

Truly Understanding Clinical Documentation Improvement for ICD-10



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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.

Documentation Matters

“If it was not documented, it was not done”

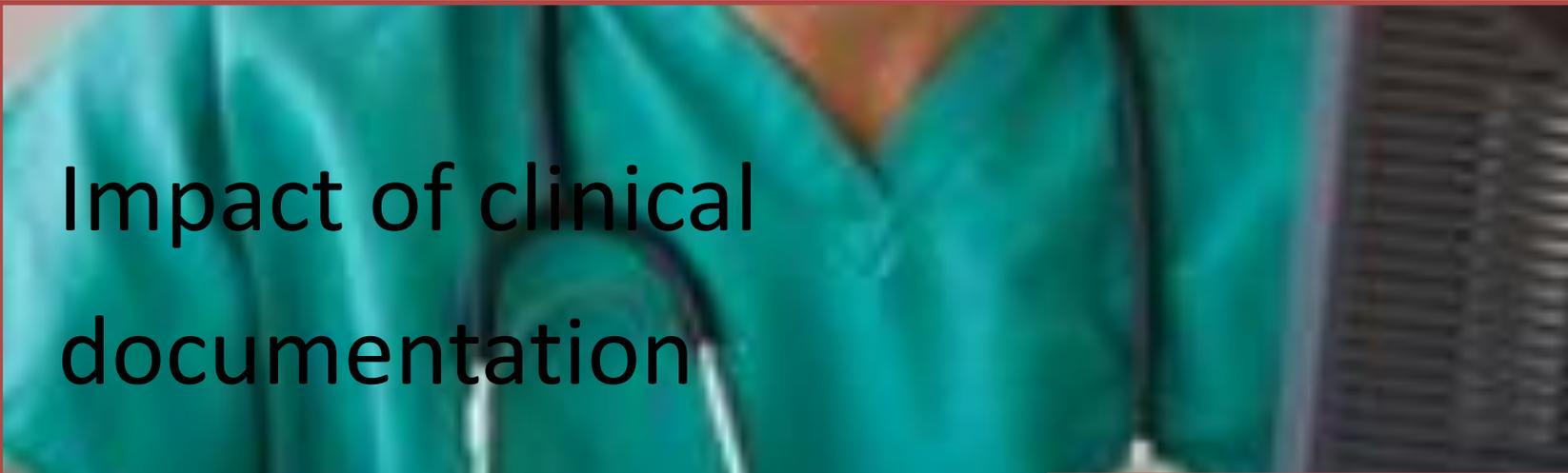


Documentation Matters

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

Documentation Matters



Impact of clinical documentation

Patient

- Quality of care provided
- Continuity of care
- Non-payment by Insurance

Physician

- Demonstrates accountability
- Performance Management
- Reduced or denied payment
- Relative Value Unit (RVU)
- Hierarchy Coding Category (HCC)

Facility

- Coding and Billing
- Supporting documentation for treatment and services rendered
- Appropriate reimbursement
- DRG

Documentation Matters

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

In a nut-shell



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



Coding Guidelines

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

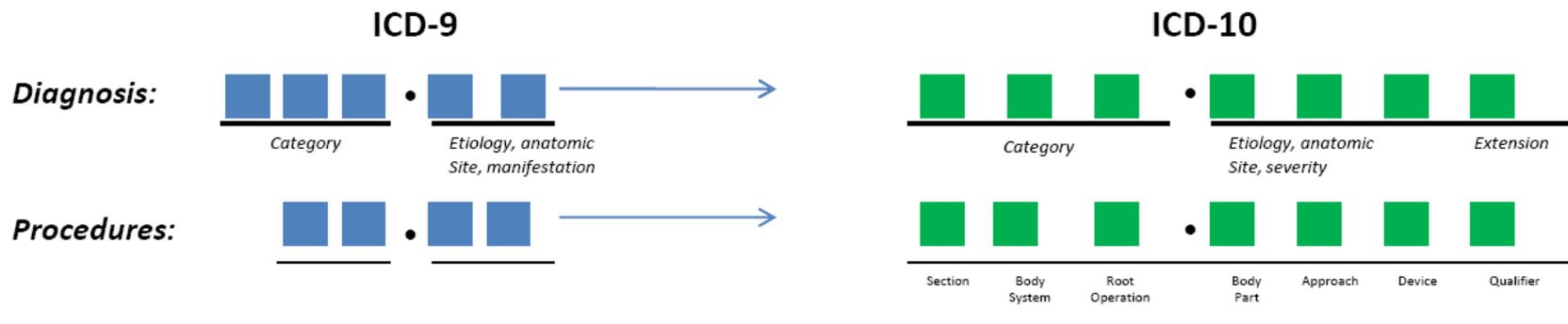
- ICD-9-CM Codes (17,000) are assigned to specific diagnoses and procedures.
 - 3-5 Digit Coding system
- ICD-9-CM Codes group to Diagnostic Related Groups (DRG) based upon similar resource consumption and care provided
- Coding Conventions that include complex and detailed information on how to use 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

