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

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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
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
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.
## Integrated Problem List Display

<table>
<thead>
<tr>
<th>Status</th>
<th>Onset Date</th>
<th>Provider Narrative</th>
<th>Comments</th>
<th>PHx</th>
<th>PIP</th>
<th>IP</th>
<th>ICD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic</td>
<td></td>
<td>Closed fracture of proximal ulna, comminuted</td>
<td>left, traumatic acute, swelling and hematoma at site</td>
<td></td>
<td></td>
<td></td>
<td>813.04</td>
</tr>
<tr>
<td>Sub-acute</td>
<td></td>
<td>Abnormal findings on diagnostic imaging of skull and head</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>793.0</td>
</tr>
<tr>
<td>Chronic</td>
<td></td>
<td>Abnormal findings diagnostic imaging heart+coronary circulat</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>793.2</td>
</tr>
<tr>
<td>Social/Environmental</td>
<td></td>
<td>Leishmaniasis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>085.9</td>
</tr>
<tr>
<td>Chronic</td>
<td>08/05/2013</td>
<td>Lactocele</td>
<td>This is a test</td>
<td>This is a test :</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic</td>
<td>06/30/2013</td>
<td>Asthma</td>
<td>Exacerbations required emergent intubation and respiratory support x 2 in past 2 years :</td>
<td></td>
<td></td>
<td></td>
<td>493.90</td>
</tr>
<tr>
<td>Chronic</td>
<td>07/24/2013</td>
<td>Diabetes mellitus type 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>250.00</td>
</tr>
<tr>
<td>Chronic</td>
<td>11/02/2013</td>
<td>Chronic otitis externa</td>
<td>right</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic</td>
<td>07/16/2008</td>
<td>Obesity</td>
<td>Can add clarification</td>
<td>I can add a comment :</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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:
- 10\textsuperscript{th} 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)
Why ICD-10? Why now?

ICD-9 code development was completed in 1973.

Source: Christi Dant, CMS Office of E-Health Standards & Services, 2-02-2012, “The ICD-10 Story”
## 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>
</tbody>
</table>

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ICD-9-CM vs ICD-10-CM

Torus fracture of lower end of right radius, initial encounter for closed fracture

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Narrative</th>
<th>ICD-10</th>
<th>Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>813.80</td>
<td>Unspecified part, (closed) Forearm</td>
<td>S52</td>
<td>Fracture of forearm (category)</td>
</tr>
<tr>
<td>813.40</td>
<td>Lower end of forearm, unspecified</td>
<td>S52.5</td>
<td>Fracture of lower end of radius</td>
</tr>
<tr>
<td>813.45</td>
<td>Torus fracture of radius (alone)</td>
<td>S52.52</td>
<td>Torus Fracture of lower end of radius</td>
</tr>
<tr>
<td></td>
<td>Same as above</td>
<td>S52.521</td>
<td>Torus Fracture lower end of right radius</td>
</tr>
<tr>
<td></td>
<td>Same as above</td>
<td>S52.521A</td>
<td>Torus Fracture lower end of right radius</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 (cont.)

<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 I10</td>
<td>“Always true” rule is a 1:1 match. Will store in POV when selected.</td>
</tr>
<tr>
<td>Type II diabetes mellitus uncontrolled</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 see - <strong>Use additional code to identify any insulin use (Z79.4).</strong></td>
</tr>
<tr>
<td>Cerebral Edema</td>
<td>Cannot be automatically mapped</td>
<td><strong>Passes map advice which can be seen by coders as they hover on problem list or in PCC data entry.</strong></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 un-coded 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.
Example of Map Advice for SNOMED CT® Term “Cerebral Edema”

Rule #1  Target Code: G93.6
ALWAYS G93.6

Rule #2  Target Code: P11.0
IF CEREBRAL EDEMA DUE TO BIRTH INJURY CHOOSE P11.0

Rule #3  Target Code: S01.80X?
IF TRAUMATIC CEREBRAL EDEMA WITH OPEN INTRACRANIAL WOUND CHOOSE S01.80X?
EPISODE OF CARE INFORMATION NEEDED
POSSIBLE REQUIREMENT FOR AN EXTERNAL CAUSE CODE

