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ICD10 (International Classification of Diseases) Clinical Coding Policy

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Type of document	Policy
Target audience	All clinical staff and the Corporate Information Team
Document purpose	To provide staff with the ICD10 clinical coding standards and requirements

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CWP documents to be read in conjunction with	HR6	Mandatory Employee Learning (MEL) policy
	CP3	Health records policy
	IM10	Information Governance Policy
	IM3	Data Quality Policy
	IM4	Standards of secondary use of information policy

Document change history

Changes made with rationale and impact on practice
1. New policy

To view the documents Equality Impact Assessment (EIA) and see who the document was consulted with during the review please click here

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1. Introduction

Clinical coding is the translation of medical terminology describing the reason for a patient's encounter; such as a patient's complaint, problem, diagnosis, treatment or other reason for medical attention; into statistical code using ICD10 codes (International Classification of Diseases version 10) to support both statistical and clinical uses.

Clinical coding has many uses. It records clinical activity using information such as clinical diagnoses, symptoms and procedures recorded in health records. The information is also used to manage and plan future services and contributes to medical knowledge and the development of new methods of treatment. Statistically the information is used to study the incidence of disease and health care planning and directing funding to the correct resources.

The aim of this policy is to provide information for clinicians to use ICD-10 more effectively.

To state the importance and responsibility of coding correctly In order to demonstrate compliance with the Information Governance toolkit, the trust needs to achieve accurate coding for both primary and secondary diagnosis.

The primary diagnosis of inpatient episodes are recorded and submitted as a mandatory part of the Mental Health Minimum Data Set (MHMDS). If outpatient and community episodes are coded then these will also be submitted as part of the MHMDS. For every diagnosis recorded on CareNotes (electronic health record) the Mental Health Minimum Data Set requires:

1. Patient ID;
2. Date of Diagnosis;
3. ICD10 Code (e.g. F32.3).

Flowchart for ICD10 clinical coding process see appendix 1

In order to support the clinicians who use the ICD-10 for categorisation of people who use services, this policy has been developed. The information detailed within the policy is taken from Clinical Coders guidelines and Information Standards Board documents.

It is the responsibility of clinicians to ensure that they are aware of the coding systems that they use. The use of coding helps and supports decision making for NHS Managers to support operational and strategic planning of services. If coding is not done correctly it can adversely impact on strategic service development and misrepresent the need of the service users of the Trust. It is imperative for the clinical coding to be correct to enable us to shape and deliver a service that meets the needs of the people we serve.

To create an ICD10 document in the CareNotes system please refer to section 7.6 of the CareNotes V4 user guide on the informatics section of the intranet by using the following link.

Note: the other systems in use within the Trust are not included as they do not record in patient episodes which are currently the only episodes mandated by MHMDS.

2. Diagnosis definitions

A major source of debate within clinical forums is what constitutes a primary and secondary diagnosis within conditions of chronicity. There is a distinction between primary and secondary diagnoses. The standardised definition used by Clinical Coders is:

2.1 Primary diagnosis definition

i) The first field of the coded clinical record (the primary diagnosis) will contain the main condition treated or investigated during the relevant episode of healthcare (the focus of assessment or treatment). This might be a Mental Health Disorder e.g. F32.1 (Moderate Depression).

ii) Where a definitive diagnosis has not been made by the responsible clinician, the main symptom, abnormal findings, or problem should be recorded in the first diagnosis field of the coded clinical record e.g. R44.1 Visual Hallucinations. If there is no symptom a Psychosocial (Z) code may be appropriate. If there is no disorder, no symptom and no other relevant Z code (unlikely) Z03.2 Observation for suspected mental and behavioural disorders could be used.

The above define the contents of the first diagnosis field of the coded clinical record. Clinical coders must continue to code any other relevant clinical information.

2.2 Secondary diagnostic definition

Medical conditions and other factors influencing health that are always considered to be clinically relevant. The conditions included on this list must always be coded for any Admitted Patient Care episode (including Day cases) when documented in the patient's medical record for the current hospital provider spell, regardless of specialty.