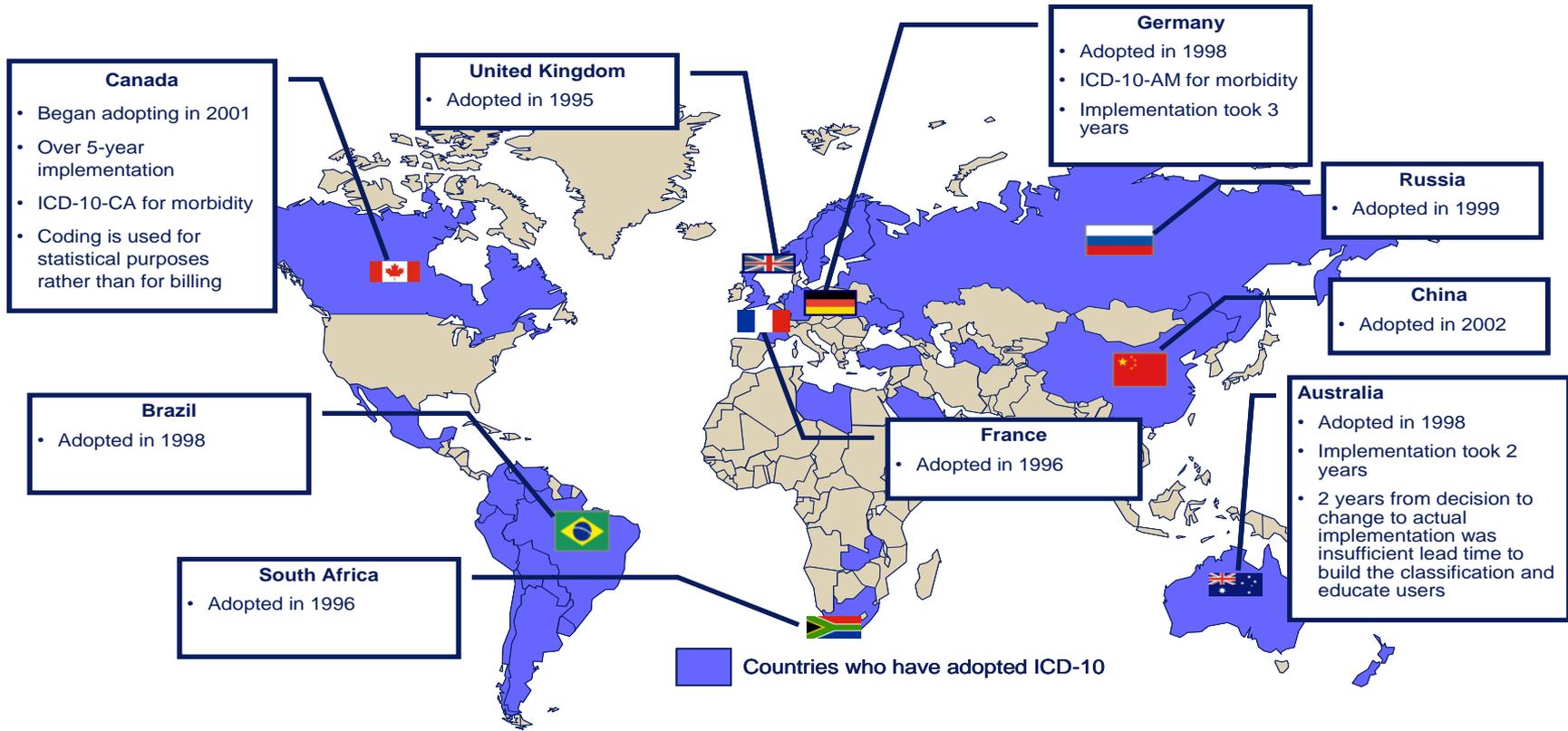
Number of Codes

	ICD-9	ICD-10
Total Codes	16,000	155,000
Diagnosis Codes	13,000	68,000
Procedure Codes	3,000	87,000

