

CHAPTER 18

SYMPTOMS, SIGNS AND ABNORMAL CLINICAL AND LABORATORY FINDINGS (R00-R99)

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CHAPTER SPECIFIC CATEGORY CODE BLOCKS

- R00-R09 Symptoms and signs involving the circulatory and respiratory systems
- R10-R19 Symptoms and signs involving the digestive system and abdomen
- R20-R23 Symptoms and signs involving the skin and subcutaneous tissue
- R25-R29 Symptoms and signs involving the nervous and musculoskeletal systems
- R30-R39 Symptoms and signs involving the urinary system
- R40-R46 Symptoms and signs involving cognition, perception, emotional state and behavior
- R47-R49 Symptoms and signs involving speech and voice
- R50-R69 General symptoms and signs
- R70-R79 Abnormal findings on examination of blood, without diagnosis

CHAPTER SPECIFIC CATEGORY CODE BLOCKS

- R80-R82 Abnormal findings on examination of urine, without diagnosis
- R83-R89 Abnormal findings on examination of other body fluids, substances and tissues, without diagnosis
- R90-R94 Abnormal findings on diagnostic imaging and in function studies, without diagnosis
- R97 Abnormal tumor markers
- R99 Ill-defined and unknown cause of mortality

CHAPTER NOTES

- This chapter includes symptoms, signs, abnormal results of clinical or other investigative procedures and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded.
- Signs and symptoms that point rather definitely to a given diagnosis have been assigned to a category in other chapters of the classification.
- In general, categories in this chapter include the less well-defined conditions and symptoms that, without necessary study of the case to establish a final diagnosis, point perhaps equally to two or more diseases or to two or more systems of the body.
- Practically all categories in the chapter could be designated ‘not otherwise specified’, ‘unknown etiology’ or ‘transient’.
- The Alphabetic Index should be consulted to determine which symptoms and signs are to be allocated here and which to other chapters .
- The residual subcategories, numbered .8, are generally provided for other relevant symptoms that cannot be allocated elsewhere in the classification.

CHAPTER NOTES (cont.)

- The conditions and signs or symptoms included in categories R00-R94 consist of:
 - a. Cases for which no more specific diagnosis can be made even after all the facts bearing on the case have been investigated.
 - b. Signs or symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined.
 - c. Provisional diagnosis in a patient who failed to return for further investigation or care.
 - d. Cases referred elsewhere for investigation or treatment before the diagnosis was made.
 - e. Cases in which a more precise diagnosis was not available for any other reason.
 - f. Certain symptoms, for which supplementary information is provided. That represent important problems in medical care in their own right.

USE OF SYMPTOM CODES

- Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

USE OF A SYMPTOM CODE WITH A DEFINITIVE DIAGNOSIS CODE

- Code for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes.
- The definitive diagnosis code should be sequenced before the symptom code.
- Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

COMBINATION CODES THAT INCLUDE SYMPTOMS

- ICD-10 contains a number of combination codes that identify both the definitive diagnosis and common symptoms of that diagnosis.
- When using one of these combination codes, an additional code should not be assigned for the symptom.

REPEATED FALLS

- Code R29.6, Repeated falls, is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated.
- Code Z91.81, History of falling, is for use when a patient has fallen in the past and is at risk for future falls.
- When appropriate, both codes R29.6 and Z91.81 may be assigned together.

COMA SCALE

- The coma scale codes (R40.2-) can be used in conjunction with traumatic brain injury codes, acute cerebrovascular disease or sequelae of cerebrovascular disease codes.
- These codes are primarily for use by trauma registries, but they may be used in any setting where this information is collected.
- The coma scale codes should be sequenced after the diagnosis code(s).
- Three codes are needed one from each subcategory (R40.21, R40.22 and R40.23) to complete the scale.
- The 7th character should match for all three codes.
- At a minimum, report the initial score documented on presentation at your facility.
- This may be a score from the emergency medicine technician (EMT) or in the emergency department.

COMA SCALE (cont.)

- If desired, a facility may choose to capture multiple coma scale scores.
- Assign code R40.24, Glasgow coma scale, total score, when only the total score is documented in the medical record and not the individual score(s).
- Seventh character indicates when the scale was recorded – should match for all three codes:

0	Unspecified time
1	In field (EMT or ambulance)
2	At arrival to ER
3	At hospital admission
4	24 hours after admission

FUNCTIONAL QUADRIPLÉGIA

- Functional quadriplegia (code R53.2) is the lack of ability to use one's limbs or to ambulate due to extreme debility.
- It is not associated with neurologic deficit or injury, and code R53.2 should not be used for cases of neurologic quadriplegia.
- It should only be assigned if functional quadriplegia is specifically documented in the medical record.
- Coders may never see the term 'functional quadriplegia' documented in a medical record; however, documentation may include 'complete immobility' for patients who are frail or who have disabling physical conditions, in this case you would query the physician for exact condition.