This includes chronic conditions that are considered to impact on patient care. As well as these any condition that are treated or managed while an inpatient should also be recorded (acute infections, injuries, etc). A full list of the conditions identified below are taken from Coding Clinic guides, it is important to note that a number of conditions/circumstances are detailed as secondary diagnosis that should be appropriately coded if exist within that episode of care. Clinicians need to consider the breadth of the conditions listed below such as those that would not in other circumstances be defined as a condition, i.e. living alone (where this has extended the hospital stay):

Condition	Reference to published guidance
Abnormal liver function tests (in the absence of an underlying cause)	Page XVIII-21 of the National Clinical Coding Standards ICD-10 4th Edition reference book
Alcohol abuse	Pages V-4 and V-5 of the National Clinical Coding Standards ICD-10 4th Edition reference book.
Alzheimer's disease including dementia in Alzheimer's disease	
Anxiety disorders including anxiety	Page V-8 of the National Clinical Coding Standards ICD-10 4th Edition reference book
Asthma	
Autism	
Cerebrovascular diseases	Pages IX-21 to IX-23 of the National Clinical Coding Standards ICD-10 4th Edition reference book.
Chronic bronchitis	
Chronic kidney diseases including chronic tubulo-interstitial nephritis, small kidney(s) and polycystic kidney(s)	
Chronic obstructive pulmonary disease / Chronic obstructive airways disease	
Congestive cardiac failure	
Current anti-coagulant therapy	
Current smoker	Pages V-4 to V-6 of the National Clinical Coding Standards ICD-10 4th Edition reference book.
Dementia including dementia in Alzheimer's disease	
Depressive disorders including depression and bipolar disorder	
Developmental delay including learning difficulties and learning disability	Pages V-11 and V-12 of the National Clinical Coding Standards ICD-10 4th Edition reference book.
Diabetes Mellitus	

Condition	Reference to published guidance
Drug abuse	Pages V-4 and V-6 of the National Clinical Coding Standards ICD-10 4th Edition reference book.
Dysphagia (difficulty in swallowing)	Pages IX-22, XVIII-2, XVIII-3 and XVIII-13 of the National Clinical Coding Standards ICD-10 4th Edition reference book
Dysphasia	Pages IX-22, XVIII-2, XVIII-3 and XVIII-13 of the National Clinical Coding Standards ICD-10 4th Edition reference book
Eating disorders	Page V-10 of the National Clinical Coding Standards ICD-10 4th Edition reference book
Emphysema	
Epilepsy	
Elderly / Geriatric falls	Pages XVIII-8 to XVIII-10 of the National Clinical Coding Standards ICD-10 4th Edition reference book
Heart failure	
Hemiplegia	Pages IX-22, XVIII-2, of the National Clinical Coding Standards ICD-10 4th Edition reference book.
Hypertension	
Ischaemic heart disease	Pages IX-7 to IX-16 of the National Clinical Coding Standards ICD-10 4th Edition reference book.
Jaundice	Pages XVIII-2 and XVIII-3 of the National Clinical Coding Standards ICD-10 4th Edition reference book
Left ventricular failure	
Living alone	Page XXI-25 of the National Clinical Coding Standards ICD-10 4th Edition reference book.
Mitral valve disease	
Multiple sclerosis	
Personal history of anti-coagulant therapy	
Personal history of self-harm	
Presence of cardiac pacemaker	
Psychosis and psychotic disorders including schizophrenia, schizotypal and delusional disorders	
Registered blind	Page VII-10 of the National Clinical Coding Standards ICD-10 4th Edition reference book.
Renal failure	
Respiratory failure	Page X-16 of the National Clinical Coding Standards ICD-10 4th Edition reference book
Rheumatoid arthritis	
Severe or profound hearing loss	Page VIII-6 of the National Clinical Coding Standards ICD-10 4th Edition reference book
Urinary retention	Page XIV-15, XVIII-11 of the National Clinical Coding Standards ICD-10 4th Edition reference book.

Note: only those conditions which have an accompanying standard have a note, e.g. dysphagia would not be coded if a condition giving rise to it was known, and the dysphagia was not treated it its own right. Coding Clinic September 2013 [V3.1] (PDF, 697.6kB)

3. Secondary diagnosis guidelines and case studies

Secondary Codes are for "background" disorders or issues. For example, CAMHS relevant codes might include developmental disorders such as Hyperkinetic Disorder (F90), ASD (F84) or LD (F70-79),

There may also be “risk factors” (usually Z codes) such as Z62.3 (Hostility towards or scapegoating of child) or Z81.1 (Family History of alcohol abuse). Asthma (J45.-), diabetes (E10.- to E14.-) or epilepsy (G40.-) could be coded, as these could be found in younger service users.

