SNOMED CT®, ICD-9 and ICD-10
Documenting Common Conditions
in the Electronic Health Record

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HIM and EHR Program
Topics for today

• SNOMED CT® and Integrated Problem List (IPL) refresher
• ICD-9 and ICD-10 overview
• Documentation of common conditions to support ICD-9 and ICD-10 encounter coding
Introduction

• Current documentation practices do not support the detail that ICD-9 offers.
• ICD-10 is even more granular so the documentation gap is even larger.
• The new Integrated Problem List (IPL) changes how clinicians will manage problems and select encounter diagnoses.
  • The IPL offers opportunities to improve documentation for both current ICD-9 encounter coding and to prepare for a smoother transition to ICD-10.
  • We will demonstrate simple strategies to improve encounter documentation to support ICD coding.
What is SNOMED CT®?

Systematized Nomenclature of Medicine Clinical Terms® (SNOMED CT®)

- SNOMED CT® is a comprehensive international multilingual clinical terminology that provides clinical content and expressivity for clinical documentation.
- SNOMED CT® is required for Meaningful Use 2014 and is used to document problems, encounter diagnoses, clinical indications, and family history conditions.
- SNOMED CT® and its mapping tools will help IHS in the ICD-10 transition.

Source: IHTSDO, www.snomed.org

Per IHTSDO (International Health Terminology Standards Development Organisation) “SNOMED CT is considered to be the most comprehensive multilingual health terminology in the world”
SNOMED CT® in EHR

- SNOMED CT® terms (human readable descriptions) are selected and used in the Problem List, Encounter Diagnoses, Clinical Indications and Family History.

- A concept ID and description ID (computer-readable codes) are stored and used for health information exchange.
SNOMED CT® in EHR (cont.)

The terms are combined with any optional “provider text” to create the displayed Provider Narrative for problems, Purpose of Visits (POVs), clinical indications.

Previous provider narrative:
Osteoarthritis right knee

New Provider narrative:
Format:  SNOMED term| provider text
Example: Osteoarthritis of knee| right
SNOMED CT® in EHR (cont.)

ICD-9 and ICD-10 codes will be automatically mapped when appropriate, and when they cannot be mapped automatically the coder will assign an ICD code.

• It is important for providers to understand what to document, to support ICD-9 and ICD-10 coding of encounters.
• This can be done in several ways in EHR.
How are ICD codes Assigned in EHR?

1. Clinicians select a SNOMED CT® Problem and sets as POV (encounter diagnosis).
2. Clinician enters provider text for visit from POV dialog (optional).
3. Coder reviews provider narrative, qualifiers, encounter notes and accepts or changes mapped codes, assigns code to uncoded entries and adds any additional codes.
   • After the conversion to ICD-10, additional “map advice” is passed to coding staff to assist with transition to ICD-10.
What is ICD-9?

ICD-9-CM (Clinical Modification)

- International Classification of Diseases, 9th Revision, developed by the World Health Organization (WHO).
- Dates from 1973, in use since 1979 in the United States – updated in U.S. at least annually.
- Volumes 1 and 2 are used for diagnoses.
- Approximately 14,000 specific codes.
- Volume 3 is used for inpatient procedures.
- U.S. is scheduled to transition to ICD-10 October 1, 2015.
What is ICD-10?

ICD-10
- 10th Revision of ICD code set from WHO
- In use worldwide since 1994
- Approximately 2000 disease families

ICD-10-CM (Clinical Modification)
- U.S. expanded set to meet U.S. reporting needs
- Approximately 69,000 specific codes

ICD-10-PCS (Procedure Classification System)
- Inpatient (hospital) coding only
- Replaces ICD-9-CM procedures
- CPT/HCPCS are unaffected (outpatient use)
There’s no denying ICD-10 is big. Bigger than most of us imagined. So why change? What’s in it for us?

Why? Modernization requires it. The ICD-9 code set is almost 40 years old, developed and vetted in the early 1970s, and completed in 1973. Pre-Electronic Data Interchange (EDI). Pre- A LOT of modern medical developments -- back when a mainframe computer’s direct response was via a teletype and responses were spit out at a whopping 10 characters per second. So essentially, we are driving our health system using the equivalent of a 1973 Chevy Vega.

ICD-9 code set lacks specificity (and space). It lacks key concepts such as laterality, staging, and trimesters. The codes are overly broad resulting in only one in five hospital bills being paid without additional requests for information.