Rule #4  Target Code: S06.1X0?
IF TRAUMATIC CEREBRAL EDEMA CHOOSE S06.1X0?
CONSIDER ADDITIONAL CODE TO IDENTIFY SPECIFIC CONDITION OR DISEASE
EPISODE OF CARE INFORMATION NEEDED
POSSIBLE REQUIREMENT FOR AN EXTERNAL CAUSE CODE

Rule #5  Target Code: S06.1X0?
IF TRAUMATIC CEREBRAL EDEMA WITH OPEN INTRACRANIAL WOUND CHOOSE S06.1X0?
EPISODE OF CARE INFORMATION NEEDED
POSSIBLE REQUIREMENT FOR AN EXTERNAL CAUSE CODE

Rule #6  Target Code: S06.1X0?
IF TRAUMATIC CEREBRAL EDEMA WITHOUT OPEN INTRACRANIAL WOUND CHOOSE S06.1X0?
EPISODE OF CARE INFORMATION NEEDED
POSSIBLE REQUIREMENT FOR AN EXTERNAL CAUSE CODE

Rule #7  Target Code: N/A
MAP SOURCE CONCEPT CANNOT BE CLASSIFIED WITH AVAILABLE DATA
SNOMED CT® Search

- 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.
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, encounter note.

Provider narrative will be more consistent.

Format: 

<table>
<thead>
<tr>
<th>Standard Term</th>
<th>Clinician Free Text</th>
</tr>
</thead>
</table>

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.
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
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”.

![Image of problem list and visit diagnosis with problem entries]
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><strong>Control (supports E&amp;M coding)</strong> - Poorly controlled, Hypoglycemia, Hyperglycemia</td>
</tr>
<tr>
<td>Type 1 uncontrolled</td>
<td><strong>Manifestation/Complication</strong> – Arthropathy, Circulatory complications, Hyperosmolarity 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><strong>Insulin use</strong> – 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><strong>Identify body system affected</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Identify insulin use for type 2 &amp; secondary diabetes</strong></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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Type 2 diabetes mellitus</td>
</tr>
<tr>
<td><strong>Provider Text:</strong> uncontrolled with persistent microalbuminuria</td>
</tr>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Type 2 diabetes mellitus</td>
</tr>
<tr>
<td><strong>Encounter note documentation:</strong> Diabetes is uncontrolled with persistent microalbuminuria</td>
</tr>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Persistent microalbuminuria associated with type 2 diabetes mellitus</td>
</tr>
<tr>
<td><strong>Provider text:</strong> uncontrolled</td>
</tr>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Type II diabetes mellitus uncontrolled</td>
</tr>
<tr>
<td><strong>Provider Text:</strong> persistent microalbuminuria</td>
</tr>
</tbody>
</table>

*Any of the combinations are acceptable.*
Diabetes Mellitus Type 2, Uncontrolled, with Persistent Microalbuminuria

Problem List

POV Entry

Visit Diagnosis Display

Note

Assessment and Plan

1) Diabetes mellitus type 2 | uncontrolled with persistent microalbuminuria [P]
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)
Diabetes Mellitus Type 2, Uncontrolled, with Persistent Microalbuminuria

Problem List

POV Entry

Visit Diagnosis Display

Note

Assessment and Plan

1) Persistent microalbuminuria associated with type II diabetes mellitus | uncontrolled [P]
Diabetes Mellitus Type 2, Uncontrolled, with Persistent Microalbuminuria

Problem List

POV Entry

Visit Diagnosis Display

Note

1) Type II diabetes mellitus uncontrolled | persistent microalbuminuria [P]
# Pregnancy

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

<table>
<thead>
<tr>
<th>EHR Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Gestational diabetes mellitus</td>
</tr>
<tr>
<td><strong>Provider Text:</strong> controlled, continue insulin</td>
</tr>
<tr>
<td><strong>EGA (vital entry):</strong> 33 weeks 1 day</td>
</tr>
</tbody>
</table>

| **SNOMED CT® Problem:** Gestational diabetes mellitus |
| **Provider Text:** 33 weeks 1 day, controlled, continue insulin |

| **SNOMED CT® Problem:** Gestational diabetes mellitus |
| **Provider text:** |
| **Encounter note subjective text:** 33 weeks 1 day |
| **Encounter note assessment/plan text:** Gestational diabetes is controlled on insulin therapy. Continue insulin. |

