportation, and violence.
- Tracking these social needs that impact patients allows providers to identify trends to:
    - Enhance patient care.
    - Improve care coordination and referrals.
    - Support quality measurement.
    - Identify community/population needs.
    - Support planning and implementation of social needs interventions.
    - Monitor SDoH intervention effectiveness.
- Because the SDoH Z diagnosis codes in these categories represent social information, rather than medical diagnoses, they can be assigned based on documentation by nonphysician clinicians involved in the care of these patients. Self-reported documentation from the patient, if the information is approved and incorporated into the medical record by a clinician or provider, can be reported as well.
- SDoH data may be documented in the problem list, patient history, diagnosis list or provider notes.
- These SDoH Z diagnosis codes are supplemental diagnosis codes and should not be used as the admitting or principal diagnosis to indicate the medical reason for the visit. Always assign all relevant SDoH Z diagnosis codes to paint the true picture of the patient's needs and situation.
- Identify workflows to minimize staff burden and define what roles each team member will play. Some examples, coders can easily assign these codes based on self-reported data and/or information documented by any member of the care team if their documentation is included in the official medical record. Pre-visit Planning teams can capture this information prior to the patient's visit.
- Implement standardized questions, for example, regarding housing stability, food security and access to transportation as part of your currently required health risk assessments. This is an additional reminder for providers to capture these codes during patient visits.
- Work with your system vendor to add these SDoH Z diagnosis codes below into your EMR.

Z55-Problems related to Education and Literacy	
ICD.10 Z Code Description	ICD.10 Z Code
Illiteracy and low-level literacy	Z55.0
Schooling unavailable and unattainable	Z55.1
Failed school examinations	Z55.2
Underachievement in school	Z55.3
Educational maladjustment and discord with teachers and classmates	Z55.4
Less than a high school diploma • No general equivalence degree (GED)	Z55.5
Problems related to health literacy • Difficulty understanding health related information • Difficulty understanding medication instructions • Problem completing medical forms	Z55.6
Other problems related to education and literacy • Problems related to inadequate teaching	Z55.8
Problems related to education and literacy, unspecified • Academic problems	Z55.9
Z56-Problems related to Employment and Unemployment	
Unemployment, unspecified	Z56.0
Change of job	Z56.1
Threat of job loss	Z56.2
Stressful work schedule	Z56.3
Discord with boss and workmates	Z56.4
Uncongenial work environment • Difficult condtions at work	Z56.5
Other physical and mental strain related to work	Z56.6
Other problems related to employment	See 5th digit codes below
Sexual harassment on the job	Z56.81
Military deployment status • Individual (civilian or military) currently deployed in theater or in support of military war, peacekeeping, and humanitarian operations	Z56.82
Other problems related to employment	Z56.89
Unspecified problems related to employment • Occupational problems NOS	Z56.9
Z57-Occupational exposure to risk factors	
Occupational exposure to noise	Z57.0
Occupational exposure to radiation	Z57.1
Occupational exposure to dust	Z57.2
Occupational exposure to other air contaminants	See 5th digit codes below
Occupational exposure to environmental tobacco smoke	Z57.31
Occupational exposure to other air contaminants	Z57.39
Occupational exposure to toxic agents in agriculture • Occupational exposure to solids, liquids, gases, or vapors in agriculture	Z57.4
Occupational exposure to toxic agents in other industries • Occupational exposure to solids, liquids, gases, or vapors in other industries	Z57.5

Occupational exposure to extreme temperature	Z57.6
Occupational exposure to vibration	Z57.7
Occupational exposure to other risk factors	Z57.8
Occupational exposure to unspecified risk factor	Z57.9
Z58-Problems related to physical environment	
Inadequate drinking-water supply • Lack of safe drinking water	Z58.6
Other problems related to physical environment	See 5th digit codes below
Basic services unavailable in physical environment • Unable to obtain internet service, due to unavailability in geographic area • Unable to obtain telephone service, due to unavailability in geographic area • Unable to obtain utilities, due to inadequate physical environment	Z58.81
Other problems related to physical environment	Z58.89
Z59-Problems related to housing and economic circumstances	
Homelessness	See 5th digit codes below
Homelessness unspecified	Z59.00
Sheltered homelessness • Doubled up • Living in a shelter such as: motel, scattered site housing, temporary or transitional living situation	Z59.01
Unsheltered homelessness • Residing in place not meant for human habitation such as: abandoned buildings, cars, parks, sidewalk • Residing on the street	Z59.02
Inadequate housing	See 5th digit codes below
Inadequate housing, unspecified	Z59.10
Inadequate housing environmental temperature • Lack of air conditioning • Lack of heating	Z59.11
Inadequate housing utilities • Lack of electricity services • Lack of gas services • Lack of oil services • Lack of water services	Z59.12
Other inadequate housing • Pest infestation • Restriction of space • Technical defects in home preventing adequate care • Unsatisfactory surroundings	Z59.19
Discord with neighbors, lodgers, and landlord	Z59.2
Problems related to living in residential institution • Boarding-school resident	Z59.3
Lack of adequate food	See 5th digit codes below
Food insecurity	Z59.41
Other specified lack of adequate food • Inadequate food • Lack of food	Z59.48