For other services other chronic conditions such as ischaemic heart disease (I20.- to I25.-) or chronic obstructive pulmonary disease (J43.-, J44.-). If respite care is included, this should be coded as the primary diagnosis Z75.5 Holiday relief care.

Ref 88: Coding of comorbidities (from the coding clinic referenced above)
This guidance supplements the co-morbidities guidance in the General Coding Standards section of the National Clinical Coding Standards ICD-10 4th Edition reference book and contains the list of medical conditions and other factors influencing health that are **always** considered to be clinically relevant. The conditions included on this list must **always** be coded for any Admitted Patient Care episode (including Day cases) when documented in the patient’s medical record for the **current** hospital provider spell, regardless of specialty. See appendix 2 for list of comorbidities.

The guidance contained within the National Clinical Coding Standards ICD-10 4th Edition reference book and the *Coding Clinic* must be applied to the listed conditions. References to guidance published in the National Clinical Coding Standards ICD-10 4th Edition reference book have been included where required.

When other conditions, not contained within the co-morbidity list, have been identified by the responsible consultant as clinically relevant, these conditions must also be coded.

Any uncertainty as to whether a documented condition is a current condition or a past medical history (PMH) must be clarified with the responsible consultant.

Acute conditions
Acute conditions will **always** affect the patient’s episode of care and will **always** be coded when documented in the medical record. This is a fundamental coding principle; consequently acute conditions do not appear on the co-morbidity list with the exception of certain conditions that can exist in both an acute or chronic form.

Symptoms
The list includes a number of symptoms that are always clinically relevant. However, it must be noted that the guidance for Recording signs and symptoms in chapter XVIII Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified of the National Clinical Coding Standards ICD-10 4th Edition reference book **must still be applied**; if the underlying cause of the symptom has been identified then the symptom must not be coded, unless it is an important problem in medical care requiring treatment.

Case studies
1. 78 year old Mr X is a widower, has no next of kin, he lives alone, develops short term memory loss of 12 months duration. He is forgetful, repetitive and develops poor motivation. He starts to neglect himself and has been noted to be wandering at odd hours in the morning and has been brought back home by passersby and police on occasions. Mr X is usually physically healthy but had a stroke 18 months ago from which he recovered with no residual symptoms. He is a hypertensive and is on blood thinners and anti-hypertensive but his blood pressure is difficult to control. He does not drink alcohol and quit smoking after his stroke having been a heavy smoker for more than five decades. He is seen in memory clinic for a series of assessments and is diagnosed with Multi Infarct Dementia.

Primary Diagnosis:
- F01.1 Multi-infarct dementia

Secondary Diagnosis:
- I69.3 Sequelae of cerebral infarction (if this is documented effectively);
- I10.X Essential (primary) hypertension;

- Z92.1 Personal history of long-term (current) use of anticoagulants (this is a national standard for any patient taking anticoagulants, such as Warfarin);
- Z86.4 Personal history of psychoactive substance abuse **(***this is not a national standard but could be considered best practice to show the ex-smoker*).

2. 85 year old Mrs A was referred by GP for sudden onset of auditory hallucinations. Mrs A who lives with her husband and who has history of diabetes, hypertension and stable angina has never had any mental health issues in the past. She developed headaches two months ago and then started hearing voices of her deceased mother reprimanding her. Neurologists ruled out any specific organic cause for her headaches and referred her via GP to the local psychiatric services for the voices. The voices was brief, transient in the first few weeks and wasn't bothering Mrs A much. She did not have any other psychotic phenomenon including hallucinations in other modalities, delusional beliefs nor met any criteria for any mental disorders and dementia was ruled out as well. Her symptoms weren't linked to any of her medications either. A few weeks after the assessment, her symptoms completely resolved. No diagnosis was made and Mrs A was subsequently discharged back to the GP.

Primary Diagnosis:

- R44.0 Auditory hallucinations.

Secondary Diagnosis:

- Z03.2 Observation for suspected mental and behavioural disorders (this is more specific than the .9);
- E14.9 Unspecified diabetes mellitus - Without complications (diabetes is a national standard to record if present in the record – the type, if known, should be recorded as this effects the code assignment);
- I20.9 Angina pectoris, unspecified (ischaemic heart disease, which angina is, is a national standard to record if present in the record);
- I10.X Essential (primary) hypertension (hypertension is a national standard to record if present in the record).