The WHO (the World Health Organization, not the band) recognizing the limitations of ICD-9, developed the much more robust and granular ICD -10 code set in the early 90s and the rest of the world moved on to ICD-10 starting in 1994.

We’re late.
Comparison: ICD-9-CM and ICD-10-CM

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>ICD 9 CM</th>
<th>ICD 10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Character Type</td>
<td>Numeric, only V &amp; E used</td>
<td>Alphanumeric</td>
</tr>
<tr>
<td>Code length</td>
<td>5 digit max</td>
<td>3-7 character max</td>
</tr>
<tr>
<td># of Codes</td>
<td>14,315</td>
<td>69,099</td>
</tr>
<tr>
<td>Supplementary codes</td>
<td>V &amp; E Codes</td>
<td>None (incorporated in main code book)</td>
</tr>
<tr>
<td>Laterality (left v. right)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Trimester</td>
<td>No</td>
<td>Yes (1st, 2nd, 3rd)</td>
</tr>
<tr>
<td>Structure of injuries</td>
<td>Wound Type, Laceration, etc.</td>
<td>Body part</td>
</tr>
<tr>
<td>ICD 9</td>
<td>Narrative</td>
<td>ICD 10</td>
</tr>
<tr>
<td>-------</td>
<td>-----------</td>
<td>--------</td>
</tr>
<tr>
<td>813.80</td>
<td>Unspecified part, (closed) forearm</td>
<td>S52</td>
</tr>
<tr>
<td>813.40</td>
<td>Lower end of forearm, unspecified</td>
<td>S52.5</td>
</tr>
<tr>
<td>813.45</td>
<td>Torus fracture of radius (alone)</td>
<td>S52.52</td>
</tr>
<tr>
<td></td>
<td>Same as above</td>
<td>S52.521</td>
</tr>
<tr>
<td></td>
<td>Same as above</td>
<td>S52.521A</td>
</tr>
</tbody>
</table>

### SNOMED CT® to ICD-9 Mapping Examples

<table>
<thead>
<tr>
<th>SNOMED Term</th>
<th>ICD 9</th>
<th>Storage of Mapped codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunburn of second degree</td>
<td>Sunburn of second degree 692.76</td>
<td>1:1: This is a 1:1 match so will store in POV when selected.</td>
</tr>
<tr>
<td>Diabetic Nephropathy</td>
<td>Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled 250.00 Nephritis and nephropathy, not specified as acute or chronic, in diseases classified elsewhere 583.81</td>
<td>1:1: This is a 1:1 match so will store both ICD-9 codes. When problem is selected as POV, 2 POVs will store.</td>
</tr>
<tr>
<td>Ganglion of the wrist</td>
<td>Ganglion of joint 727.41</td>
<td>Narrow to Broad: Closest ICD-9 code is less specific than the SNOMED. This will store in POV when selected.</td>
</tr>
</tbody>
</table>

When there is no mapping available OR when the closest ICD-9 code is more specific than the SNOMED, then the system will assign .9999 un-coded. The code assigned by coders will depend on the SNOMED term selected and the remainder of the visit documentation.
SNOMED CT® to ICD-10 Mapping Examples

<table>
<thead>
<tr>
<th>SNOMED Term</th>
<th>ICD 10</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential Hypertension</td>
<td>Essential hypertension 110</td>
<td>&quot;Always true&quot; rule is a 1:1 match. Will store in POV when selected.</td>
</tr>
<tr>
<td>Type II diabetes mellitus</td>
<td>Type 2 diabetes mellitus with hyperglycemia E11.65</td>
<td>This is a 1:1 match so this will map automatically when selected as POV. Also contains map advice which coders can use - Use additional code to identify any insulin use (E279.4).</td>
</tr>
<tr>
<td>Cerebral Edema</td>
<td>Cannot be automatically mapped</td>
<td>Passes map advice which can be seen by coders as they hover on problem list or in PCC data entry.</td>
</tr>
</tbody>
</table>

"Always true" map rule is a 1:1 mapping. SNOMEDs assigned any other map rules require additional data to determine codes and the system will assign ZZZ.999 uncoded diagnosis.