Extreme poverty	Z59.5
Low income	Z59.6
Insufficient social insurance and welfare support	Z59.7
Other problems related to housing and economic circumstances	See 5th and 6th digit codes below
Housing instability, housed • Foreclosure on home loan • Past due on rent or mortgage • Unwanted multiple moves in the last 12 months	Z59.81
○ Housing instability, housed, with risk of homelessness ▪ Imminent risk of homelessness	Z59.811
○ Housing instability, housed, homelessness in past 12 months	Z59.812
○ Housing instability, housed unspecified	Z59.819
Transportation insecurity • Excessive transportation time • Inaccessible transportation • Inadequate transportation • Lack of transportation • Unaffordable transportation • Unreliable transportation • Unsafe transportation	Z59.82
Financial insecurity • Bankruptcy • Burdensome debt • Economic strain • Financial strain • Money problems • Running out of money • Unable to make ends meet	Z59.86
Material hardship due to limited financial resources, not elsewhere classified • Material deprivation due to limited financial resources • Unable to obtain adequate childcare due to limited financial resources • Unable to obtain adequate clothing due to limited financial resources • Unable to obtain adequate utilities due to limited financial resources • Unable to obtain basic needs due to limited financial resources	Z59.87
Other problems related to housing and economic circumstances • Foreclosure on home • Isolated dwelling • Problems with creditors	Z59.89
Problems related to housing and economic circumstances, unspecified	Z59.9
Z60-Problems related to social environment	
Problems of adjustment to life-cycle transitions • Empty nest syndrome • Phase of life problem • Problem with adjustment to retirement [pension]	Z60.0
Problems related to living alone	Z60.2
Acculturation difficulty • Problem with migration • Problem with social transplantation ○ DEF: Problem adapting to a different culture or environment not based on any coexisting medical disorder	Z60.3

Social exclusion and rejection • Exclusion and rejection on the basis of personal characteristics, such as unusual physical appearance, illness or behavior • Social isolation	Z60.4
Target of (perceived) adverse discrimination and persecution	Z60.5
Other problems related to social environment • Inadequate social support • Lack of emotional support	Z60.8
Problem related to social environment, unspecified	Z60.9
Z62-Problems related to upbringing	
Inadequate parental supervision and control	Z62.0
Parental overprotection	Z62.1
Upbringing away from parents	See 5th digit codes below
Child in welfare custody • Child in foster care • Child in welfare guardianship	Z62.21
Institutional upbringing • Child living in group home • Child living in orphanage	Z62.22
Child in custody of non-parental relative • Child in care of non-parental family member • Child in custody of grandparent • Child in kinship care • Guardianship by non-parental relative	Z62.23
Child in custody of non-relative guardian	Z62.24
Other upbringing away from parents	Z62.29
Hostility towards and scapegoating of child	Z62.3
Inappropriate (excessive) parental pressure	Z62.6
Other specified problems related to upbringing	See 5th and 6th digit codes below
Personal history of abuse in childhood • Personal history of abuse in adolescence	Z62.81
Personal history of physical and sexual abuse in childhood	Z62.810
Personal history of psychological abuse in childhood	Z62.811
Personal history of neglect in childhood	Z62.812
Personal history of forced labor or sexual exploitation in childhood	Z62.813
Personal history of child financial abuse	Z62.814
Personal history of intimate partner abuse in childhood	Z62.815
Personal history of unspecified abuse in childhood	Z62.819
Parent-child conflict	See 6th digit codes below
Parent-biological child conflict • Parent-child problem NOS	Z62.820
Parent-adopted child conflict	Z62.821
Parent-foster child conflict	Z62.822
Parent-step child conflict	Z62.823
Non-parental relative or guardian-child conflict	See 6th digit codes below
Non-parental relative-child conflict • Grandparent-child conflict • Kinship-care child conflict	Z62.831