Structural Change

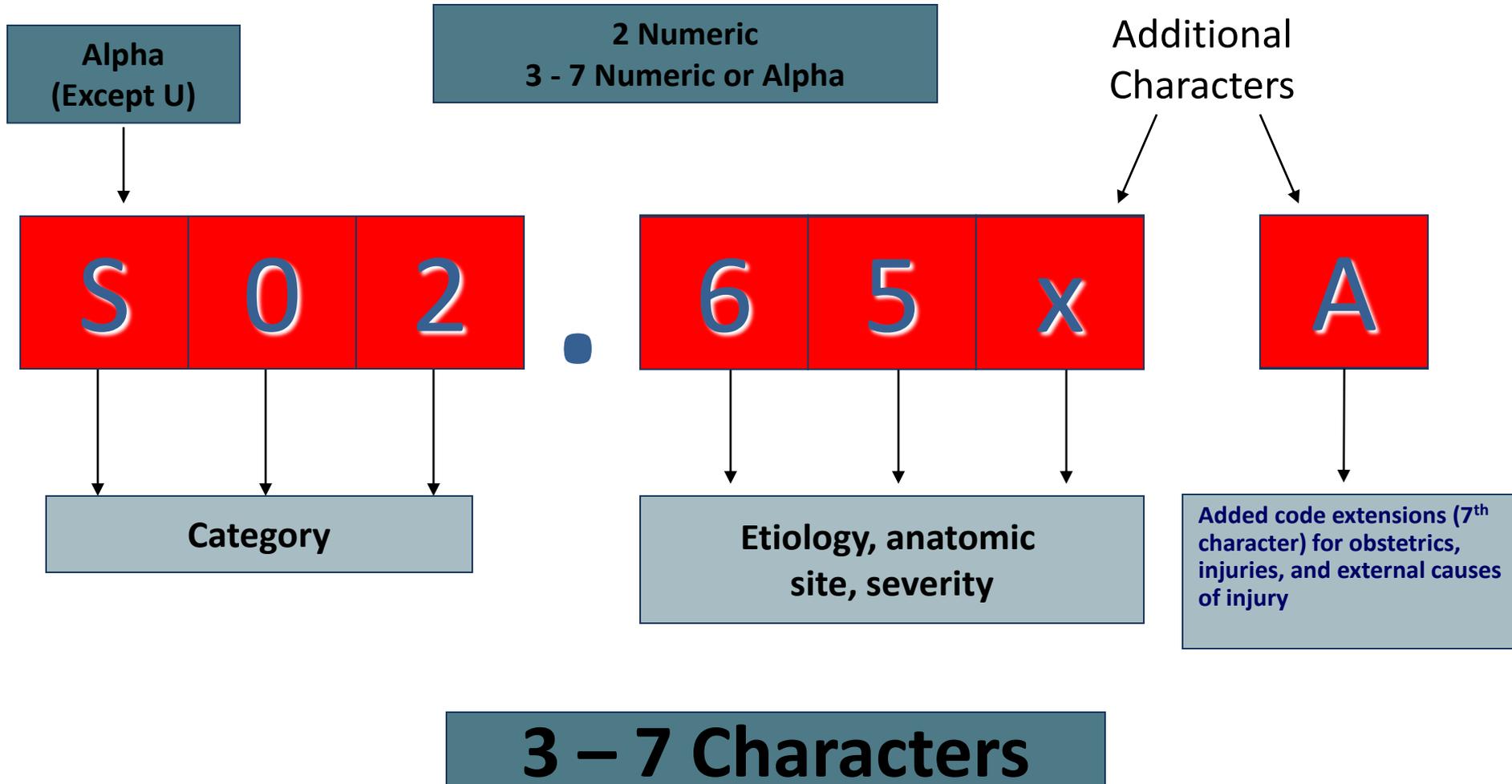


Global usage ICD-10



SOURCE: <http://www.who.int/classifications/icd/en/>

Coding and 7th Character Extensions



ICD-9-CM vs ICD-10-CM Codes

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

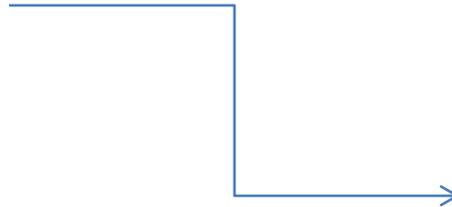


- ICD-10-CM **H40.83** for aqueous misdirection (malignant glaucoma)
 - H40.83**1** Aqueous misdirection, **right** eye
 - H40.83**2** Aqueous misdirection, **left** eye
 - H40.83**3** Aqueous misdirection, **bilateral** eyes
 - H40.83**9** Aqueous misdirection, **unspecified** eye

