Truly Understanding
Clinical Documentation Improvement for ICD-10

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ASC-E/M, CCS, CCS-P, CPC, CPC-H, CIRCC, CPMA, CPC-I, CEMC, CFPC, ICD-10-CM/PCS Trainer
Objectives

- Identify areas in ICD-10-CM that include new terminology for clinical documentation
- Define areas in ICD-10-CM that enable improved data capture if more specific conditions are documented
- Discuss methods to employ education to clinicians
- Identify how documentation affects quality measure reporting and reimbursement
- Explain how to get buy-in from the physicians.
“If it was not documented, it was not done”
Why is clinical documentation important?

- Documentation is critical for patient care
- Serves as a legal document
- Quality Reviews
- Validates the patient care provided
- Good documented medical records reduce the re-work of claims processing
- Compliance with CMS, Tricare and other payers regulations and guidelines
- Impacts coding, billing and reimbursement
### Impact of clinical documentation

<table>
<thead>
<tr>
<th>Patient</th>
<th>Physician</th>
<th>Facility</th>
</tr>
</thead>
</table>
| - Quality of care provided  
  - Continuity of care  
  - Non-payment by Insurance | - Demonstrates accountability  
  - Performance Management  
  - Reduced or denied payment  
  - Relative Value Unit (RVU)  
  - Hierarchy Coding Category (HCC) | - Coding and Billing  
  - Supporting documentation for treatment and services rendered  
  - Appropriate reimbursement  
  - DRG |
CMS (Medicare) requires that ALL medical conditions evaluated and treated as well as a patient’s health history, past & present illness, and outcomes are documented in the medical record.
Documentation Matters

Clinical Documentation in the Medical Record should be:

- Complete
- Legible
- Timely
- Concise
- Clear
- Patient Centered

In a nutshell
Summary

Why is clinical Documentation Important?

- Improved quality of care
- Compliance with CMS regulations
- Drives revenue
Summary of clinical documentation

A successful clinical documentation program leads to

- Better communication with providers
- Decreased retrospective queries
- Increase in reimbursement
- Minimize denied accounts
- But most of all – improved clinical documentation!
Documentation Effects

ARE YOU PREPARED?

RAC Audits

LOST
CONFUSED
UNCLEAR
DORIENTED
UNSURE
PERPLEXED
BEWILDERED
For reporting purposes the documentation that must be followed are those by the 4 cooperating parties:

- American Hospital Association (AHA)
- American Health Information Management (AHIMA)
- National Center for Health Statistics (NCHS)
- Centers for Medicare and Medicaid Services (CMS)
Role of the Clinical Documentation Specialist

- Monitor the clinical documentation so that it accurately demonstrates the intensity of service and level of care provided for the patient.
- Review all Medicare admissions after the first 24 hours to ensure comprehensive documentation outlining the reason for admission, the patient’s treatment, and any POA indicators.
- Review medical records for accuracy and compliance.
- Clarify all documentation for accuracy of severity of illness and resource consumption.
- Provide ongoing education regarding clinical documentation for the multidisciplinary team.
Clinical Documentation Team

- Physicians
- Professional Coders (PC)
- Clinical Documentation Specialists (CDS)
- Case Managers (CM)
- Healthcare Quality
- Allied care providers
The Development of ICD-9-CM

- ICD-9-CM Codes (17,000) are assigned to specific diagnoses and procedures.
  - 3-5 Digit Coding system
- ICD-9-CM Codes group to Diagnostic Related Groups (DRG) based upon similar resource consumption and care provided
- Coding Conventions that include complex and detailed information on how to use the system appear in the front of each ICD-9-CM Coding book.
- Official Guidelines are composed and updated regularly by DHHS’ Centers for Disease Control and Prevention (CDC).
- ICD-10-CM Codes (155,000) have a projected target start date of October 1, 2014.
ICD-10 has a significantly different structure, increased specificity, and greater volume of terms, which equals greater complexity.

<table>
<thead>
<tr>
<th>Number of Codes</th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Codes</td>
<td>16,000</td>
<td>155,000</td>
</tr>
<tr>
<td>Diagnosis Codes</td>
<td>13,000</td>
<td>68,000</td>
</tr>
<tr>
<td>Procedure Codes</td>
<td>3,000</td>
<td>87,000</td>
</tr>
</tbody>
</table>

**Structural Change**

**ICD-9**
- Diagnosis: Category → Etiology, anatomic Site, manifestation
- Procedures:

**ICD-10**
- Category
- Etiology, anatomic Site, severity
- Extension
- Section
- Body System
- Root Operation
- Body Part
- Approach
- Device
- Qualifier
Global usage ICD-10