*Any of the combinations are acceptable.*
Gestational Diabetes, Controlled on Insulin Therapy

Problem List

POV Entry

Visit Diagnosis
Display

Note

Assessment/Plan
1) Gestational diabetes mellitus | controlled, continue insulin [P]
Gestational Diabetes, Controlled on Insulin Therapy

Problem List

POV Entry

Visit Diagnosis Display

Note

1) Gestational diabetes mellitus | 33 weeks 1 day, controlled, continue insulin [P]
Gestational Diabetes, Controlled on Insulin Therapy

Problem List

POV Entry

Visit Diagnosis

Display

Note (info added to note by user)
### Asthma

<table>
<thead>
<tr>
<th>Required documentation for ICD-9</th>
<th>Required documentation for ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>- Identify Type</strong></td>
<td><strong>- Identify Type</strong></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>Exercise induced bronchospasm</td>
</tr>
<tr>
<td></td>
<td>Cough variant</td>
</tr>
<tr>
<td><strong>- Identify asthma as complicated by:</strong></td>
<td><strong>- Identify Complications:</strong></td>
</tr>
<tr>
<td>Acute exacerbation</td>
<td>Uncomplicated</td>
</tr>
<tr>
<td>Status asthmaticus</td>
<td>With acute exacerbation</td>
</tr>
<tr>
<td></td>
<td>With status asthmaticus</td>
</tr>
</tbody>
</table>

- Identify asthma as complicated by:
- Acute exacerbation
- Status asthmaticus
- Other specified types
- Exercise induced bronchospasm
- Cough variant
- Other
- Identify Complications:
- Uncomplicated
- With acute exacerbation
- With status asthmaticus
Asthma, Moderate Persistent, Not Well Controlled with Current Exacerbation

<table>
<thead>
<tr>
<th>EHR Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Asthma</td>
</tr>
<tr>
<td><strong>Classification</strong> (entered on Problem Add/Edit): Moderate persistent</td>
</tr>
<tr>
<td><strong>Asthma control</strong> (entered on Problem Add/Edit if select as POV):</td>
</tr>
<tr>
<td><strong>Provider text:</strong> exacerbation</td>
</tr>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Asthma</td>
</tr>
<tr>
<td><strong>Provider text:</strong> moderate persistent, not well controlled, exacerbation</td>
</tr>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Asthma</td>
</tr>
<tr>
<td><strong>Provider Text:</strong></td>
</tr>
<tr>
<td><strong>Encounter note assessment/plan:</strong> moderate persistent asthma, not well controlled, current exacerbation</td>
</tr>
<tr>
<td><strong>SNOMED CT® Problem:</strong> Moderate persistent asthma</td>
</tr>
<tr>
<td><strong>Provider Text:</strong> not well controlled, exacerbation</td>
</tr>
</tbody>
</table>

*Any of the combinations are acceptable*
Asthma, Moderate Persistent, Not Well Controlled with Current Exacerbation

Problem List

Class/Control

POV

Visit Diagnosis

Display

Note

Assessment/Plan
1) Asthma | exacerbation [P]  Control: NOT WELL CONTROLLED (May 17, 2014)
Asthma, Moderate Persistent, Not Well Controlled with Current Exacerbation

Problem List

POV Entry

Visit Diagnosis Display

Note

1) Asthma | moderate persistent, not well controlled, exacerbation [P] Control: NOT WELL CONTROLLED (May 17, 2014)
Asthma, Moderate Persistent, Not Well Controlled with Current Exacerbation

Problem List

POV Entry

Visit Diagnosis

Display

Note (info added to note by user)
Asthma, Moderate Persistent, Not Well Controlled with Current Exacerbation

Problem List

POV

Visit Diagnosis

Display

Note

Assessment/Plan

1) Moderate persistent asthma | not well controlled, exacerbation [P]
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
QUESTIONS?
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.*