Any "map advice" from the SNOMED to assist coders in selecting ICD-10 code is passed for viewing in EHR and PCC data entry.
Map Advice

- Part of the SNOMED CT® to ICD-10 mapping tool released by the National Library of Medicine (NLM)
- Advice is specific for selected SNOMED CT® code and part of the information that is retrieved from the SNOMED CT® database
- Provides coders with a target code (and secondary codes when applicable) and tips to help them assign ICD-10 based on the encounter documentation
- Visible via hover on the IPL in the EHR and in PCC Data Entry for each SNOMED CT® concept
- Can help coding staff educate providers about required documentation for ICD-10
  - Map advice does not replace validating code look-up – map advice is a tool

NLM – National Library of Medicine
IPL – Integrated Problem List
Example of Map Advice for SNOMED CT® Term “Cerebral Edema”

<table>
<thead>
<tr>
<th>Rule</th>
<th>Target Code</th>
<th>Rule Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>09518</td>
<td>ALWAYS VT</td>
</tr>
<tr>
<td>2</td>
<td>7110</td>
<td>IF CEREBRAL EDema DUE TO BIRTH INJURY CHOOSE 09518</td>
</tr>
<tr>
<td>3</td>
<td>51157</td>
<td>IF TRAUMATIC CEREBRAL EDema WITH OPEN INTRAcranial WOUND CHOOSE 51157 EPISODE OF CARE INFORMATION NEEDED POSSIBLE REQUIREMENT FOR AN EXTERNAL CAUSE CODE</td>
</tr>
<tr>
<td>4</td>
<td>51157</td>
<td>CONSIDER ADDITIONAL CODE TO IDENTIFY SPECIFIC CONDITION OR DISEASE EPISODE OF CARE INFORMATION NEEDED POSSIBLE REQUIREMENT FOR AN EXTERNAL CAUSE CODE</td>
</tr>
<tr>
<td>5</td>
<td>51157</td>
<td>IF TRAUMATIC CEREBRAL EDema WITH OPEN INTRAcranial WOUND CHOOSE 51157 EPISODE OF CARE INFORMATION NEEDED POSSIBLE REQUIREMENT FOR AN EXTERNAL CAUSE CODE</td>
</tr>
<tr>
<td>6</td>
<td>51157</td>
<td>IF TRAUMATIC CEREBRAL EDema WITH OPEN INTRAcranial WOUND CHOOSE 51157 EPISODE OF CARE INFORMATION NEEDED POSSIBLE REQUIREMENT FOR AN EXTERNAL CAUSE CODE</td>
</tr>
<tr>
<td>7</td>
<td>51157</td>
<td>MAP SOURCE CONCEPT CANNOT BE CLASSIFIED WITH AVAILABLE DATA</td>
</tr>
</tbody>
</table>
• Automatically mapped codes are visible to the user for information only.
• Clinicians should not be dissuaded from selecting a SNOMED CT® that describes the problem well simply because there is not an automatically mapped ICD code.

Mappings reflect what codes can be automatically assigned based on the SNOMED CT® concept. This does not mean that an ICD code does not exist for the problem. The map is provided for information only and may help select between two very similar terms; however clinicians should not be dissuaded from selecting a SNOMED CT® that accurately describes the problem simply because there is not an automatically mappable ICD-10 code.
What about ICD-10 for Clinicians?

SNOMED CT® is now the EHR interface for problems and diagnoses.

“Awesome - so as a provider, I don’t have to worry about ICD-10?”

Incorrect!

- Although you will not be assigning the actual ICD-10 code, clinicians must understand and are responsible for the documentation required to support ICD-10 diagnoses and to work to improve clinical documentation and avoid denial of payment of claims.
Potential Risks with ICD-10 Transition

Reduced provider productivity

Mitigation:
- Meaningful Use 2014 introduces a new process for documenting problems and encounter diagnoses that incorporates SNOMED CT® and maps to ICD.
- Providers will already be accustomed to the new Integrated Problem List, and ICD-10 transition will be relatively transparent.
- Documentation improvement will reduce queries from coding for clarification.
Potential Risks with ICD-10 Transition (cont.)

Reduced coder productivity

Mitigation:
  • Maps and stores ICD-10 when appropriate
  • Exposes “map advice” to coders and providers
  • Documentation improvement will reduce queries to providers for clarification

*Documentation improvement is required to mitigate potential productivity impact for both provider and coding staff.*
Clinical Documentation is the KEY to success with SNOMED CT® and ICD diagnosis coding
Process for Coding Visits

• Much of the process is unchanged
• Coders still validate and assign appropriate ICD codes for encounter diagnoses (POVs) based on Provider Narrative, which is comprised of the SNOMED CT® term and Provider text, qualifiers, asthma control, and encounter note.

