ICD-10 incorporates much greater clinical detail and specificity as well as updated terminology to be consistent with current clinical practices.

ICD-10-CM diagnosis codes offer much more specificity because of the expansion of codes. In the event that you have a patient with a condition which is impacting your care plan, but that you are not directly treating, it is still possible to assign nonspecific codes. Otherwise, it is imperative that the most specific code be reported to maximize ICD-10's ability to provide meaningful data on patient care and severity of illness. Please refer to the enclosed crosswalk showing the ICD-9 codes used most frequently by Hospital Medicine Providers and the ICD-10 codes to which they map.

Below are some of the diagnoses/conditions that have expanded code specificity:

### Altered Mental Status
- Document the etiology of the altered mental status as:
  - Coma
  - Confusion/delirium (including drug-induced)
  - Drowsiness/somnolence
  - Stupor/semi-coma
  - Transient alteration of awareness
- Encephalopathy
  * Alcoholic
  * Anoxic/hypoxic
  * Drug-induced/toxic *(specify drug)*
  * Metabolic/septic
- (Document underlying cause of encephalopathy)
- Document any associated diagnoses/conditions

### Anemia
- Documentation of Anemia should include the type of anemia:
  - Nutritional (iron deficiency, vitamin B12 deficiency, dietary or drug induced, vegan)
  - Hemolytic
  - Aplastic
  - Due to blood loss (acute or chronic)
  - Other (please specify)
- Include in documentation if Anemia is due to nutrition or mineral deficits, resulting in a nutritional anemia
- Document if the Anemia is due to a neoplasm (primary and/or secondary)
- Document whether the ANEMIA is “related to or due to” chemo or radiotherapy treatments
- Document any “cause–and-effect” relationship between the intervention and the blood or immune disorder
- Document the specific drug if anemia is drug-induced
Link any laboratory findings to a related diagnosis (if appropriate)
Document any associated diagnoses/conditions

Burns
- Type:
  - Corrosion
  - Thermal
- Site:
  - Specify body part
  - Include laterality
- Degree:
  - First
  - Second
  - Third
- Document total body surface area (TBSA) burned (percentage)
- Specify the percentage of third degree burns
- Include the external cause of the burn, such as house fire, stove, acid, etc.
- Document any associated diagnoses/conditions

Cardiac Arrest
- When there is a “Cardiac Arrest” the documentation should include:
  - due to underlying cardiac condition
  - due to other underlying condition
  - cardiac arrest, cause unspecified
- In addition, specify if:
  - postprocedural cardiac arrest following cardiac surgery
  - postprocedural cardiac arrest following other surgery
  - intraoperative cardiac arrest during cardiac surgery
  - intraoperative cardiac arrest during other surgery
- Always document the “underlying cardiac condition” if known
- Document any associated diagnoses/conditions

Circulatory and Vascular Disorders
- CHF
  - Acute, chronic or acute on chronic
  - Systolic, diastolic or systolic and diastolic
- MI
  - Specify artery of involvement (if known), such as left main coronary and location such as inferior or anterior wall
  - Document date of any recent acute MIs within 28 days of admission
  - Document whether or not the current MI has occurred within 28 days of a previous MI
- Hypotension
  - Document type (orthostatic, postural, idiopathic, drug-induced, chronic, postoperative, other, etc.)
- Peripheral Vascular Disease
  - PVD can be further specified to a site with laterality
    (native vs. bypass graft arteries, at rest vs. intermittent claudication, with or without ulcer or gangrene)
- Chest Pain – specify by exact location or type
  - anterior wall, precordial, intercostal
  - non-cardiac, on breathing, pleurodynia, ischemic, atypical
- Cardiomyopathy
  - Dilated
  - Obstructive hypertrophic
  - Other hypertrophic
  - Endomyocardial
  - Endocardial
  - Other restrictive
  - Alcoholic
  - Due to Drug or external agent or other

**Diabetes:** (documentation will need to include)
- Type or cause of diabetes:
  - Type 1
  - Type 2
  - Due to drugs or chemicals
  - Due to underlying condition
  - Other specified diabetes
  - Poorly controlled or out of control diabetes is reported as diabetes with hyperglycemia
  - Insulin Use
- Body system complications related to diabetes, such as kidney or neurological complications
  *The physician must state a cause and effect relationship before the condition is reported as a diabetic condition.*
  Specific complications, such as: Chronic kidney disease, Foot ulcer

**Digestive System**

**Crohn’s Disease/Regional Enteritis**
- With Complication
  - Abscess
  - Fistula
  - Intestinal obstruction
  - Rectal bleeding
  - Other (specify)
- Site
  - Small intestine
  - Large intestine
  - Both small and large intestines
- Document any associated diagnoses/conditions

**Hepatic Encephalopathy**
- Etiology
Due to alcohol
Due to drugs
Post-procedural

- Acuity
  - Acute
  - Subacute
  - Chronic

- Severity
  - With coma
  - Without coma

- Document any associated diagnoses/conditions

Kidney Disease

Acute Kidney Failure

- Document underlying condition(s) contributing/causing acute renal failure if known or suspected
- Document if acute kidney injury (AKI) is due to traumatic injury or if due to a non-traumatic event
- Document if acute renal failure is due to:
  - Acute tubular necrosis (ATN)
  - Acute cortical necrosis
  - Acute medullary necrosis
  - Other (specify)
- Be specific with documentation
  - Acute renal insufficiency and acute kidney disease are not reported as acute renal failure
- Document any associated diagnoses/conditions

