Priority Health

Diagnosis coding tips

Asthma

- From the J45 code section, document and code all asthma that's under treatment, whether mild, moderate, severe, intermittent, persistent, in exacerbation, asymptomatic, stable, exercise-induced or allergic.
- When asthma is managed and inhalers are prescribed by a specialist, the PCP should address this condition with MEAT.

Cancer

- Document and code all cancer that's active (unresolved and still being treated) to the highest level of specificity using the malignant neoplasm codes in the C and D code sections.
- Document the active primary malignancy and all active secondary malignancies/metastases.
- When cancer is documented as resolved, in remission, no evidence of disease, no recurrence and no treatment is being directed toward a malignancy, use a "history of" cancer code from the Z85 code section.
- If the patient is diagnosed with cancer and is currently receiving any active treatment including adjuvant treatment for cancer, then code as an active diagnosis. If the cancer is in remission, code cancer as in remission. If the cancer is not in remission, code personal history of cancer. If the patient is on therapy for prophylaxis, code personal history of cancer.

Chronic non-pressure ulcers of the skin

- Specify the site, laterality and severity of the ulcer.
- Specify if the ulcer is current or healing.

Coagulation defects / other specified hematological disorders

- Code section D5-D7 should be documented and coded in the PCP's comprehensive record, including but not limited to, sickle cell disease, anemias, Factor V Leiden, von Willebrand, hemophilia, hereditary deficiencies.
- Document and code any resultant or related diagnoses to the hematological disorders and/or treatment pharmaceuticals, such as immunocompromise, chronic joint disease, spinal cord disease, cardiac disorder.

Some cancers, including leukemia and multiple myeloma, have code sections that differentiate between "not having achieved remission", "in remission" and "in relapse".

Chronic Obstructive Pulmonary Disease (COPD)

- Document and code COPD with lower respiratory infection, with acute exacerbation or unspecified, which would also include when it's stable.
- Don't forget respiratory failure codes, acute, chronic and for acute on chronic.
- Code the supplemental oxygen code, where applicable.

Kidney disease

- Document the stage(Stage 1-5). V28 splits Stages 3a-3b into separate HCC's.
- Document presumed linked diagnoses for CKD.
- Document dialysis and dependence status.

Major depressive, bipolar and paranoid disorders

- Avoid nonspecific behavioral health diagnoses whenever possible. Instead, choose a code that specifies mild, moderate, severe and single episode versus recurrent.
- When depression is severe, document if the condition is with or without psychotic features.

Morbid obesity

- Weight-related diagnosis codes are used with abnormal BMI codes, at the provider's discretion, to fully describe the condition (BMI codes alone are insufficient). Medical record documentation of the weight-related diagnosis and diet/exercise counseling are also required to support the code.
- BMI mapping
    - =/> 30 → Obesity
    - =/> 40 → Morbid obesity
    - =/> 35 with related comorbidities and provider supported documentation → Morbid obesity

Myocardial infarction

- Document the site and type (Type 1-5) of the infarction; acute MI during the 4 week (28 day) acute phase; 'old MI' after 28 days; any relevant co-existing conditions.

Rheumatoid arthritis / inflammatory connective tissue disease

- All types of rheumatoid arthritis and other inflammatory connective tissue diseases, such as systemic sclerosis, Sjogren, psoriasis, lupus and more, can be documented and coded according to the code section M0-M3.
- Code to greatest specificity regarding type, location and laterality; since there's no bilateral option in this code section, use both laterality codes (2 codes, left and right) to describe bilateral disease.

Seizure disorders and convulsions

- Document and code all epilepsy and other seizure disorders (code section G40) to the greatest specificity including options of generalized, focal partial, symptomatic, idiopathic, intractable/not intractable.
- When seizures have been absent for a long period of time due to pharmaceutical treatment that's still current and active, document and code the seizure disorder to support the medication that's yielding stable control of the condition.

Deep vein thrombosis (DVT)

- Specify if the DVT is acute, chronic or history of.
- Document laterality and/or the vessels involved.
- Specify the timeframe on anti-coagulants.

Dementia

- Dementia maps in the new V28 model by severity whether its mild, moderate or severe.

Diabetes Mellitus (DM) with complications

- Submit all codes from the "DM with complications" category that describe related conditions, such as CKD and other nephropathy, retinopathy, angiopathy and other circulatory complications, neuropathy, arthropathy, skin ulcers, periodontal disease, ketoacidosis, hypoglycemia, hyperglycemia.
- Long-term current use of insulin and on oral hypoglycemic medication can both be coded when applicable.

DM without complications

- Appropriate when the diabetes is well controlled w/o related conditions.
- Long-term current use of insulin and on oral hypoglycemic medication can both be coded when applicable.

Endocrine and metabolic disorders

- Examples: Parathyroid, pituitary and adrenal gland disease, mucopolysaccharidosis and amyloidosis, among other metabolic and endocrine system disorders and deficiencies.
- Document and code these conditions, whether congenital or secondary, to the highest level of specificity.

Heart failure (HF)

- Code on its own or in relation to hypertensive heart disease and/or diabetes.
- HF codes in the I50 code section are the same regardless of association.
- Associated HTN codes change in relationship to HF and DM (codes I10-I13).

Anticoagulant timeframes

Initial: w/in the first 10 days

Long term: 3-6 months or administered indefinitely

Code for pancreas transplant status, when applicable. This code now maps to an HCC in the V28 model.

Heart transplant status now maps to an HCC in the V28 model.

HTN-DM-HF-CKD

- Hypertension, diabetes, heart failure and renal disease have assumed relationships in the ICD-10-CM code set.
- The HTN code changes from I10 to a combination code with HF, CKD or both, ranging from I11-I13.
- The DM code section also has combination codes to reflect DM w/CKD.
- Include all condition codes with the combination code. Example: Hypertensive heart disease with heart failure and chronic kidney disease, along with diabetes with chronic kidney disease would be coded with the HTN combo code, the DM combo code, the HF code and the CKD code.

Specified heart arrhythmias

- Code all active cardiac arrhythmias and blocks to the highest level of specificity from codes I44-I49 and choose only one code per arrhythmia. For example, choose one code for atrial fibrillation (a-fib) from the options of paroxysmal, persistent, longstanding persistent, other persistent, permanent, chronic.
- If a-fib is treated and controlled by a pacemaker, code only the pacemaker, not the a-fib. If a pacemaker and pharmaceutical are used to control the a-fib, code the pacemaker and the a-fib.

Substance use disorders

- Use only one descriptor (i.e., use, abuse or dependence) per substance on any given date of service. If two are documented, code the most severe.
- Use the ICD-10-CM codes for substance disorders in remission, rather than active substance use disorder codes, when remission is documented.

Vascular disease

- Document and code all vascular disease, whether cerebral (code section I6), cardiac (code section I25) or peripheral (code section I7 and I8) and its effects, i.e., paresis, angina, skin ulcer.
- Code to greatest specificity including specific vessels involved, as well as laterality.
- Code CVA and other vascular events including embolism/thrombus appropriately based on acute episode versus chronic phase/residual deficit. For example, the actual CVA would be coded during the ER visit, hospital admission, and any immediate subsequent short-term rehab. After this, a code should be used to describe the history of the CVA without residual deficits or a code to describe the specific residual deficit resulting from CVA , such as hemiplegia following nontraumatic intracerebral hemorrhage.

ICD-10-CM definition of "Substance"
Nicotine, cannabis, alcohol, opioid, sedative, cocaine, inhalant, hallucinogen, heroin and more.

Be specific since vascular disease without complications will no longer map to an HCC in the V28 model.