Provider narrative will be more consistent

**Format:** SNOMED CT® term | provider text

| Standard term | Clinician free text |

**Example:** Hyperlipidemia | uncontrolled
Tips for POV Documentation in IPL

- Appropriate SNOMED CT® term selection for problem
- May use qualifier dropdowns on problem list if desired but not mandatory
- Leverage the “provider text” to incorporate data needed for clinical documentation
  - May enter “provider text” specific to the encounter
  - Displayed for coders
  - Included in Note Templates
- Encounter note may still be used for any additional information

Using less specific SNOMED CT® terms: Clinicians may find that in some cases a less specific SNOMED CT® is best for a problem, particularly some chronic problems. For example, it may be easier to use a fairly generic Diabetes Mellitus Type 2 as the term on the problem list. When using this problem as POV, the user can then add “uncontrolled, on insulin with episodes of hypoglycemia past 2 months” or “well controlled” in the provider text to add context at the time of the encounter. This provides information for the coders to assign a more detailed code. SNOMED CT®: Diabetes Mellitus Type 2 PROVIDER TEXT: add encounter specific when selecting as POV

Using more specific SNOMED CT® terms: Clinicians may find in other cases a more specific SNOMED CT® is best for a problem. For example, if a patient sustains a right femur fracture, using the most specific SNOMED CT® is best and reduces documentation as this problem is managed. SNOMED CT®: Closed avulsion fracture of greater trochanter of femur PROVIDER TEXT: Right and add encounter specific detail when selecting as POV
POV Selection Tool for Clinicians

This tool provides the opportunity for clinicians to enter provider text specific to the encounter

- "Provider Text" entered in the POV selection tool is stored along with the SNOMED CT® term as part of the Provider Narrative for the POV.
- This provides a simple way to add context to the POV.

Problem entry example, use as POV for initial encounter:
Fracture of distal end of radius | right, from fall off bike with edema

Problem used as POV for fracture follow up
Fracture of distal end of radius | right, edema resolved, normal healing

“Provider Text” entered on the POV dialog does not change the “Provider Text” on the problem list.
POV Selection Tool Example:
Initial Visit for Ankle Fx and HTN

Scenario: Patient presents for ankle fracture. The patient also has had a few blood pressure checks and the provider is now diagnosing patient with hypertension.

Problem/POV documentation: Add problems. Mark “use as POV” on Add Problem dialog. Note addition of fracture and accident detail placed in “provider text”.

![POV Selection Tool](image-url)
POV Selection Tool Example:
Follow up Visit for Ankle Fx and HTN

Scenario: Patient presents for follow up. Ankle contusions and edema have resolved, x-ray reveals normal expected healing. Blood pressure is controlled.

Problem/POV documentation: Highlight problems and click POV button.
- If the Problem has no Provider Text, any text you add will be used only for this encounter (does not add to the Problem notation).
- If the Problem has Provider Text, any text you add will replace it for this encounter only.
### Diabetes

<table>
<thead>
<tr>
<th>Required documentation for ICD 9</th>
<th>Required documentation for ICD 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Type and Control:</strong></td>
<td>- <strong>Type:</strong> Type 1, Type 2, Drug/chemical induced, Due to underlying condition, Specified type</td>
</tr>
<tr>
<td>Type 1 controlled/not specified</td>
<td>- Control (supports E&amp;M coding) – Poorly controlled, Hypoglycemia, Hyperglycemia</td>
</tr>
<tr>
<td>Type 1 uncontrolled</td>
<td>- Manifestation/Complication – Arthropathy, Circulatory complications, Hyperosmolality with or without coma, Hypoglycemia with or without coma, Ketoacidosis with or without coma, Kidney complications, Neurological complications, Ophthalmic complications, Oral complications, Skin complications, Without complications</td>
</tr>
<tr>
<td>Type 2 controlled/not specified</td>
<td>- Insulin use – not required for type 1</td>
</tr>
<tr>
<td>Type 2 uncontrolled</td>
<td></td>
</tr>
<tr>
<td>Secondary diabetes controlled/not specified</td>
<td></td>
</tr>
<tr>
<td>- Identify body system affected</td>
<td></td>
</tr>
<tr>
<td>- Identify insulin use for type 2 &amp; secondary diabetes</td>
<td></td>
</tr>
</tbody>
</table>
Diabetes Coding Example

Patient is a 35-year-old Native American female patient who presents for follow-up appointment for type 2 diabetes. Her latest urine reveals microalbuminuria again. Her HGBA1C today is 10, which is up from 7.5 six months ago. On exam this is a petite woman. WT 130 lbs., P76, RR14, BP 120/80.