Canada
• Began adopting in 2001
• Over 5-year implementation
• ICD-10-CA for morbidity
• Coding is used for statistical purposes rather than for billing

United Kingdom
• Adopted in 1995

Germany
• Adopted in 1998
• ICD-10-AM for morbidity
• Implementation took 3 years

France
• Adopted in 1996

Russia
• Adopted in 1999

China
• Adopted in 2002

Australia
• Adopted in 1998
• Implementation took 2 years
• 2 years from decision to change to actual implementation was insufficient lead time to build the classification and educate users

South Africa
• Adopted in 1996

Brazil
• Adopted in 1998

Countries who have adopted ICD-10

SOURCE: http://www.who.int/classifications/icd/en/
Coding and 7th Character Extensions

Category

Etiology, anatomic site, severity

Added code extensions (7th character) for obstetrics, injuries, and external causes of injury

3 – 7 Characters
ICD-9-CM vs ICD-10-CM Codes

- **ICD-9-CM** 365.83 for aqueous misdirection (malignant glaucoma)

- **ICD-10-CM** H40.83 for aqueous misdirection (malignant glaucoma)
  - H40.831 Aqueous misdirection, right eye
  - H40.832 Aqueous misdirection, left eye
  - H40.833 Aqueous misdirection, bilateral eyes
  - H40.839 Aqueous misdirection, unspecified eye
One More Example

**ICD-9-CM**
- Sprained Ankle
- 5 Codes

**ICD-10-CM**
- Sprained Ankle
- 45 Codes
- Which part of the ankle was injured?
- Right or Left?
- First-time Injury?
The Federal Government through the Centers for Medicare and Medicaid Services (CMS) is driving the healthcare industry to upgrade diagnosis and procedure coding standards (ICD-10) by October 1, 2013.

**Background: ICD-10 Overview**

**ICD-10 Changes**

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>Complete Overhaul of Diagnosis &amp; Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM (Diagnosis)</td>
<td>ICD-10-CM (Procedure)</td>
</tr>
<tr>
<td>3-5 digits alphanumeric</td>
<td>7 digits numeric or alphanumeric characters</td>
</tr>
<tr>
<td>≈14,000 unique codes</td>
<td>&gt; 72,000 unique codes</td>
</tr>
</tbody>
</table>

**Implications**

**Pervasive Impacts**
- Diagnosis codes and procedure codes flow through mission critical operational systems and analytical tools
- External trading partners represent a myriad of complex connection points

**Multi-Disciplinary Challenge**
- Alignment of technology remediation with business and technology strategies
- Business process reengineering, training and change management is essential
Transition to ICD-10 Impact

**People**
- Patient Access
  - ED Registration
  - Central Registration - Ambulatory
  - Point of Service
  - Ambulatory/Satellite Services
  - Admitting
  - Transaction 270/271 (Eligibility)
  - Transaction 278 (Referrals/Authorizations)

**Clinical & Ancillary**
- Physician/Nurse Documentation
  - Ancillary & Support Services Documentation
- Use of workflow within EMR
- Case Management
- Charge Reconciliation
  - Clinical Documentation Improvement Programs
- Workflow between clinical units
- Order Entry

**Health Information Management**
- Coding and Abstracting
- Deficiency Tracking
- Claim Edit Work Lists
- NCCI/LRP Edits
- Encoding & Grouping
- Transaction 837P/I (Claims – Professional & Institutional)

**Charge Entry / Claims / Billing**
- Claims
  - Contracting
  - Cash Application
  - Physician Billing
  - Charge Entry
- Transaction 837I/P (Claims – Professional & Institutional)

**Receivables**
- Cash Application/Payment Posting
- Follow Up & Denial Management
- Transaction 835 (Remittance)
- Transaction 276/277 (Claims Status)

**Analytics / Reporting**
- Clinical Analytics
- Revenue Analytics
- Federal & State Reporting
- ICD-9 to ICD-10 mapping and translation

Source: Ingenix
## Benefits of ICD-10

<table>
<thead>
<tr>
<th>Quality Measurement</th>
<th>Data availability to assess quality standards, patient safety goals, mandates and compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health</td>
<td>Improved disease and outbreak information, Improved ability to track and respond to public health threats</td>
</tr>
<tr>
<td>Research</td>
<td>Better data mining for increased analysis of diagnosis, treatment efficacy, prevention, etc., Recognition of advances in medicine and technology</td>
</tr>
<tr>
<td>Organizational Monitoring and Performance</td>
<td>Enhanced ability to identify and resolve problems and ability to differentiate payment based on performance</td>
</tr>
</tbody>
</table>
Outpatient Scenario

