ICD-10 & Clinical Documentation Improvement Strategies

Presented By: Jen Cohrs CPC, CPMA, CGIC
Director of Educational Strategies
AHIMA-Approved ICD-10-CM Trainer
Wisconsin Medical Society

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Objectives

Following this learning activity, participants should be able to:

• Realize the importance of accurate documentation and specified ICD-10-CM code selection
• Recognize key methods of implementing and/or improving a clinical documentation improvement program for continuous improvement among physicians, coders and staff
• Apply strategies for teaching and discussing documentation gaps and areas for improvement with physicians and other healthcare providers
Facts About ICD-10

• The compliance date is 10/01/2014
• Applies to all HIPAA-covered entities
• ICD-10 codes are more precise and provide better information and
  – Will enhance accurate payment for services rendered
  – Will help evaluate medical processes and outcomes
  – Will decrease the need to include supporting documentation with claims
Facts About ICD-10

• Documentation details needed for specified ICD-10 code selection are clinically relevant
• ICD-10 was developed by the National Center for Health Statistics (NCHS) a division of the US Centers for Disease Control (CDC) with input from a variety of stakeholders including physicians, specialty societies, and more
Data Capture Challenges for Health Care Providers

- Multiple patients per day
- Numerous problems per patient
- Several treatment options per problem
- Various details needed to support medical necessity
Medical Necessity- Defined

“reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.”
SSA 1862(a)(1)

“overarching criterion for payment in addition to the individual requirements of a CPT code.”
CMS Claims Processing Manual 100-04

“Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms…”
American Medical Association
Impact of Accuracy

- Data Integrity
- Quality of Care
- Communication
- Profile - Reflection
- Patient Safety
- Reimbursement
- Medical Necessity
ICD-10 Alignment

- EHRs & Meaningful Use
- Value-based Purchasing
- ACO’s & PCMHs
- Other Healthcare Reforms & eHealth Initiatives
Reimbursement Variations

Fee-for-service -> Capitation and risk-based models -> Pay-for-performance

ICD-10 Impact?
ICD-10-PCS
ICD-10-PCS & Physicians

Physicians will not use ICD-10-PCS codes for billing or reporting.

Physician documentation is required for accurate ICD-10-PCS code selection.
ICD-10-PCS Characters

- Section
- Body System
- Root Operations
- Body Part
- Approach
- Device
- Qualifier

What does this mean to physicians?

Each selection is entirely dependent on documentation!

If it wasn’t documented with enough specificity- the physician will be asked to clarify!
Facts About ICD-10-PCS

• ICD-10-PCS does not replace CPT
• ICD-10-PCS does replace ICD-9-CM Volume 3 for reporting inpatient procedures
• Physicians do not use ICD-10-PCS for reporting services
• ICD-10-PCS for inpatient facility reporting relies on accurate, detailed physician or other health care professional documentation
ICD-10-CM
ICD-10-CM Code Structure

Category

Etiology, Anatomical Site, Severity

7th Character
Key Features of ICD-10-CM

- Combination codes
- External cause codes
- Additional codes for added laterality
- Expanded codes
- Injuries by anatomical site
- Episode of care within descriptor
ICD-10 Concept: Combination Codes

• A combination code is a single code used to classify:
  – Two diagnoses, or
  – A diagnosis with an associated secondary process (manifestation)
  – A diagnosis with an associated complication

\[A + B = C\]
Combination Code Example

Diagnosis: Coronary artery disease of native coronary artery with unstable angina pectoris

<table>
<thead>
<tr>
<th>ICD-9 Codes</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>414.01 Coronary</td>
<td><strong>I25.110</strong> Atherosclerotic heart disease of native coronary artery with unstable angina pectoris</td>
</tr>
<tr>
<td>atherosclerosis of native coronary artery</td>
<td></td>
</tr>
<tr>
<td>411.1 Intermediate coronary syndrome</td>
<td></td>
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</tbody>
</table>
ICD-10-CM Conventions: 
*Etiology/Manifestation*

- a.k.a. cause and effect relationship
- Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology
- “Code first” the underlying condition followed by manifestation
Hypertension vs Hypertensive

- Hypertension (HTN) is a separate disease process and may or may not be linked to another disease
  - Exception: HTN with CKD = hypertensive chronic kidney disease
- Hypertensive represents a causal relationship between the HTN and the other disease process
  - “Due to” or “because of”
SUBJECTIVE: The patient is a 78-year-old female who returns for recheck. She has hypertension and chronic heart failure. She denies difficulty with chest pain, palpitations, orthopnea, nocturnal dyspnea, or edema.