Diagnosis: Diabetes mellitus type 2, uncontrolled with persistent microalbuminuria
Diabetes Mellitus Type 2, Uncontrolled, with Persistent Microalbuminuria

<table>
<thead>
<tr>
<th>EHR Documentation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Type 2 diabetes mellitus Provider Text: uncontrolled with persistent microalbuminuria</td>
<td></td>
</tr>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Type 2 diabetes mellitus Encounter note documentation: Diabetes is uncontrolled with persistent microalbuminuria</td>
<td></td>
</tr>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Persistent microalbuminuria associated with type 2 diabetes mellitus Provider text: uncontrolled</td>
<td></td>
</tr>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Type II diabetes mellitus uncontrolled Provider Text: persistent microalbuminuria</td>
<td></td>
</tr>
</tbody>
</table>

*Any of the combinations are acceptable*
**SNOMED CT® Problem:** Type 2 diabetes mellitus

**Provider Text:** uncontrolled with persistent microalbuminuria

TIU Objects can incorporate Provider Narrative (SNOMED CT® term + provider text) in the encounter notes

Supports ICD-9 documentation of control, body system affected
Supports ICD-10 documentation of Type, manifestation or complication
**Diabetes Mellitus Type 2, Uncontrolled, with Persistent Microalbuminuria**

**Problem List**

**POV entry**
(no added Provider text)

**Visit Diagnosis Display**

**Note** (info added to note by user)

**SNOMED CT® Problem:** Type 2 diabetes mellitus

**Provider Text:**

**Encounter note:** User types in additional information required into encounter note “uncontrolled, with persistent microalbuminuria, start ACEI”

Supports ICD-9 documentation of control, body system affected
Supports ICD-10 documentation of Type, manifestation or complication
**SNOMED CT® Problem:** Persistent microalbuminuria associated with type II diabetes mellitus

**Provider Text:** uncontrolled

**TIU Objects can incorporate Provider Narrative (SNOMED CT® term + provider text) in the encounter notes**

Supports ICD-9 documentation of control, body system affected
Supports ICD-10 documentation of Type, manifestation or complication
Diabetes Mellitus Type 2, Uncontrolled, with Persistent Microalbuminuria

**SNOMED CT® Problem:**  Type 2 diabetes mellitus uncontrolled

**Provider Text:**  persistent microalbuminuria

**TIU Objects can incorporate Provider Narrative (SNOMED CT® term + provider text) in the encounter notes**

Supports ICD-9 documentation of control, body system affected

Supports ICD-10 documentation of Type, manifestation or complication
<table>
<thead>
<tr>
<th>Required documentation for ICD 9</th>
<th>Required documentation for ICD 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify the condition</td>
<td>Identify the condition</td>
</tr>
<tr>
<td>Gestational diabetes (648.8-)</td>
<td>Abnormal glucose (O99.81-)</td>
</tr>
<tr>
<td>Identify episode of care</td>
<td>Gestational diabetes (O24.4-)</td>
</tr>
<tr>
<td>Antepartum condition</td>
<td>Identify the maternal episode of care</td>
</tr>
<tr>
<td>Delivered</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>• With or without mention of</td>
<td>Childbirth</td>
</tr>
<tr>
<td>antepartum condition</td>
<td>Puerperium</td>
</tr>
<tr>
<td>• With mention of postpartum</td>
<td>Specify method of control (for diabetes)</td>
</tr>
<tr>
<td>complication</td>
<td>Diet controlled</td>
</tr>
<tr>
<td>Postpartum condition</td>
<td>Insulin controlled</td>
</tr>
<tr>
<td>Unspecified/Not Applicable</td>
<td>Unspecified control</td>
</tr>
<tr>
<td>Insulin use (for diabetes)</td>
<td>Weeks Gestation</td>
</tr>
<tr>
<td>• 648.83 Abnormal glucose</td>
<td>• O24.414 Gestational diabetes mellitus in pregnancy, insulin controlled</td>
</tr>
<tr>
<td>tolerance, antepartum condition</td>
<td>• Z3A.33 33 weeks gestation of pregnancy</td>
</tr>
<tr>
<td>or complication</td>
<td></td>
</tr>
<tr>
<td>• V58.67 Long-term (current) use</td>
<td></td>
</tr>
<tr>
<td>of insulin</td>
<td></td>
</tr>
</tbody>
</table>
Pregnancy Coding Example