*Patient is returning for follow up of previous right humeral fracture.*

*Documentation does not specify site of humeral fracture.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>812.20</td>
<td>Fracture humerus, unspecified site</td>
</tr>
<tr>
<td>S42201X</td>
<td>Unspecified fracture of upper end of right arm, subsequent encounter</td>
</tr>
</tbody>
</table>

**Additional Specificity Needed for ICD-10**

- Anatomical site
- Episode of care 7th character - Subsequent encounter for fracture with routine healing, delayed healing, nonunion, malunion or sequela
Clinical Documentation Gaps

Common Scenario

*Patient presents to the ED with a wound to the ear from a fall.*
*Patient is experiencing palpitations due to under-dosing of Digoxin as his prescription ran out last week.*
*Patient placed on IV Dig and sutures were necessary.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>872.00</td>
<td>Open Wound of External Ear</td>
</tr>
<tr>
<td>785.1</td>
<td>Palpitations</td>
</tr>
<tr>
<td>E885.9</td>
<td>Fall on Same Level</td>
</tr>
<tr>
<td>184</td>
<td>Suture of Ear</td>
</tr>
<tr>
<td>S01.311A</td>
<td>Laceration of the right ear w/o foreign body, initial encounter</td>
</tr>
<tr>
<td>T45.526A</td>
<td>Under-dosing of anti-arrhythmic, initial encounter</td>
</tr>
<tr>
<td>R00.2</td>
<td>Palpitations</td>
</tr>
<tr>
<td>Z91.138</td>
<td>Under-dosing unintentional</td>
</tr>
<tr>
<td>W1849xA</td>
<td>Fall from same level, initial encounter</td>
</tr>
<tr>
<td>09Q0XZZ</td>
<td>Repair of the right external ear, external approach</td>
</tr>
</tbody>
</table>

**Additional Specificity Needed for ICD-10**
- Type of wound Injury
- Foreign body or not
- Laterality of ear injury
- Episode of care
- Under-dosing
- Under-dosing intentional or not
- Anatomical site of procedure
- Approach for procedure
Impact to Clinicians

The transition to ICD-10 will affect physician productivity for related to increased specificity in clinical documentation and to select the appropriate ICD-10 codes

Example: The patient has a “fracture of the wrist”, fracturing the left wrist. A month later, the patient comes in with a fracture of the right wrist.

Current Scenario: The ICD-9-CM diagnosis codes do not currently identify left vs. right for wrist fractures or for any other part of the body, so additional documentation is required to show the location

Future Scenario: ICD-10-CM diagnosis codes are much more descriptive (e.g., left vs. right, initial vs. subsequent encounter, routine healing, delayed healing, nonunion, or malunion)
# Alcohol/Drug Dependence

## ICD-9

- Alcohol dependence syndrome
  - 303.xx
  - 4<sup>th</sup> digit intoxication
  - 5<sup>th</sup> digit status
- Drug Dependence
  - 304.xx
  - 4<sup>th</sup> digit type of drug
  - 5<sup>th</sup> digit status

## ICD-10

- F10-F19 Alcohol –Inhalant related disorders
  - F10.XXX
  - Abuse
  - Psycotic
  - Withdrawal
  - Delusions
  - Dementia
  - Hallucinations
  - Delirum
    - intoxication
Coronary Artery Arteriosclerosis (CAD)

ICD-9
- 414.0X
  - 414.0X
  - 5\textsuperscript{th} type of artery/vein
    - Unspecified
    - Native
    - Autologous vein bypass graft
    - Non-autologous biological graft
    - Artery bypass graft
    - Transplanted heart

ICD-10
- I25.XXX
  - Type
    - Unspecified
    - Native
    - Autologous vein bypass graft
    - Non-autologous biological graft
    - Artery bypass graft
    - Transplanted heart
  - Angina
    - Unstable
    - Spasm
    - Other
Non-Coronary Artery Arteriosclerosis

ICD-9

- 440.XX
  - Renal
  - Extremities
    - Native/Graft
  - Other Specified site(s)

ICD-10

- I70.XXX
- More specific Sites
- Concept of laterality
  - Right
  - Left
  - Bilateral
- Intermittent claudication
- Rest pain
- Ulceration
- Gangrene
Occlusion of cerebral arteries (CVA)

**ICD-9**
- 434.XX
  - 4\(^{th}\) thrombosis, embolism, occlusion
  - 5\(^{th}\) w or w/o infarction

**ICD-10**
- I63.XXX
  - Precerebral
  - Cerebral
  - Right/left – Anterior – Posterior - Middle
  - Cerebellar
    - Thrombosis
    - Embolism
    - Occlusion or Stenosis
    - Infarction
Asthma