One More Example

ICD-9-CM

- Sprained Ankle
- 5 Codes

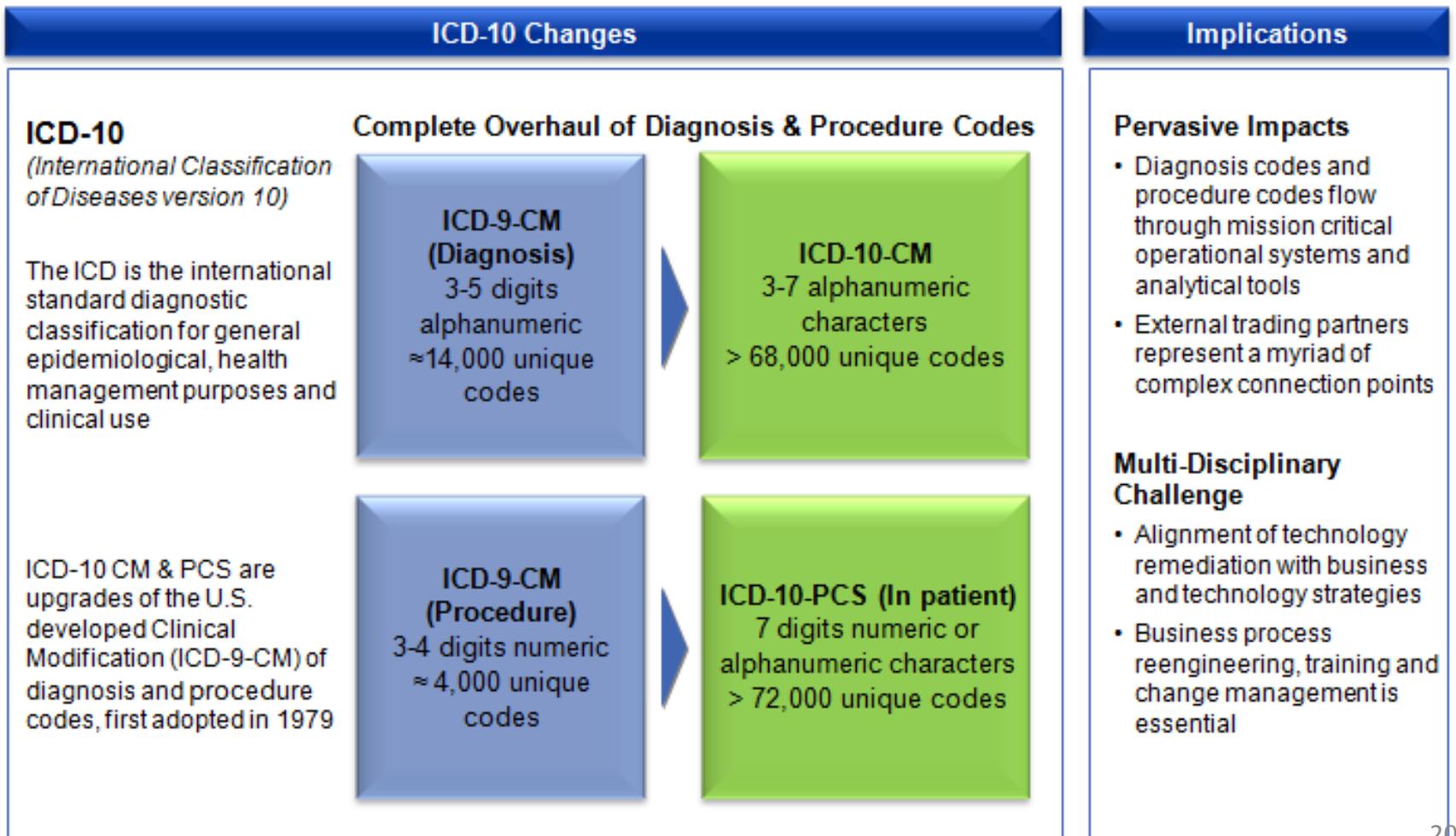


ICD-10-CM

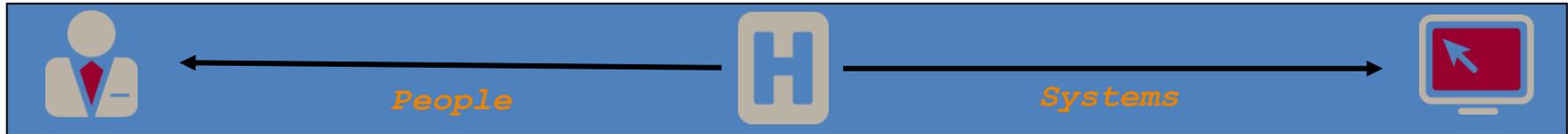
- Sprained Ankle
- 45 Codes
- Which part of the ankle was injured?
- Right or Left?
- First-time Injury?

Background: ICD-10 Overview

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.



Transition to ICD-10 Impact



Patient Access	Clinical & Ancillary	Health Information Management	Charge Entry / Claims / Billing	Receivables	Analytics / Reporting
ED Registration	Physician/Nurse Documentation	Coding and Abstracting	Claims	Cash	Clinical Analytics
Central Registration - Ambulatory	Ancillary & Support Services Documentation	Deficiency Tracking	Contracting	Application/Payment Posting	Revenue Analytics
Point of Service	Use of workflow within EMR	Claim Edit Work Lists	Cash Application	Follow Up & Denial Management	Federal & State Reporting
Ambulatory/Satellite Services	Case Management	NCCI/LRP Edits	Physician Billing	Transaction 835 (Remittance)	ICD-9 to ICD-10 mapping and translation
Admitting	Charge Reconciliation	Encoding & Grouping	Charge Entry	Transaction 276/277 (Claims Status)	
Transaction 270/271 (Eligibility)	Clinical Documentation Improvement Programs	Transaction 837P/I (Claims – Professional & Institutional)	Transaction 837I/P (Claims – Institutional & Professional)		
Transaction 278 (Referrals/ Authorizations)	Workflow between clinical units				
	Order Entry				

Benefits of ICD-10