• Non-parental relative legal guardian-child conflict • Other relative-child conflict	
Non-relative guardian-child conflict	Z62.832
Group home staff-child conflict	Z62.833
Other specified problems related to upbringing	See 6th digit codes below
Parent-child estrangement NEC	Z62.890
Sibling rivalry	Z62.891
Runaway (from current living environment) • Child leaving living situation without permission	Z62.892
Other specified problems related to upbringing	Z62.898
Problems related to upbringing, unspecified	Z62.9
Z63-Other problems related to primary support group, including family circumstances	
Problems in relationship with spouse or partner • Relationship distress with spouse or intimate partner	Z63.0
Problems in relationship with in-laws	Z63.1
Absence of family member	See 5th digit codes below
Absence of family member due to military deployment • Individual or family affected by other family member being on military deployment	Z63.31
Other absence of family member	Z63.32
Disappearance and death of family member • Assumed death of family member • Bereavement	Z63.4
Disruption of family by separation and divorce • Marital estrangement	Z63.5
Dependent relative needing care at home	Z63.6
Other stressful life events affecting family and household	See 5th digit codes below
Stress on family due to return of family member from military deployment • Individual or family affected by family member having returned from military deployment (current or past conflict)	Z63.71
Alcoholism and drug addiction in family	Z63.72
Other stressful life events affecting family and household • Anxiety (normal) about sick person in family • Health problems within family • Ill or disturbed family member • Isolated family	Z63.79
Other specified problems related to primary support group • Family discord NOS • Family estrangement NOS • High expressed emotional level within family • Inadequate family support NOS • Inadequate or distorted communication within family	Z63.8
Problem related to primary support group, unspecified • Relationship disorder NOS	Z63.9
Z64-Problems related to certain psychosocial circumstances	
Problems related to unwanted pregnancy	Z64.0
Problems related to multiparity	Z64.1
Discord with counselors • Discord with probation officer	Z64.4

• Discord with social worker	
Z65-Problems related to other psychosocial circumstances	
Conviction in civil and criminal proceedings without imprisonment	Z65.0
Imprisonment and other incarceration	Z65.1
Problems related to release from prison	Z65.2
Problems related to other legal circumstances • Arrest • Child custody or support proceedings • Litigation • Prosecution	Z65.3
Victim of crime and terrorism • Victim of torture	Z65.4
Exposure to disaster, war, and other hostilities	Z65.5
Other specified problems related to psychosocial circumstances • At risk for feeling loneliness • Religious or spiritual problem	Z65.8
Problem related to unspecified psychosocial circumstances	Z65.9

Documentation and Coding Tips

Substance Disorders: Use, Abuse, Dependence, Remission

Substance disorders are increasingly diagnosed and treated by the patient's primary care provider. These conditions are divided into four categories of use, abuse, dependence, and remission by severity. It's the provider's responsibility to document whether this condition is mild, moderate, or severe. DSM-5 provides further guidance regarding the criteria required for diagnosing the disorder and the patient's current severity.

Use:

- The irregular or low-frequency use of a substance that is not habitual. Typically, not coded unless there is a documented medical concern linked to the use.

Abuse:

- The habitual use of a substance that negatively impacts a patient's health or social functioning but has not arrived at the point of physical and/or mental dependency. The patient has "mild" substance abuse disorder. Mild is the presence of 2-3 symptoms.

Dependence:

- Chronic mental and physical state where the patient must use a substance to function normally. Patients generally experience signs of withdrawal upon cessation of the substance. The patient has "moderate or severe" substance use disorder. Moderate is presence of 4-5 symptoms. Severe is presence of 6 or more symptoms.

In Remission: Requires provider's clinical judgement and documentation if the patient is in remission or not.

Document these key points for the accurate and specific assignment of the correct ICD.10 code(s) for Alcohol, Drug and Substance disorders:

- **Status:** Use, abuse, or dependence.
- **Substance type:** Alcohol, cannabis, opioids, etc.
- **Severity:** Mild, moderate, or severe. (i.e., "Use disorder" is insufficient for proper code assignment).
- **Substance-induced mood/psychotic symptoms:** Depression, hallucinations, anxiety, etc.
- **Current complications/presentation:** Intoxicated, drunkenness, withdrawal, sleep disorder, etc.
- **History/pattern of use:** Continuous use, in remission, relapsed, etc.
  - Do not use the word "history" if the condition is still active.
- **Treatment plan:** Counseling, rehabilitation, maintenance therapy (specify drug), Alcoholic Anonymous (AA), etc**.**

Documentation and Coding Examples:

Nonspecific Example:
Patient is being admitted to the treatment center with a history of opioid dependence

Rationale: If the patient is being admitted, it seems unlikely this patient is in remission but, by stating "history of", this is what is documented. Patient has opioid dependence, not a history of opioid dependence.