ICD-9
- 493.XX
  - 4th Digit
    - Extrinsic
    - Intrinsic
    - Chronic Obstructive
    - Other
  - 5th Digit
    - Exacerbation or status asthmaticus

ICD-10
- J45.XXX
  - Extrinsic
  - Intrinsic
  - Chronic Obstructive
  - Other

<table>
<thead>
<tr>
<th>Asthma Severity</th>
<th>Frequency of Daytime Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermittent</td>
<td>Less than or equal to 2 times per week</td>
</tr>
<tr>
<td>Mild Persistent</td>
<td>More than 2 times per week</td>
</tr>
<tr>
<td>Moderate Persistent</td>
<td>Daily. May restrict physical activity</td>
</tr>
<tr>
<td>Severe Persistent</td>
<td>Throughout the day. Frequent severe attacks limiting ability to breathe.</td>
</tr>
</tbody>
</table>
• Greater specificity
  – Type of fracture
  – Specific anatomical site
  – Displaced vs nondisplaced
  – Laterality
  – Routine vs delayed healing
  – Nonunion
  – Malunion
– Type of encounter
  • Initial
  • Subsequent
  • Sequela
ICD-10 Pathological or Stress Fracture Extensions

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Initial encounter</td>
</tr>
<tr>
<td>D</td>
<td>Subsequent – routine healing</td>
</tr>
<tr>
<td>G</td>
<td>Subsequent – delayed healing</td>
</tr>
<tr>
<td>K</td>
<td>Subsequent – nonunion</td>
</tr>
<tr>
<td>P</td>
<td>Subsequent – malunion</td>
</tr>
<tr>
<td>S</td>
<td>Sequela</td>
</tr>
</tbody>
</table>

**Coding Note:** ICD-10-CM has three different categories for pathologic fractures – due to neoplastic disease, due to osteoporosis, and due to other specified disease.
• Initial encounter
  – The patient is receiving active treatment for the injury
  • Surgical treatment
  • Emergency department encounter
  • Evaluation and treatment by a new physician
ICD-10 Extensions

- 0 – not applicable or unspecified
- 1 – fetus 1
- 2 – fetus 2
- 3 – fetus 3
- 4 – fetus 4
- 5 – fetus 5
- 9 – other fetus

Pregnancy Complications
Subsequent encounter

– After patient received active treatment of injury and receiving routine care during healing or recovery phase

• Cast change or removal
• Removal of external or internal fixation device
• Medication adjustment
• Other aftercare and follow-up visits following injury treatment.
### Highest Risks Identified

<table>
<thead>
<tr>
<th>Category</th>
<th>Areas of Impact/Risks</th>
<th>Level of Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coding</td>
<td>Coders- Productivity; Payment delays</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physicians – Pt throughput; Pt documentation, reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nurses/MAs – Coordination; Support</td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td>Physician <em>Office</em> – required doctor coder; scheduling; patient throughput</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician <em>Hospital</em> – MD Documentation drives majority of coding</td>
<td></td>
</tr>
<tr>
<td>Systems</td>
<td>Financial – Billing, Coding, Registration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical – Documentation, Scheduling</td>
<td></td>
</tr>
</tbody>
</table>

- Must support both ICD9 & ICD10
- Interfaces included
ICD 10 Clinical Documentation Improvement (CDI)

- Clinical Documentation Improvement (CDI)
  - Goal
    - To ensure Clinical Documentation supports ICD-10 coding specificity with minimal impact to productivity and quality scores.
    - CDI Materials review by team
Computer Assisted Coding (CAC)

– Goal
  – Select and implement an application to help HIM coders and physicians in the assignment of correct ICD10 codes.
  – Select and implement an tool to help physicians improve physician documentation to assign codes.
Dual Coding Strategy

Definition

“Dual Coding” - means assigning both ICD-9 and ICD-10 codes simultaneously to a record

“Code and Capture” - Implementation of ICD-10 codes in production, prior to October 1, 2014; for the purposes of data analytics/reporting. This will impact existing processes, technologies and resources; magnitude will depend on the strategy and approach adopted.

Assumptions

• Payers will not accept and/or adjudicate ICD-10 claims prior to 10/1/14. Therefore, it’s not an option to early adopt for purposes of claim submission and reimbursement.
• ICD-10 codes will be included in remediation activities to prepare for the 10/1/14 activation date, for purposes of testing, identifying impact to reimbursement, training and technology remediation.

Key Considerations

• Business requirements (i.e., reporting needs)
• Technology readiness
• Resource and training impact/readiness
• Existing production process implications
• Risk to existing applications, initiatives, and resources within the organization
• Timing
• Competing initiatives
QUESTIONS