Patient is a 26-year-old Native American female at 33 weeks gestation who presents to OB clinic for her follow-up appointment for gestational diabetes. Patient had an abnormal glucose tolerance test 6 weeks ago and has been followed by the dietician. She was started on insulin therapy 2 weeks ago. Fasting BGL and postprandial levels have been WNL since beginning of insulin therapy.

On exam this is a young woman. Wt. 175 HR 88, RR14, BP 138/86. Gravid abdomen, single fetus. FHR 150. No edema noted in extremities. NST unremarkable, biophysical profile shows normal for GA fetus, adequate amniotic fluid. Patient will continue on insulin therapy.

Diagnosis: Gestational Diabetes
Gestational Diabetes, Controlled on Insulin Therapy

Any of the combinations are acceptable
SNOMED CT® Problem: Gestational diabetes mellitus
Provider Text: controlled, continue insulin
EGA entered via Vital Measurements: 33 weeks 1 day

TIU Objects can incorporate Vital Measurements (EGA) and Provider Narrative (SNOMED CT® term + provider text) in the encounter notes

Supports ICD-9 documentation of episode of care and insulin use
Supports ICD-10 documentation of episode of care, weeks gestation, method of control
**SNOMED CT® Problem:** Gestational diabetes mellitus

**Provider Text:** 33 weeks 1 day, controlled, continue insulin

**TIU Objects can incorporate Provider Narrative (SNOMED CT® term + provider text) in the encounter notes**

Supports ICD-9 documentation of episode of care and insulin use
Supports ICD-10 documentation of episode of care, weeks gestation, method of control
**SNOMED CT® Problem:** Gestational diabetes mellitus

**Provider Text:**

**Chief Complaint text:** Patient presents at 33 weeks 1 day gestation for follow up for Gestational Diabetes

**Encounter note text:** Gestational diabetes mellitus [P] controlled on insulin therapy. Continue insulin.

**TIU Objects can incorporate Chief Complaint and Provider Narrative (SNOMED CT® term + provider text) in the encounter notes**

Supports ICD-9 documentation of episode of care and insulin use
Supports ICD-10 documentation of episode of care, weeks gestation, method of control
## Asthma

<table>
<thead>
<tr>
<th>Required documentation for ICD 9</th>
<th>Required documentation for ICD 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Identify Type</td>
<td>- Identify Type</td>
</tr>
<tr>
<td>Extrinsic</td>
<td>• Mild</td>
</tr>
<tr>
<td>Intrinsic</td>
<td>• Intermittent</td>
</tr>
<tr>
<td>Chronic Obstructive</td>
<td>• Persistent</td>
</tr>
<tr>
<td>Exercise Induced bronchospasm</td>
<td>• Moderate Persistent</td>
</tr>
<tr>
<td>Cough variant</td>
<td>• Severe Persistent</td>
</tr>
<tr>
<td>- Identify asthma as complicated by:</td>
<td>- Other specified types</td>
</tr>
<tr>
<td>Acute exacerbation</td>
<td>Exercise Induced bronchospasm</td>
</tr>
<tr>
<td>Status asthmaticus</td>
<td>Cough variant</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>- Identify Complications:</td>
</tr>
<tr>
<td></td>
<td>Uncomplicated</td>
</tr>
<tr>
<td></td>
<td>With acute exacerbation</td>
</tr>
<tr>
<td></td>
<td>With status asthmaticus</td>
</tr>
</tbody>
</table>

- Identify Type:
  - Extrinsic
  - Intrinsic
  - Chronic Obstructive
  - Exercise Induced bronchospasm
  - Cough variant

- Identify asthma as complicated by:
  - Acute exacerbation
  - Status asthmaticus

- Identify Complications:
  - Uncomplicated
  - With acute exacerbation
  - With status asthmaticus
Asthma, Moderate Persistent, Not Well Controlled with Current Exacerbation