3. Mrs X 28 year old, tearful, co-operative, good eye contact. Speech coherent and relevant. Her mood subjectively and objectively low. Poor sleep and appetite. Thought-negative cognition. Feels she is a failure and cannot cope. A feeling of worthlessness and hopelessness but is not suicidal. Cognition is within normal limits. Insight present "I do not want to be with my baby". Uneventful pregnancy. Began to become convinced that the baby hated her some three days after birth and began to lose interest in daily activities. Diagnosed with severe postpartum mental and behavioural disorder.

The patient is known to have previously self-harmed and is a current smoker.

Primary Diagnosis:

- F53.1 Severe mental and behavioural disorders associated with the puerperium, not elsewhere classified.

Secondary Diagnosis:

- Z91.5 Personal history of self-harm;
- F17.1 Mental and behavioural disorders due to use of tobacco – Harmful use.

4. Training

The Information Governance Toolkit states:

Overall: Training programmes for clinical coding staff entering coded clinical data are comprehensive and conform to national standards.

Clinical coding is undertaken by clinical staff, and on occasions, administrative staff. Some staff have received accredited coding training. The Trust is employing an accredited clinical coder (ACC) to quality check and correct where necessary, the codes which are entered onto the clinical system. Clinical coding will be developed within the Trust which will conform to national standards.

5. Audits

ICD10 coding is included in the weekly data quality dashboards. The reports detail percentage of discharged inpatients, who have had an ICD10 primary and secondary diagnosis entered onto the CareNotes clinical system and the codes which have been allocated.

Independent audits are also undertaken annually by Mersey Internal Audit Agency as per the Information Governance Toolkit.

In accordance with the national clinical coding audit methodology (version 5) and the Code of Best Practice for Clinical Coding Auditors, the audit report provides an assessment and opinion upon:

- The appropriateness of coding processes;
- The accuracy of clinical coding sampled and;
- Whether accuracy meets NHS Classifications Service defined standards.

The outcomes of such audits will review the effectiveness of the implementation of this policy.

Appendix 1 – Flowchart for ICD10 clinical coding process

Patient journey
Coding is mandated by MHMDS for wards Coding is good practice for outpatient and community services Coding should be done as soon as symptoms are ascertained, reviewed if symptoms change and reviewed on discharge

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Clinical staff
Pick ICD10 code from the drop down menu on CareNotes (mandated field) There are two systems for coding on CareNotes – multi axial and standard CareNotes training manual – Section 34

▼

Clinical staff
Pick ICD10 secondary codes (comorbidities list – See appendix 2) from the drop down menu on CareNotes (mandated field) There are two systems for coding on CareNotes – multi axial and standard CareNotes training manual – Section 34

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Information team
Submit clinical codes as per MHMDS to the Department of Health

Appendix 2 – Co morbidities List

Below is a list of co morbidities that Coders must code if they are present within the episode regardless as to whether they are deemed relevant to the patient's treatment at that time.

Co morbidities List	Codes
Abnormal LFTs- when underlying cause not known	R94.5
Alcohol abuse	F10.2
Alcohol abuse with alcohol withdrawal	F10.2 + F10.3
Alcohol abuse with alcohol withdrawal/ delirium	F10.2 + F10.4
Alzheimer disease- unspecified	G30.9
Alzheimer disease with early onset	G30.0
Alzheimer disease with late onset	G30.1
Other Alzheimer disease	G30.8
Alzheimer disease (Dementia in Alzheimer's)	G30.9 + F00.9
Alzheimer disease with early onset (Dementia in early Alzheimer)	G30.0 + F00.0
Alzheimer disease with late onset (Dementia in late Alzheimer)	G30.1 + F00.1
Alzheimer disease, atypical or mixed type in Dementia	G30.8 + F00.2
Angina	I20.9
Anticoagulant therapy (Warfarin, Dagbigatron, Rivaroxaban)	Z92.1
Anxiety	F41.9
Anxiety (panic attacks)	F41.0
Asthma	J45.9
Autism (Childhood, infantile)	F84.0
Autism- atypical	F84.1
Blindness (inc registered blind both eyes) if cause known also code	H54.0
Blindness (registered blind one eye) If cause known also code	H54.4
Bronchitis, chronic	J42X
Bronchitis, chronic purulent	J41.1
Bronchitis, chronic simple	J41.0
Cerebrovascular disease, unspecified	I67.9
Cerebrovascular disease- small vessel disease/cerebral ischaemia	I67.8
Congestive heart failure (CCF)	I50.0
Current smoker	F17.1
COAD / COPD-unspecified	J44.9
Current Anticoagulant therapy	Z92.1
Chronic kidney disease- unspecified	N18.9
Chronic kidney disease- end stage (ESRF)	N18.5
Chronic kidney disease- stage 1	N18.1
Chronic kidney disease- stage 2	N18.2
Chronic kidney disease- stage 3	N18.3
Chronic kidney disease- stage 4	N18.4
Chronic kidney disease- stage 5	N18.5
Dementia-unspecified	F03X
Dementia-Vascular, of acute onset	F01.0
Dementia-Vascular, of multi-infarct type	F01.1
Dementia- Vascular, of subcortical type	F01.2
Dementia-Vascular, of mixed cortical and subcortical type	F01.3
Dementia- Vascular, other	F01.8
Dementia-Vascular, unspecified	F01.9
Dementia in Pick disease	F02.0 + G31.0
Dementia in Creutzfeldt-Jakob disease	F02.1 + A81.0