Quality Measurement	<ul style="list-style-type: none">▪ Data availability to assess quality standards, patient safety goals, mandates and compliance
Public Health	<ul style="list-style-type: none">▪ Improved disease and outbreak information▪ Improved ability to track and respond to public health threats
Research	<ul style="list-style-type: none">▪ Better data mining for increased analysis of diagnosis, treatment efficacy, prevention, etc.▪ Recognition of advances in medicine and technology
Organizational Monitoring and Performance	<ul style="list-style-type: none">▪ Enhanced ability to identify and resolve problems and ability to differentiate payment based on performance

Documentation Improvement Gaps

Outpatient Scenario

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

Documentation does not specify site of humeral fracture.

	Code	Code Description
ICD-9	812.20	Fracture humerus, unspecified site
ICD-10	S42201X	Unspecified fracture of upper end of right arm, subsequent encounter

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.

	Code	Code Description
ICD-9	872.00	Open Wound of External Ear
	785.1	Palpitations
	E885.9	Fall on Same Level
	184	Suture of Ear
ICD-10	S01.311A	Laceration of the right ear w/o foreign body, initial encounter
	T45.526A	Under-dosing of anti-arrhythmic, initial encounter
	R00.2	Palpitations
	Z91.138	Under-dosing unintentional
	W1849xA	Fall from same level, initial encounter
	09Q0XZZ	Repair of the right external ear, external approach

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.

