BUTLER HEALTH SYSTEM

ICD-10 Compliant Documentation

Acute Renal Failure/Acute Kidney Injury - any of the following 3 criteria
- Serum creatinine increased by 0.3 mg/dl over baseline within 48 hours
- Rise in serum Cr ≥ 1.5 x baseline
- Urine volume < 0.5 ml/kg/hr for 6 hours
- Must document baseline creatinine

ATN (Acute Tubular Necrosis)
- Positive ATN Screen
- Relate positive screen to AKI

Chronic Kidney Disease - Must document Stage

Stage I: est. GFR ≥ 90
Stage II: est. GFR 60-89
Stage III: est. GFR 30-59
Stage IV: est. GFR 15-29
Stage V: est. GFR < 15 (not on HD/PD)
ESRD: on dialysis

Congestive Heart Failure
- Specify if acute or chronic **OR** acute on chronic
- Specify if Systolic (EF <40%) or Diastolic (>40% or heart failure with preserved systolic function) or both
- Specify right vs. left ventricular dysfunction (not always CHF)
- Important to note & document underlying cause of HF (i.e. HTN, ASHD, CKD)
- The terms "decompensated" or "exacerbation" correlate to the concept of ACUTE in ICD 10

Cardiorenal Syndrome
- HF with limited therapy due to declining renal function
- Note the reduction in estimated GFR

Pneumonia: CAP, HCAP, Nosocomial PNA —> all code to simple pneumonia
- Document responsible organism - OK to use likely/suspected or probable
- Gram Negative Pneumonia (probable) = If abx include Zoysn, Maxipime, etc.
- MRSA Pneumonia (suspected) = If abx include Vancomycin
- Aspiration Pneumonia (likely) = If abx include Clindamycin or Flagyl

Respiratory Failure: Acute, Chronic, Acute on Chronic (P/F ratio pO2/FiO2 <300)
- Acute Respiratory Failure: Respiratory distress on exam and one of the following:
  pH ≤ 7.35 &-pCO2 > 50 **or** pO2 <60 (RA pulse ox <88%)
- Include descriptive terminiology noting patient distress: sternal retractions, speaking in short sentences, using accessory muscles, cyanosis, tripod breathing/leaning forward
- Document type - **hypercapnic** or **hypoxic**
- Chronic Resp. Failure = Normal pH w/high pCO2 on ABG or continuous home O2
- Must document if continuous O2/around the clock & chronic condition - i.e. COPD
- In obesity consider OHS (Obesity Hypoventilation Syndrome)

Sepsis Definition: Infection (probable or likely) and SOME of the following:
- Temp >100.4 F or < 96.8 F
- Respiratory Rate > 20
- Altered mental status
- Hypoxemia (PaO2/FiO2 <300)
- Tachycardia > 90
- WBC's 12,000 or < 4,000 or diff > 10% bands
- CRP more than two SD above the normal value
- Severe hypotension (SBP <90 mmHg or SBP decrease >40 mmHg)

SIRS = Clinical response to a nonspecific condition of noninfectious origin
Severe Sepsis = Sepsis with end organ damage
Septicemia = Sepsis with bacteremia; "bacteremia" is just a lab finding
Septic Shock = Sepsis refractory to IVF bolus or elevated lactate
Shock = Specify type (septic, anaphlyactic, hypovolemic, hemorrhagic, cardiogenic)
- Clues to cardiogenic shock (IABP, dobutamine drip, hypotension w/poor EF)
- The term Sepsis Syndrome and Urosepsis are NOT codable dx in ICD 10

Acidosis: pH <7.35, pCO2>45, HCO3<20
Alkalosis: pH >7.45, pCO2<35, HCO3>28

Acute conditions require pH values as noted plus 1 other criteria
Chronic conditions require a normal pH value plus 1 other criteria

Acute Myocardial Infarction
- MI must be diagnoses as a STEMI or NSTEMI - if not specified - will default to NSTEMI
- Must specify the artery affected
- Document specific location; anterloateral, septal, etc.
- Note category: "initial" or "subsequent" - recent MI defined as 4 weeks or less in ICD 10 (document date)
- Physician must document clinical relevance of "troponinemia" → is it an MI?
- Chest pain is a symptom. Document diagnosis if known. Suspected is OK.
- Document tobacco use and cessation counseling

Acute Encephalopathy
- Document encephalopathy as opposed to AMS, confusion or delirium
- Document etiology: i.e., hypertensive, post-ictal, anoxic, toxic/metabolic, alcohol/drug induced, hepatic, infectious

Anemia: Document as separate problem (**acute** blood loss, aplastic, hemolytic, nutritional)
- Document type and link to suspected cause (GI bleed, acute blood loss, etc.)