ASSESSMENT/PLAN: Hypertension and CHF. She is advised to continue with the same medication.
Key Words Impact Final Diagnosis

- I10 Essential (primary) hypertension
- I50.9 Congestive heart failure, unspecified  
  -OR-  
- I11.0 Hypertensive heart disease with heart failure
- I50.9 Congestive heart failure, unspecified
- Which option is best? Is a query needed?
ICD-10-CM Conventions: More Key Words

• “And” should be interpreted to mean either “and” or “or” when it appears in a title
  – Example: K12.2 Cellulitis and abscess of mouth

• “With” should be interpreted to mean “associated with” or “due to”
  – Example: K51.012 Ulcerative pancolitis with intestinal obstruction
How Much is Coded?

• List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided.

• List additional codes that describe any coexisting conditions, but only if they require or affect patient care, treatment, or management.

• *If its not documented with enough specificity, then it cannot be coded or reported!*
Facts About ICD-10-CM

• ICD-10-Clinical Modification (CM) is the US version of the World Health Organization’s ICD-10
• ICD-10-CM will be used by all physicians and other health care professionals in every health care setting
• ICD-10-CM contains unspecified diagnosis codes for use when a more specific diagnosis is unknown
• The diagnosis code-set increases substantially, but ICD-10 is not that radically different than ICD-9
The challenge is most physicians don’t realize:

- Coders shouldn’t assume anything
- Coders cannot use lab or x-ray findings alone
- Coders cannot use pathology findings alone
- Coders cannot interpret physician documentation to mean something simply because of experience
Documentation Impact

High quality documentation will be the standard
– Added details are needed for specified codes
– Will need to link symptoms, complications, and manifestations to disease process
– Better equipped to show clinical severity due to increase in detail of claim data
– Clinical documentation improvement (CDI) workgroups for physician practices will support continued improvement
Diagnosis Details Needed Vary

• Type of disease or injury
• Acuity and severity
• With or without signs and symptoms
• Etiology and manifestation
• Due to medication or substance
• Laterality and anatomical location
• With or without complications
• External cause
Details Impact $$$

Congestive Heart Failure (CHF)

- Systolic vs diastolic
- Left vs right
- Acute vs chronic
- Example: **I50.21** Acute systolic (congestive) heart failure
- Example: **I50.33** Acute on chronic diastolic (congestive) heart failure
CHF & DRGs

- I21.4 NSTEMI myocardial infarction
- I50.20 Systolic (congestive) heart failure (CC)
  - DRG 281 Relative Weight 1.1912

- I21.4 NSTEMI myocardial infarction
- I50.21 Acute systolic (congestive) heart failure (MCC)
  - DRG 280 Relative Weight 1.8503
Location & Laterality Matter!

• Anatomical location/body parts such as:
  – Eyelid
  – Patella
  – Thumb
  – Carpometacarpal (CMC) joint
  – Acromioclavicular (AC) joint

• Laterality
  – Right, left or bilateral
  – Distal, proximal
Laterality Supports Medical Necessity

Example: While walking to her car from her house, pulling two suitcases, the patient fell in her driveway. She landed on her left knee, striking her left shoulder. Patient states she heard a pop type sound of her right foot. Patient's right foot is swollen, bruised, and sore to the touch. X-ray of the right foot reveals a fracture of the 5th metatarsal at the proximal site. Patient was placed in a walking boot and will return in two weeks to evaluate the healing process. If there has been no progress then the patient will be scheduled for surgery to place a screw at the fracture site.
Specified ICD-10-CM Codes

• **S92.354A** Displaced fracture of fifth metatarsal bone, right foot, initial encounter for closed fracture

Also:
• **W18.30XA** Fall on same level, unspecified, initial encounter
• **Y93.01** Activity, walking, marching and hiking
• **Y92.014** Private driveway to single-family (private) house as the place of occurrence of the external cause
Inpatient Surgery Scheduled

• Surgeon will need all injury details to support medical necessity of screw placement

• Still considered “active” care, theoretically the surgeon’s documentation would support:
  – S92.354A Displaced fracture of fifth metatarsal bone, right foot, initial encounter for closed fracture

• The ICD-10-PCS code would align:
  – i.e. 0SHK04Z Lower joint insertion, metatarsal-tarsal joint, right, open, internal fixation device
Details Define Precise Location

Bonnie presents for a follow up with her physician. The results from her recent mammogram and breast biopsy are in and reveal Stage III lobular carcinoma of the central portion of the left breast. She is scheduled for mastectomy followed by chemotherapy, and possibly hormone therapy in the following weeks.

