International Classification of Diseases, 10th Revision (ICD-10)

As of October 2015, International Classification of Diseases, 10th Revision (ICD-10) was published by the World Health Organization (WHO). The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings.
The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated. Diagnosis codes are to be used and reported at their highest level of specificity.

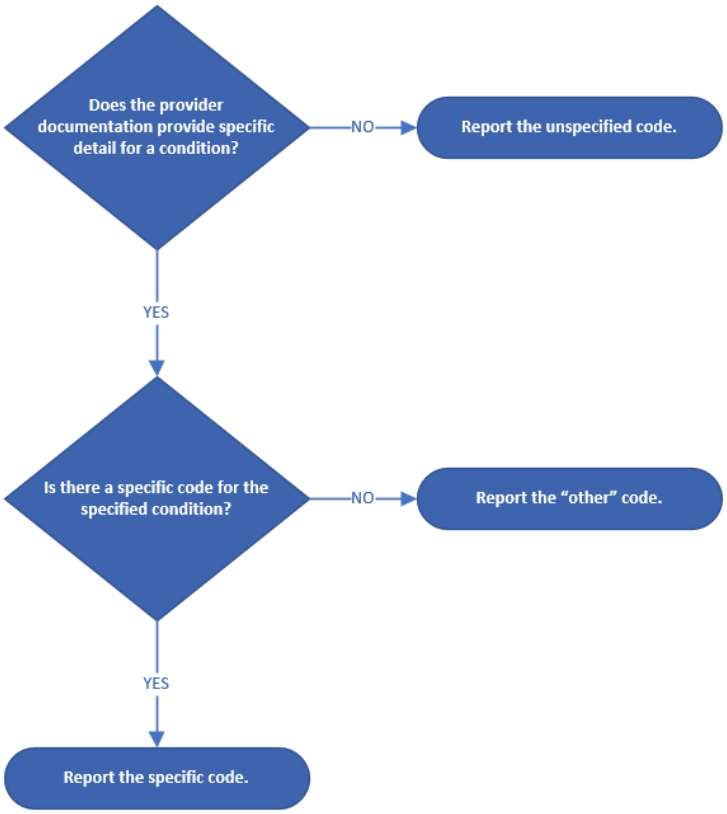
Signs and Symptoms

When a definitive diagnosis has not been established (confirmed) by the provider, use codes that describe signs and symptoms.

Example: Patient's symptoms are chest pain, cough with phlegm, high fever, and difficulty breathing. Chest x-ray and lab work ordered for confirmed diagnosis.
Report patient's signs and symptoms until patient's x-ray and lab work has confirmed the patient's specific diagnosis.

At the time of the encounter, signs and symptoms should be coded. Based on the x-ray and lab results, any follow-up encounter will be coded as the confirmed diagnosis.

Unspecified vs Other Specified



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Unspecified Codes

Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. Report unspecified codes according to what is known about the patient's condition at the time of that encounter.

Example: Once signs and symptoms have been diagnosed as a condition such as pneumonia, but the specific type has not been determined, it would be appropriate to report an unspecified diagnosis code.

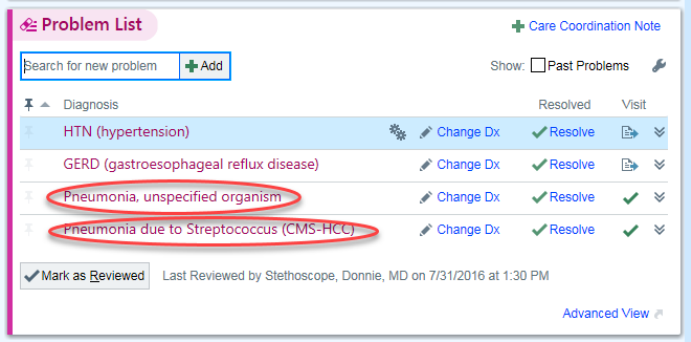
J15.20	Pneumonia due to staphylococcus, **unspecified**

Once specific pneumonia type has been determined use a more specific diagnosis (see examples below)

J15.211	Pneumonia due to Methicillin susceptible Staphylococcus aureus
J15.212	Pneumonia due to Methicillin resistant Staphylococcus aureus
J15.29	Pneumonia due to other staphylococcus
J15.3	Pneumonia due to streptococcus, group B
J15.4	Pneumonia due to other streptococci

Note: Unspecified diagnosis codes may be flagged during claim adjudication and may require the provider to submit documentation to justify the unspecified code.

Below is an example of conflicting diagnosis in the patient's problem list.
Once definitive diagnosis has been determined, **review and update** patient's problem list in EPIC.



"Other Specified" Diagnosis Codes

Use "other specified" diagnosis codes when the information in the medical record provides detail for a code that does not exist in ICD-10 and the provider is left with choosing a more generalized code.

Examples:
E07.89 (Other specified disorders of thyroid) can be used for abnormality of thyroid-binding globulin, hemorrhage of thyroid, or infarction of thyroid

E04.8 (Other specified nontoxic goiter) can be used for a nodular enlargement of the thyroid gland that isn't related to an inflammatory or neoplastic process and is not associated with abnormal thyroid function.

Resources:
https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2020-Coding-Guidelines.pdf
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1518.pdf