Co morbidities List	Codes
Dementia in Huntington disease	F02.2 + G10X
Dementia in Parkinson's disease	F02.3 + G20X
Dementia in HIV	F02.4 + B22.0
Dementia in other specified disease (please see ICD10 for codes)	F02.8 + CODE
Dementia- Senile with delirium or acute confusional state	F05.1
Depression- Bipolar affective disorder, current episode mild or moderate depression	F31.3
Depression- Bipolar affective disorder, current episode severe depression without psychotic symptoms	F31.4
Depression- Bipolar affective disorder, current episode severe depression with psychotic symptoms	F31.5
Depression- Bipolar affective disorder, current episode mixed presentation	F31.6
Depression- Mild episode	F32.0
Depression- moderate episode	F32.1
Depression- Severe episode without psychotic symptoms	F32.2
Depression- Severe episode with psychotic symptoms	F32.3
Depression- other	F32.8
Depression- unspecified	F32.9
Depression- Recurrent, mild episode	F33.0
Depression- Recurrent, moderate episode	F33.1
Depression- Recurrent, Severe without psychotic symptoms	F33.2
Depression- Recurrent, Severe with psychotic symptoms	F33.3
Depression- Recurrent, currently in remission	F33.4
Depression- Recurrent, other disorders	F33.8
Depression- Recurrent unspecified	F33.9
Developmental delay- Global	F89X
Developmental Delay- Language (see ICD10 for further info)	F80-
Developmental Delay- Scholastic skills (see ICD10 for further info)	F81-
Developmental delay- Learning disability / disorder NOS	F81.9
Developmental delay- motor function	F82X
Developmental delay-mixed (Should be used when two or more of F80, F81 and F82 are present)	F83X
Drug Abuse- non dependence producing substances (includes abuse of antacids, herbal or folk remedies, steroids or hormones, vitamins and laxatives)	F55X
Drug Abuse- alcohol (non-dependent)	F10.1
Drug Abuse- opoids (heroin ,methadone, buprenorphine ,morphine)	F11.1
Drug Abuse- Cannaboids	F12.1
Drug Abuse- Sedatives or hynotics (Temazepam / valium)	F13.1
Drug Abuse-Cocaine (crack)	F14.1
Drug Abuse- Other stimulants (inc Caffeine, GHB, ecstasy , speed, amphetamine, mephedrone ,bubble)	F15.1
Drug Abuse- Hallucinogens (LSD, magic mushrooms)	F16.1
Drug Abuse- Tabacco	F17.1
Drug Abuse- Volatile solvents	F18.1
Drug Abuse- Multiple drug use (**ONLY** be used when two or more psychoactive substances are used and it is impossible to assess which substance is contributing most to the disorder)	F19.1
Dysphagia	R13X
Dysphasia	R47.0
Diabetes- Type unknown (Without complication)	E14.9
Diabetes- Type I (Without complication)	E10.9
Diabetes- Type II (Without complication)	E11.9
Diabetes- Malnutrition related (Without complication)	E12.9
Diabetes- Other specified (Without complication)	E13.9