Any of the combinations are acceptable
**SNOMED CT® Problem:** Asthma
Classification: Moderate persistent
Control: Not well controlled
**Provider Text:** exacerbation

**TIU Objects** can incorporate Provider Narrative (SNOMED CT® term + provider text) and **Asthma Control** in the encounter notes

Supports ICD-9 documentation of type
Supports ICD-10 documentation of episode of type, complications
Asthma, Moderate Persistent, Not Well Controlled with Current Exacerbation

**Problem List**

**POV entry**

**Visit Diagnosis Display**

**Note**

**SNOMED CT® Problem:** Asthma

**Provider Text:** moderate persistent, not well controlled, exacerbation

**TIU Objects can incorporate Provider Narrative (SNOMED CT® term + provider text) in the encounter notes**

Supports ICD-9 documentation of type
Supports ICD-10 documentation of episode of type, complications
Asthma, Moderate Persistent, Not Well Controlled with Current Exacerbation

**Problem List**

**POV entry**

**Visit Diagnosis Display**

**Note (info added to note by user)**

**SNOMED CT® Problem:** Asthma

**Provider Text:**

**Note text:** moderate persistent, not well controlled, exacerbation

TIU Objects can incorporate Provider Narrative (SNOMED CT® term + provider text) in the encounter notes. User may free text additional information.

Supports ICD-9 documentation of type

Supports ICD-10 documentation of episode of type, complications
**SNOMED CT® Problem:** Moderate persistent asthma

**Provider Text:** not well controlled, exacerbation

**TIU Objects can incorporate Provider Narrative (SNOMED CT® term + provider text) in the encounter notes**

Supports ICD-9 documentation of type
Supports ICD-10 documentation of episode of type, complications
Conclusion

- Documentation improvement is ongoing
- Use EHR Tools to support good documentation
  - POV dialog and provider text for encounter
  - Templates
  - Consistent location of documentation
  - Use of map advice (for ICD-10)
- Use current internal and external audits, and reviews to support successful Meaningful Use and ICD-10 implementation
Conclusions – Internal Audits/Reviews

- Accreditation data – trended and specific data
- Ongoing Medical Record Reviews
- Point of Care Reviews
- Peer Reviews
- Coding and Compliance Reviews

Build on current audits and reviews to identify opportunities to incorporate specificity of ICD-10 and support meeting Meaningful Use.
Conclusion - External Audits

- Recovery Audit Contractors (RACs) – Medicare
- Zone Program Integrity Contractor (ZPIC) – Medicare
- Medicare Administrative Contractors (MACs) – Medicare
- Comprehensive Error Rate Testing (CERT) – Medicare
- Medicaid Integrity Contractors (MIC) – Medicaid
- Department of Justice (DOJ) – Both
- Office of Inspector General (OIG) – Both
- Independent Payment Advisory Board (IPAB) – Both
- Program for Evaluating Payment Patterns Electronic Report (PEPPER)
- Current RAC Audits
- CERT Audits
Resources

SNOMED CT® issues – select “SNOMED (DTS) for application

http://www.ihs.gov/rpms/index.cfm?module=Feedback

Enhancement requests – select “Electronic Health Record (EHR)” for application

http://www.ihs.gov/rpms/index.cfm?module=Feedback

ICD 10 Documentation examples

http://www.crozerkeystone.org/healthcare-professionals/icd-10-update/icd-10-documentation/
New Problem and POV Selection Process
(changes in *italics and marked with an asterisk*)

When a provider enters a problem, s/he may do one of the following:

- *Enter SNOMED CT® term.*
- *Add provider text (part of the provider narrative), if desired.*

When a provider enters POV, s/he may do one of the following:

- *Select problem from problem list and store as POV.*
- *SNOMED CT® concept (number) and mapped ICD (or .9999) along with provider narrative, which contains SNOMED CT® term (human readable text) stored in POV.*
New Problem and POV Selection Process
(changes in *italics and marked with an asterisk*)

Data entry/coding reviews POV and documentation and:
• Accepts mapped code.
• Corrects ICD code if indicated based on visit documentation.
• Adds ICD code(s) if indicated.
• Assigns ICD code if un-coded.
• For ICD-10, will also see “map advice” to assist in code assignment and correction.*
• Provider Narratives displayed in PCC and EHR are no longer highly variable because they are selecting SNOMED CT® terms. Narratives will be more consistent with mapped code.*