ICD-10-CM:

- **C50.112** Malignant neoplasm of central portion of left female breast
Details Support Multiple Procedures

PRE OP DIAGNOSIS: Right colon and left colon cancers with carcinomatosis and hepatic metastasis

OPERATIVE PROCEDURE: 1. Resection of distal ileum and ascending colon with ileocolonic anastomosis, 2. Resection of the descending and sigmoid colon with low anterior anastomosis, 3. Needle biopsy of the liver

DETAILS OF OPERATION: After satisfactory general endotracheal anesthesia was obtained, the patient's abdomen was prepped and draped in the usual fashion. Midline incision was made and carried down to the intra-abdominal cavity…
The right colon was rotated anteriorly. The retroperitoneum was markedly inflamed, and the patient's right colon tumor had metastatic nodules that attached approximately 30-40 cm proximal to the ileocecal valve…..Patient tolerated the procedure well. Pathology reveals malignancies of the right and left colon with hepatic metastasis. Final diagnosis: Right colon and left colon cancers with carcinomatosis and hepatic metastasis.

ICD-10-CM:

- **C18.2** Malignant neoplasm of ascending colon
- **C18.8** Malignant neoplasm of overlapping sites of colon
- **C78.7** Secondary malignant neoplasm of liver and intrahepatic bile duct
Accurate Coding Supports Data Analytics, Population Health

- **Use**: Using something for a purpose, habitually or regularly
  - i.e. Smoking cigarettes, chewing tobacco, social alcohol use, taking prescriptions

- **Abuse**: Pattern of use that becomes harmful to the individual as well as others
  - i.e. Driving under the influence of drugs or alcohol

- **Dependence**: Pattern of substance use where adverse consequences are accompanied by physical or psychological dependence on a substance
  - i.e. Alcoholism
Occurrence of Drug Toxicity

Is this an adverse effect, poisoning, underdosing, or toxic effect? Clinical interpretations may vary from ICD-10 instruction:

- **Adverse effect:** correctly prescribed and properly administered drug, with an unintended effect
  - i.e. tachycardia, delirium, GI bleeding, etc.

- **Underdosing:** taking less than is prescribed

- **Toxic effects:** harmful substance is ingested or comes in contact with a person
  - i.e. venomous snake, vehicle exhaust, pesticides, etc.
Occurrence of Drug Toxicity

**Poisoning:** improper use of a medication

1. Errors made in drug prescription or in the administration of the drug by provider, nurse, patient, or other person

2. Overdose of a drug intentionally taken resulting in drug toxicity

3. Non-prescribed drug taken with correctly prescribed and properly administered drug resulting in drug toxicity or other drug interaction

4. Interaction/reaction of drug(s) and alcohol
Pt presented to the ED in the care of his brother who said that he is belligerent, hallucinating, and is high on cocaine, yet again. Brother is concerned for pt’s health and safety and wants him to be seen immediately to stop the cocaine abuse. Brother states patient has not been suicidal. Admit to rehab for detox and care. Follow up with psychiatrist for behavior modifications.

Impression: Cocaine abuse with hallucinations
# Behavioral Health Example

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10-CM Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>292.12 Drug-induced psychotic disorder with hallucinations</td>
<td>T40.5x1A Poisoning by cocaine, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td></td>
<td>F14.151 Cocaine abuse with cocaine-induced psychotic disorder with hallucinations</td>
</tr>
</tbody>
</table>
What About External Cause Codes?

• What happened?
  – Fall, assault, MVA, etc.

• Where did it happen? *Place of Occurrence*
  – Park, soccer field, school, work, etc.

• What were you doing? *Activity*
  – Playing baseball, water skiing, walking, etc.

• Who are you? *Y99-External Status*
  – Civilian, military, volunteer, or activity NEC
Reporting of External Cause Codes

• There is no national requirement for mandatory ICD-10-CM external cause code reporting.

• *Unless* a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of these codes is not required.
  
  – Wisconsin Hospital Association requires reporting in some situations- be sure to watch for updates for hospital and ambulatory surgery center mandated data capture requirements
External Cause Codes: Seriously?

Media hype comes from:

- **V91.07xA** Burn due to water-skis on fire
- **W22.02xA** Walked into lamppost
- **W58.13xA** Crushed by crocodile
- **W59.22xA** Struck by turtle, initial encounter
- **X52.xxxA** Prolonged stay in weightless environment
- **W61.33xA** Pecked by chicken, initial encounter
- **Y92.72** Chicken coop (hen house) as the place of occurrence
External Cause Codes: Serious!

Data analytics could really learn to appreciate:

- **V20.4xxA** Motorcycle driver injured in collision with pedestrian or animal in traffic accident
- **V47.61xA** Passenger of SUV injured in collision with fixed or stationary object in traffic accident
- **Y38.812A** Terrorism involving suicide bomber, civilian injured
- **W09.2xxA** Fall on or from jungle gym
- **Y92.210** Daycare center as place of occurrence
- **Y99.0** Civilian activity done for income or pay
CDIP

Not just for hospitals anymore!
Think Like a Physician

• Patient care is priority
  – Diagnosis & treatment

• Highly educated and intelligent

• Analytical and generally logical
  – Don’t like rules!