Co morbidities List	Codes
Eating disorder -Anorexia nervosa	F50.0
Eating disorder- Atypical anorexia nervosa	F50.1
Eating disorder- Bulimia nervosa	F50.2
Eating disorder- Atypical bulimia nervosa	F50.3
Eating disorder- psychogenic overeating	F50.4
Eating disorder- Vomiting associated with psychological disturbances	F50.5
Eating disorder- other (includes pica in adults)	F50.8
Eating disorder- unspecified	F50.9
Emphysema- unspecified	J43.9
Epilepsy-localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localised onset	G40.0
Epilepsy-localisation related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizure	G40.1
Epilepsy- localisation related (focal) (partial) symptomatic epilepsy and epileptic with complex partial seizures	G40.2
Epilepsy- Generalised idiopathic epilepsy and epileptic syndromes	G40.3
Epilepsy-Other generalised epilepsy and epileptic syndromes	G40.4
Epilepsy- Special syndromes (see ICD10 for further specification)	G40.5
Epilepsy-Grand mal unspecified,(with or without petit mal)	G40.6
Epilepsy-Petit mal, unspecified, without grand mal seizures	G40.7
Epilepsy- Other	G40.8
Epilepsy-unspecified	G40.9

Geriatric falls	R29.6

Hearing loss, severe or profound (if cause known, both must be coded) not otherwise specified	H91.9
Heart failure- due to hypertension	I11.0
Heart Failure- due to hypertension with renal disease	I13-
Heart Failure- congestive (CCF)	I50.0
Heart Failure- Left Ventricular Failure (LVF)	I50.1
Heart Failure- unspecified	I50.9
Heart Failure- as a long term effect of cardiac surgery	I97.1
Heart Failure- ischaemic	I25.5
NB if a patient has LVF and CCF only code CCF	I50.0
Hemiplegia- flaccid	G81.0
Hemiplegia- spastic	G81.1
Hemiplegia- unspecified	G81.9
Hemiplegia- congenital	G80.8
Hemiplegia- congenital, spastic	G80.2
Hypertension (benign, essential, primary, idiopathic, malignant)	I10X

IHD- Atherosclerotic cardiovascular disease, so described	I25.0
IHD- Atherosclerotic heart disease	I25.1
IHD- Old myocardial infarction	I25.2
IHD- Aneurysm of heart	I25.3
IHD- Coronary artery spasm	I25.4
IHD- Ischaemic cardiomyopathy	I25.5
IHD- Silent myocardial ischaemia	I25.6
IHD- other	I25.8
IHD-Unspecified	I25.9

Jaundice	R17X
Jaundice-malignant	K72.9

Co morbidities List	Codes
LVF	I50.1
Living alone (only code if it has extended stay)	Z60.2

Mitral valve disease (not further specified)	I05.9
Mitral valve disease- non rheumatic	I34.9
Mitral valve disease- regurgitation	I34.0
Mitral valve disease- Prolapse	I34.1
Mitral valve disease- regurgitation rheumatic	I05.1
Multiple sclerosis	G35X

Nephritis, Chronic tubulo-intestitial, unspecified	N11.9

Pacemaker in situ	Z95.0
Personal history of self harm	Z91.5
Polycystic kidneys, unspecified	Q61.3
Polycystic kidneys, adult type	Q61.2
Polycystic kidneys, infantile type	Q61.1
Psychosis and psychotic disorders inc delusional disorders unspecified	F29X
Psychosis and psychotic disorders -specific please refer to ICD10 for specific code relating to condition	

Registered blind- see blindness for code	
Renal failure- Unspecified	N19X
Renal failure acute with tubular necrosis	N17.0
Renal failure-acute with acute cortical necrosis	N17.1
Renal failure- acute, other	N17.8
Renal failure- acute, unspecified (AKI)	N17.9
Renal failure- Chronic please see Chronic kidney disease	
Respiratory failure- acute	J96.0
Respiratory failure- chronic	J96.1
Respiratory failure-unspecified	J96.9
Rheumatoid Arthritis- Seropositive (see ICD10 for further info)	M05-
Rheumatoid Arthritis- Seronegative	M06.0
Rheumatoid Arthritis- unspecified	M06.9

Schizophrenia- acute (undifferentiated)	F23.2
Schizophrenia-cyclic	F25.2
Schizophrenia- paranoid	F20.0
Schizophrenia- hebephrenic	F20.1
Schizophrenia- catatonic	F20.2
Schizophrenia- undifferentiated	F20.3
Schizophrenia- post schizophrenic depression	F20.4
Schizophrenia- residual	F20.5
Schizophrenia- simple	F20.6
Schizophrenia- other	F20.8
Schizophrenia- unspecified	F20.9
Smoker	F17.1

Urinary retention (only code if the underlying cause is not known)	R33X