Specific Example:
Patient is being admitted to the treatment center for treatment of opioid dependence. She has been an IV heroin user for five years.

Rationale: Documentation quantifies the time the patient has been an opioid user without making the mistake of using "history of".

*Per ICD.10, if the provider documents use, abuse, or dependence of the **same substance**, only one code should be assigned to identify the pattern of use based on the below hierarchy.*

Documented	***Assign Only***
Use and abuse	*Abuse*
Abuse and dependence	*Dependence*
Use, abuse, and dependence	*Dependence*
Use and dependence	*Dependence*

Documentation and Coding Tips

Fractures-Traumatic Initial, Subsequent and Sequela Encounters

We all know fracture coding can be a challenge. Provider documentation determines all aspects of the fracture puzzle and how the pieces fit together. Documenting key details in progress notes and knowing how to delineate initial, subsequent and sequela encounter visits is crucial for proper code selection.

Note: Fractures in patients with known osteoporosis whose injury would not usually break a normal, healthy bone should not be classified with a traumatic injury code, but with a combination code from category M80 Osteoporosis with current pathological fracture.

When documenting Traumatic Fractures, specify the following details:

- **Date and cause**
- **Site, laterality and specific bone fractured:** Displaced fracture of medial phalanx or right index finger
- **Type:** Comminuted, greenstick, oblique, physeal, segmental, spiral, transverse
  - Open versus closed (if not indicated, fractures are coded as closed)
  - Displaced versus non-displaced (if not indicated, fractures are coded as displaced)
- **Episode of care:** (7th character assignment indicates if patient is receiving initial or subsequent treatment)
  - **Initial** is when the patient is receiving active treatment (Initial is also assigned for the patient who delayed seeking treatment)

    Examples: Closed treatment, surgical treatment, ED visit for acute fracture treatment, evaluation and treatment by new provider (not in healing stage)
    - A-Initial encounter for closed fracture
    - B-Initial encounter for open fracture type I or II
    - C-Initial encounter for open fracture type IIIA, IIIB, or IIIC
  - **Subsequent** is after the patient has completed active treatment and is receiving routine care during the healing or recovery phase

    Examples: Cast change/removal, x-rays for evaluating healing status, removal of external or internal fixation device, medication adjustment and aftercare follow-up visits following initial fracture treatment
    - D-Subsequent encounter for closed fracture with routine healing
    - E-Subsequent encounter for open fracture type I or II with routine with routine healing
    - F-Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
    - G-Subsequent encounter for closed fracture with delayed healing
    - H-Subsequent encounter for open fracture type I or II with delayed healing
    - J-Subsequent encounter for open type IIIA, IIIB, or IIIC with delayed healing
    - K-Subsequent encounter for closed fracture with nonunion
    - M-Subsequent encounter for open fracture type I or II with nonunion
    - N-Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
    - P-Subsequent encounter for closed fracture with malunion
    - Q-Subsequent encounter for open fracture type I or II with malunion
    - R-Subsequent encounter for open fracture type IIIA, IIIB or IIIC with malunion
  - **Sequela-**S is assigned when there are complications or late effects that arise as a direct result of the fracture
- **Associated complications/injuries:** Blood vessels, infection, nerves, spinal cord injuries
- **Diagnostic tools/treatment:** CT scan, DEXA, MRI, x-ray, physical therapy, restricted activity, rest, medications prescribed

Most Common Fracture Questions and Answers

Active treatment provided by different physicians-Initial Example:

Question: Patient is seen by a physician for surgical treatment of a closed fracture. The same patient is seen by a different physician who continues to provide ongoing active treatment. Are both encounters assigned the 7th character "A" for initial encounter?

Answer: Yes, both encounters are assigned the 7th character "A, initial encounter" since both encounters provided active treatment. An initial encounter character may be used each time the patient is seen by a different provider over the course of the active treatment. The code assignment is not limited to the patient's initial medical evaluation.

Fracture follow-up provided by a new provider-Subsequent Example:

Question: A patient with a healed fracture, who is status post fracture treatment four months ago, is seen by a new provider for the first time for a follow-up visit. Is this visit to the new provider assigned the 7th character "A" for initial encounter?

Answer: Since the patient's fracture is healed and no longer receiving active treatment, you would assign the appropriate 7th character for "subsequent encounter".

Degenerative process in ankle-Sequela Example:

Question: Patient fell and broke his right ankle several years ago. He has developed a degenerative process in this same ankle and his primary care provider indicated it was related to his previous injury. Would this be coded as initial treatment?

Answer: No, in this scenario, the patient is having a residual effect after the acute phase of an injury has terminated. You would use the 7th character S for sequela.