ICD-9 – 814.00 Closed Fracture of Carpal Bone



ICD-10 – More than 2,000 codes representing Wrist Fracture

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)

36925	S62172S	Displaced fracture of trapezium [larger multangular], left wrist, sequela
36926	S62173A	Displaced fracture of trapezium [larger multangular], unspecified wrist, initial encounter for closed fracture
36927	S62173B	Displaced fracture of trapezium [larger multangular], unspecified wrist, initial encounter for open fracture
36928	S62173D	Displaced fracture of trapezium [larger multangular], unspecified wrist, subsequent encounter for fracture with routine healing
36929	S62173G	Displaced fracture of trapezium [larger multangular], unspecified wrist, subsequent encounter for fracture with delayed healing
36930	S62173K	Displaced fracture of trapezium [larger multangular], unspecified wrist, subsequent encounter for fracture with nonunion
36931	S62173P	Displaced fracture of trapezium [larger multangular], unspecified wrist, subsequent encounter for fracture with malunion
36932	S62173S	Displaced fracture of trapezium [larger multangular], unspecified wrist, sequela
36933	S62174A	Nondisplaced fracture of trapezium [larger multangular], right wrist, initial encounter for closed fracture
36934	S62174B	Nondisplaced fracture of trapezium [larger multangular], right wrist, initial encounter for open fracture
36935	S62174D	Nondisplaced fracture of trapezium [larger multangular], right wrist, subsequent encounter for fracture with routine healing
36936	S62174G	Nondisplaced fracture of trapezium [larger multangular], right wrist, subsequent encounter for fracture with delayed healing
36937	S62174K	Nondisplaced fracture of trapezium [larger multangular], right wrist, subsequent encounter for fracture with nonunion
36938	S62174P	Nondisplaced fracture of trapezium [larger multangular], right wrist, subsequent encounter for fracture with malunion
36939	S62174S	Nondisplaced fracture of trapezium [larger multangular], right wrist, sequela
36940	S62175A	Nondisplaced fracture of trapezium [larger multangular], left wrist, initial encounter for closed fracture
36941	S62175B	Nondisplaced fracture of trapezium [larger multangular], left wrist, initial encounter for open fracture
36942	S62175D	Nondisplaced fracture of trapezium [larger multangular], left wrist, subsequent encounter for fracture with routine healing
36943	S62175G	Nondisplaced fracture of trapezium [larger multangular], left wrist, subsequent encounter for fracture with delayed healing
36944	S62175K	Nondisplaced fracture of trapezium [larger multangular], left wrist, subsequent encounter for fracture with nonunion
36945	S62175P	Nondisplaced fracture of trapezium [larger multangular], left wrist, subsequent encounter for fracture with malunion
36946	S62175S	Nondisplaced fracture of trapezium [larger multangular], left wrist, sequela
36947	S62176A	Nondisplaced fracture of trapezium [larger multangular], unspecified wrist, initial encounter for closed fracture

Alcohol/Drug Dependence

ICD-9

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

ICD-10

- F10-F19 Alcohol –Inhalant related disorders
 - F10.XXX
 - Abuse
 - Psychotic
 - Withdrawal
 - Delusions
 - Dementia
 - Hallucinations
 - Delirium
 - intoxication

Coronary Artery Arteriosclerosis (CAD)

ICD-9

- 414.0X
 - 414.0X
 - 5th 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
 - 4th thrombosis, embolism, occlusion
 - 5th 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



Asthma Severity	Frequency of Daytime Symptoms
Intermittent	Less than or equal to 2 times per week
Mild Persistent	More than 2 times per week
Moderate Persistent	Daily. May restrict physical activity
Severe Persistent	Throughout the day. Frequent severe attacks limiting ability to breathe.

ICD-10

Fractures

- 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

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.