Chronic Kidney Disease

- Document the stage of CKD
- Document any underlying cause of CKD such as Diabetes or Hypertension
- Document if the patient is dependent on Dialysis
- Chronic renal failure without a documented stage will be assigned to Chronic kidney disease, unspecified
- Document any associated diagnoses/conditions

Malnutrition

- Severity:
  - Mild (first degree)
  - Moderate (second degree)
  - Severe (third degree)
- Avoid documenting a range of severity, such as “moderate to severe”
- Form:
  - Kwashiorkor (rarely seen in the U.S.)
  - Marasmus
  - Marasmic kwashiorkor
  - Other
MRSA/MSSA
Methicillin-resistant Staphylococcus aureus
- Include documentation of “MRSA infection” when the patient has that condition.
- Document if sepsis and/or septic shock is present.
- Document any associated diagnoses/conditions.

Methicillin susceptible Staphylococcus aureus
- Include documentation of “MSSA infection” when the patient has that condition.
- Document if sepsis, and/or septic shock is present.
- Document any associated diagnoses/conditions.

Musculoskeletal Disorders
- Osteoarthritis
  - Specify type (primary/secondary) and location
- Rheumatoid arthritis
  - Specify type and location as well as with and without rheumatoid factor and organ or system involvement
- Chronic pain
  - Specify if due to trauma, post-thoracotomy, or other post-procedural chronic pain
- Back pain
  - Specify by exact location
- Osteopenia
  - Specify by the affected site as well as laterality

Neurology Diagnoses
- Hemiplegia
  - Laterality
  - Flaccid or Spastic
  - Affected Side – Dominant or Non-Dominant
- Migraines
  - Specify type (with or without aura, intractable or not intractable)
- Epilepsy
  - Specify type (intractable or not intractable, with or without status epilepticus)
- Alzheimer’s
  - Early onset
  - Late onset
- Convulsions
  - Specify type (simple febrile, complex febrile, post traumatic, due to epilepsy, etc.)

Respiratory Disorders (documentation will need to include the following if known)
- Respiratory Failure:
  - With hypoxia
  - With hypercapnia
  - Acute
- Chronic
- Acute and chronic

- Asthma:
  - Mild intermittent
  - Mild persistent
  - Moderate persistent
  - Severe persistent
  - With acute exacerbation
  - With status asthmaticus

- Pneumonia
  - Document causative organism (if known)
  - Document mechanism:
    * Aspiration
    * Ventilator-associated
    * Radiation-induced
    * Other (specify)

- Bronchitis
  - Document acuity and if specific organism is known

- Document history of tobacco use—present or past

Systemic Infection/Inflammation

- Bacteremia (positive blood cultures only)
- Urosepsis—MUST specify sepsis with UTI, versus UTI only
- Sepsis—specify causative organism if known
- Sepsis due to:
  - Device
  - Implant
  - Graft
  - Infusion
  - Abortion
- Severe sepsis—sepsis with organ dysfunction
  - Specify organ dysfunction
    * Respiratory failure
    * Encephalopathy
    * Acute kidney failure
    * Other (specify)
- SIRS (Systemic Inflammatory Response Syndrome)
  - With or without organ dysfunction
- Document septic shock if present
- Document any associated diagnoses/conditions

Ulcers

Pressure Ulcers

- Site (include laterality):
-Elbow    -Sacral    -Buttock    -Heel    -Other
-Back (upper/lower)    -Hip    -Ankle    -Head

- Pressure Ulcer Stage: --Other (specify)
- With gangrene
- Document any associated diagnoses/conditions
- Document if ulcer (including stage) is present on admission

Non-Pressure Ulcers

- Site:
- Laterality
- Specific site/area (e.g. ankle, calf, heel/midfoot, plantar surface, thigh)
- Ulcer depth:
  - Limited to skin breakdown
  - With fat layer exposed
  - With muscle necrosis
  - With bone necrosis
- Cause of lower limb ulcers:
  - Atherosclerosis of lower extremity
  - Chronic venous hypertension
  - Diabetic ulcer
  - Postphlebitic syndrome
  - Postthrombotic syndrome
  - Varicose ulcer
  - Other (specify)
- With gangrene
- Document any associated diagnoses/conditions

Alcohol, Tobacco and Substance Use

- Identify the specific type of drug or substance
- Describe the frequency of usage as:
  - Use
  - Dependence
  - Abuse
  - In remission
- Describe mode of nicotine use as cigarettes, chewing tobacco, pipe, and/or gum
- Specify intoxication/withdrawal as “Uncomplicated” or “With delirium”
- Document any withdrawal symptoms
- Document any associated diagnoses/conditions
- List the blood alcohol level, if available
- State “no related complications,” when applicable
- Document any related mood disorder
- Document any delusions, hallucinations, anxiety, sleep disorders, sexual dysfunctions, or other related conditions
- List any treatment provided:
  - Detoxification services
  - Medication management
  - Counseling
  - Pharmacotherapy
  - Psychotherapy
**Underdosing**

Under-dosing is a new code in ICD-10-CM. It identifies situations in which a patient has taken less of a medication than prescribed by the physician. The medical condition is sequenced first followed by the underdosing code. If known, additional information can be captured to explain why the patient is not taking the medication (e.g., financial reasons).

- Using a prescribed medication less frequently than prescribed, in small doses, or not using the medication as instructed should be documented as “underdosing” by the provider.
- If the reduction in the prescribed dose of the medication results in a relapse or an exacerbation of the medical condition for which the drug is prescribed, the medical condition must also be documented.