• Human
  – Possess same emotions as other humans

• Love to teach
Think Like a Coder

- Love structure
- Rules oriented
  - Black and white definition is important
- Provide feedback
- Want to be “part of the solution”
  - Add value
  - Maintain compliance
- Love to learn new things
Why Bridge the Gap?

• High quality documentation will be the standard
  – Will need to link symptoms, complications, and manifestations to disease process
  – Be better equipped to show clinical severity due to increase in detail of claim data
  – Implementation of ICD-10 means more detail in documentation will be necessary
  – Clinical documentation improvement (CDI) workgroups for physician practices will support continued improvement
  – Team-based patient care will emerge
CDI Program

- Coding
- Auditing
- Documentation Improvement
CDI Program: Benefits

• Promotes medical record completeness during the patient’s course of care
• Improves coders clinical knowledge
• Improves communication between physician and other members of the healthcare team
• Improves documentation as a whole
• Reflects quality of care and outcome scores
• Provides continuing education
Steps to Successful CDI

- Engage physician advisors early and often
- Identify key players
- Review current coding practices
  - Offer suggestions for improvement
- Identify documentation gaps
- Offer peer-to-peer training
  - Celebrate success
- Rollout changes
CDI Program: Ideas

• Set a frequency for review sessions
  – Monthly, quarterly, etc.

• Keep everyone updated on progress
  – Add as agenda item during a staff meeting
  – Share recent audit findings

• Hold department-specific meetings

• Create cheat sheets
  – For use by coders and physicians
CDI Program: Physician Query

- Used to improve the coding accuracy
- Must be compliant with state and federal guidelines
- Used when clarification and specificity is needed
- Cannot be leading
- Contains specific clinical documentation

- Presents facts from medical record
- Allows for physicians to document specific diagnosis
- Must be clear and concise
- Could coincide with technology already in use (i.e. EHR)
When to Query

• When there are clinical indicators of a diagnosis, but no documentation
  – Causing coder assumption
• Evidence for a higher degree of severity
• To establish a cause/effect relationship between two diagnoses
• To specify an underlying cause of symptoms
• Treatment is documented, but no diagnosis is documented
Example Physician Query

Inappropriate Query:

Patient A has COPD and is on oxygen every night at home and has been on continuous oxygen since admission. Please document “Chronic Respiratory Failure.”
Example Physician Query

Appropriate Query:
Patient A has COPD and is on oxygen every night and has been on continuous oxygen since admission. O2 saturation falls to 89% on room air. Based on these indications, please indicate if you were treating one of the following diagnoses:

– Chronic respiratory failure
– Acute respirator failure
– Acute-on chronic respiratory failure
– Hypoxia
– Unable to determine
Use Tools & Site Resources!

- Templates, forms
- Specialty societies (i.e. APA, ACOG, etc.)
- Reference materials
  - CPT, ICD-9-CM, ICD-10, anatomy and physiology books or charts, Medicare manuals, contractor policies and/or benchmarking stats, etc.
- Remember… if it wasn’t documented, it wasn’t done!
  - Future: if it wasn’t documented *with enough specificity*… it wasn’t done!
Avoid the Blame Game!
“Try to see the forest, not the trees”
References

• AHIMA
  – http://www.ahima.org/ICD10

• National Center for Health Statistics: CDC ICD-10-CM
  – http://www.cdc.gov/nchs/icd.htm

• Centers for Medicare and Medicaid Services (CMS)
  – http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

• 2014 ICD-10-CM/PCS The Complete Official Draft Code Sets
• ICD-10-PCS: An Applied Approach by Lynn Kuehn/Therese Jorwic
• Journal of AHIMA June 2013
  – http://journal.ahima.org
Thank you for your time and attention!

Questions?

Jen.cohrs@wismed.org

DISCLAIMER: The information presented and responses to the questions posed are not intended to serve as coding or legal advice. Many variables affect coding decisions and any response to the limited information provided in a question is intended only to provide general information that might be considered in resolving coding issues. All coding must be considered on a case-by-case basis and must be supported by appropriate documentation in the medical record. Therefore, the Wisconsin Medical Society recommends consulting directly with payers to determine specific payers’ guidance regarding appropriate coding and claim submission. The CPT codes that are utilized in coding claims are produced and copyrighted by the American Medical Association (AMA). Specific questions regarding the use of CPT codes may be directed to the AMA.