A

- Initial encounter

D

- Subsequent – routine healing

G

- Subsequent – delayed healing

K

- Subsequent – nonunion

P

- Subsequent – malunion

S

- Sequela



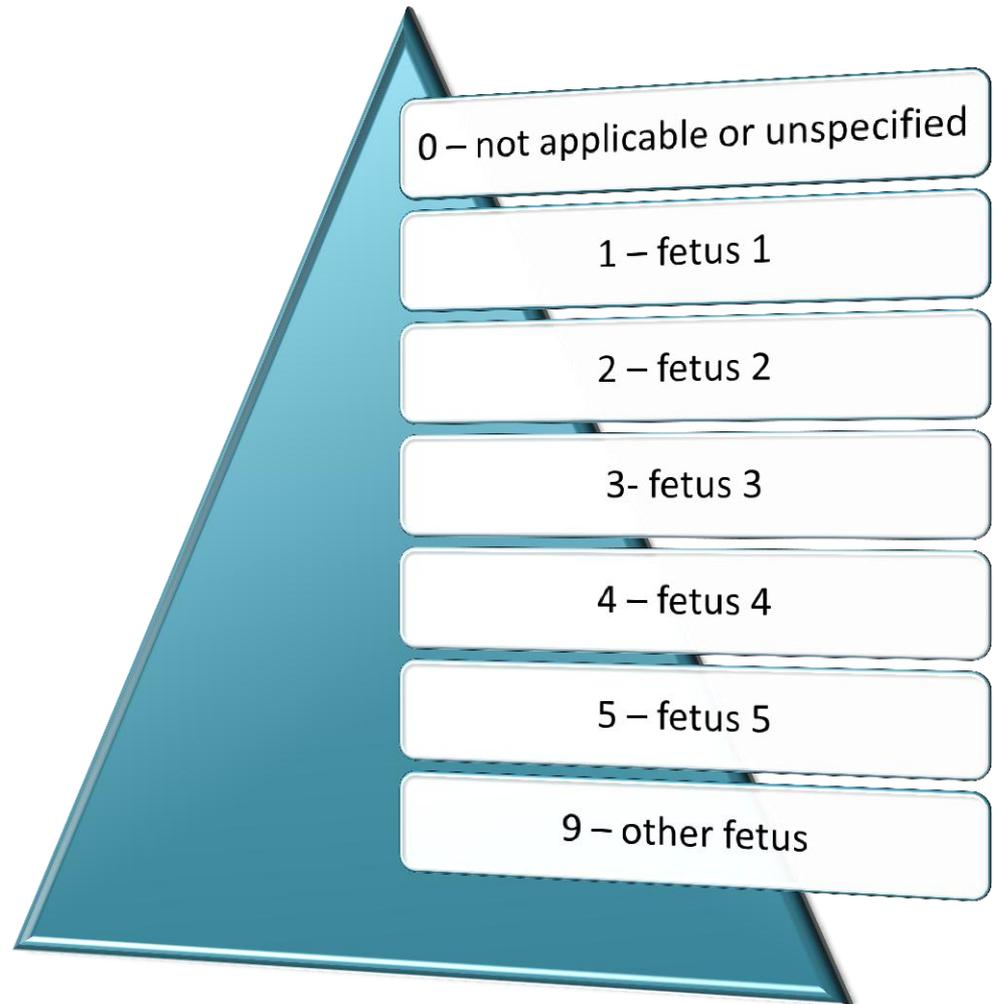
- Initial encounter

- The patient is receiving active treatment for the injury



- Surgical treatment
 - Emergency department encounter
 - Evaluation and treatment by a new physician

ICD-10 Extensions





Chapter
19

Subsequent encounter

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

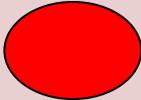
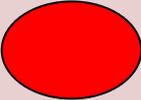
- Cast change or removal
- Removal of external or internal fixation device
- Medication adjustment
- Other aftercare and follow-up visits following injury treatment.



ARE YOU READY



Highest Risks Identified

Category	Areas of Impact/Risks	Level of Impact
Coding	<p>Coders- Productivity; Payment delays</p> <p>Physicians – Pt throughput; Pt documentation, reporting</p> <p>Nurses/MAs – Coordination; Support</p>	
Documentation	<p>Physician <i>Office</i> – required doctor coder; scheduling; patient throughput</p> <p>Physician <i>Hospital</i> – MD Documentation drives majority of coding</p>	
Systems Must support both ICD9 & ICD10 Interfaces included	<p>Financial – Billing, Coding, Registration</p> <p>Clinical – Documentation, Scheduling</p>	

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