Arrhythmia: Document all arrhythmias including chronic controlled
- Atrial Fibrillation - note paroxysmal, persistent or chronic
- Atrial Flutter - document type: Type I (atrial rate of 230-340 bpm), Type II (atrial rate 340-440 bpm)

Asthma: Specify mild, moderate or severe
- Specify persistent or intermittent; uncomplicated, acute or status asthmaticus

Bronchitis: Acute, subacute, chronic. Document if related to tobacco

Cirrhosis: Document etiology and complications (i.e. alcoholic cirrhosis with ascites)
- Complications (esophageal varices, ascites, jaundice)

COPD: Document **acute** exacerbation if treating; does patient have acute respiratory failure?

Diabetes Mellitus: Specify Type 1 or Type 2 (if not indicated will default to Type 2)
- Note control; inadequately controlled, out of control or poorly controlled (ICD10 does not contain any diabetes codes that use the term *uncontrolled*)
- List all known complications (acute and chronic), specify if on long term insulin

Decubitus Ulcer: Document location, cause, stage, present on admission (POA)

Excision Debridements: Must be titled as "Excisional Debridements"
1. Specifics of wound site, location & size
2. Depth debrided in tissue layers
3. Removal of devitalized/necrotic tissue
4. Exact instrumentation used

Drug Abuse: Include use, abuse, dependence. Avoid "history of" if use is current
- Underdosing: Taking less of a medication than is Rx'd; includes noncompliance
- Overdosing/Poisioning: Overdose (intentional/unintentional), wrong substance given or taken in error, wrong route of administration

Fractures: Stress, traumatic or pathological (consider osteoporosis after a fall)
- Specify R vs. L, location, joint vs. end of bone, open vs. cl., displaced/nondisplaced
- Open fx: document type per Gurstill-Anderson classification system (I, II, III)

GI Bleed: Upper vs. lower
- Document Acute Blood Loss Anemia - refrain from use of abbreviation - ABLA
- Do not use abbreviation BRBPR - must document terms
- Document the cause if known

Hypertension: List complications → hypertensive encephalopathy, hypertensive heart disease
- Hypertension codes no longer classify the type (malignant, benign or unspecified)
- The essential hypertension code INCLUDES: arterial, benign, essential, malignant, primary or systemic

Injuries: Document anatomic LOCATION, LATERALITY (R, L, B/L) and SEVERITY
- w or w/o LOC, hemorrhage, traumatic v. non-traumatic, w or w/o spinal cord damage w or w/o open wound

Malnutrition: Any 2 of the criteria below → NOT albumin/pre-albumin

Insufficient energy intake	Decr grip strength	Cachexia
Loss of Subq fat	Loss of muscle mass	Muscle wasting
Weight loss	Fluid accumulation masking wt loss	

Morbid Obesity: BMI >40 physician must document the diagnosis of Morbid Obesity

Underweight: Document underweight dx with BMI ≤19

Neoplasms: Document STAGE, LYMPH NODE INVOLVEMENT, METS

Stroke vs. TIA:
- Stroke: Document OCCLUSION, STENOSIS or EMBOLISM and SITE (R/L precerebral, vertebral, carotid or basilar artery)
- Expand documentation to note cause: thrombosis, embolism or unspecified occlusion/stenosis resulting in cerebral infarction
- Include artery involved: precerebral, cerebral
- And Laterality - i.e. right Carotid Artery
- Also if h/o CVA please note from patient assessment if with or without residuals i.e. - hemiparesis, hemiplegia
- Stroke: evidence of stroke on MRI or clinically diagnosed
- Aborted Stroke: transient sx's due to ischemia with normal MRI - following t-PA
- TIA: brief cerebral, spinal or retinal ischemia without acute infarct (MRI/MRA neg.)

Syncope and Collapse: Document cause if known - typically **not** an inpatient diagnosis

Tobacco Use: If nicotine patch ordered, document "nicotine withdrawal" if appropriate

ESSENTIAL DOCUMENTATION GUIDELINES FOR ICD 10

- Remember to document DIAGNOSES not SIGNS/SYMPTOMS
- Probable, Suspected and Likely are acceptable → these terms are preferred over "possible"
- Document **ALL DIAGNOSES** on the Discharge Summary – particularly "queried" diagnoses
- Document POA "present on admission" when appropriate
- If a "suspected" diagnosis is ruled out after study - document "ruled out" in your progress notes