SIRS (SYSTEMIC INFLAMMATORY RESPONSE SYNDROME) DUE TO NON-INFECTIOUS PROCESS

- The systemic inflammatory response syndrome (SIRS) can develop as a result of certain non-infectious diseases processes, such as trauma, malignant neoplasm, or pancreatitis.
- When SIRS is documented with a noninfectious condition, and no subsequent infection is documented, the code for the underlying condition, such as injury, should be assigned, followed by code R65.10, Systemic inflammatory response syndrome (SIRS) of non-infectious origin without acute organ dysfunction, or code R65.11, Systemic inflammatory response syndrome (SIRS) of non-infectious origin with acute dysfunction.
- If an associated acute organ dysfunction is documented, the appropriate code(s) for the specific type of organ dysfunction(s) should be assigned in addition to code R65.11.
- If acute organ dysfunction is documented, but it cannot be determined if the acute organ dysfunction is associated with SIRS or due to another condition (e.g., directly due to the trauma), the provider should be queried.
- Sepsis not classified to R65 - coded to infection. e.g., A41.9 assigned for sepsis, unspecified

DEATH NOS

- Code R99, Ill-defined and unknown cause of mortality, is only for use in the very limited circumstance when a patient who has already died is brought into an emergency department or other healthcare facility and is pronounced dead upon arrival.
- It does not represent the discharge disposition of death.

CODING EXAMPLES

1. Assign the Glasgow coma scale code(s) when the patient had the following documented by the EMT: Eyes do not open, no verbal response, with no motor response. The neurologist documented the following on day 2 of the hospital admission: Eyes open to sound, verbal response produced inappropriate words, and motor response with flexion withdrawal.

Answer: R40.2111-Coma, with opening of eyes (never)
R40.2211-Coma, with verbal response (none)
R40.2311-Coma, with motor response (none)
R40.2134-Coma, with opening of eyes, in response to sound
R40.2234-Coma, with verbal response, inappropriate words
R40.2344-Coma, with motor response, flexion withdrawal

Rationale: In order to report the scale, all three categories must be identified. The first set of codes identified the condition as reported by the EMT. The second set of codes corresponds to the neurologist's assessment on day two. It is appropriate to report more than one set of codes if desired. The seventh character for the first set of codes (1) identifies that this was done by the EMT in the field, and the second set (4) 24 hours or more after hospital admission. This case is used to illustrate the coma scale codes, but they would not be used alone.

CODING EXAMPLES (cont.)

2. The patient is admitted through the emergency room with a complaint of chest pain. The EKG and laboratory tests completed in the ER are inconclusive, but an acute myocardial infarction is ruled out. During the hospital stay, the cardiovascular workup did not reveal any coronary artery disease and the patient did not want to have a cardiac catheterization study performed at this time. The patient is known to have gastroesophageal reflux disease. Given the conflicting information, the attending physician concluded the patient had “atypical chest pain due to wither angina or GERD.” What diagnosis codes are assigned?

Answer: R07.89-Pain(s), chest (central), atypical

I20.9-Angina (attack) (cardiac) (chest) (heart) (pectoris) (syndrome) (vasomotor)

K21.9-Disease, diseased, gastroesophageal reflux (GERD)

Rationale: In the instance where a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional codes.

CODING EXAMPLES (cont.)

3. The patient who has experienced a fever of 101 degrees Fahrenheit with chills was brought to the emergency room. Laboratory tests, including a complete blood count and urinalysis, were performed with normal results. The ER physician wrote the final diagnosis as “fever with chills , possible viral syndrome.” What diagnosis code is assigned?

Answer: R50.9-Fever (inanimation) (of unknown origin) (persistent) (with chills) (with rigor)

Rationale: ICD-10-CM Diagnostic Coding and Reporting Guidelines for Outpatient Services (IV. H.) states the following for uncertain diagnoses: “Do not code diagnoses documented as ‘probable,’ ‘suspected,’ ‘questionable,’ ‘rule out,’ or ‘working diagnosis,’ or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reasons for the visit.” It would be incorrect to code the viral syndrome in this case. Fever, unspecified includes fever with chills.

CODING EXAMPLES (cont.)

4. The patient is seen complaining of right upper quadrant abdominal pain. In addition, the patient is having nausea and vomited several times. Patient also has elevated blood pressure readings but a diagnosis of hypertension is not made at this visit. The patient was given an order for an outpatient sonogram. What diagnosis codes are assigned?

Answer: R10.11-Pain(s) (see also Painful), abdominal, upper, right quadrant
R11.2-Nausea, with vomiting
R03.0-Elevated, elevation, blood pressure, reading (incidental) (isolated)
(nonspecific), no diagnosis of hypertension

Rationale: No conclusive diagnosis was documented, therefore the symptoms are coded.

CODING EXAMPLES (cont.)

5. Assign the code for the following diagnosis: Microcalcification found on breast mammography.

Answer: R92.0-Microcalcifications, breast

Rationale: ICD-10-CM has individual codes for mammographic microcalcification found on diagnostic imaging of the breast and mammographic calcification found on diagnostic imaging of breast.

6. Assign the code(s) for the following diagnosis: Sinoatrial bradycardia

Answer: R00.1-Bradycardia (sinoatrial) (sinus) (vagal)

Rationale: Code R00.1 includes sinoatrial bradycardia. In ICD-9-CM, this condition is classified in the Circulatory chapter, while in ICD-10-CM it is in Chapter 18. There is an Excludes one note at category I49, Other cardiac arrhythmias, excluding bradycardia.

TRAINING SOURCES

American Health Information Management Association

www.ahima.org

American Academy of Professional Coders

www.aapc.com

HCPRO

www.hcpro.com