Tips on ICD-10 Clinical Documentation for Providers

Objectives

- To reinforce quality clinical documentation guidelines
- To provide examples of documentation necessary to support ICD-10
- To outline the granularity of ICD-10

The Inpatient and Outpatient Medical Record Must Support:

- Severity of illness
- Publically reported data
- Quality Indicators
- Enough information for the coder to apply the correct code

Documentation Principles for ALL Settings: Inpatient and Outpatient

- Each encounter includes:
  - Reason for encounter
  - Relevant history
  - Physical examination findings
  - Prior diagnostic test results
  - Assessment
  - Clinical impression or diagnosis
  - Medical Plan of Care

Documentation Principles: Inpatient and Outpatient

- Rationale for ordering diagnostics and ancillary services
- Health risk factors identified
- Patient’s progress
- Patient’s response to treatment
- Revisions of diagnosis documented based on clinical results
- All codes reported on the claim form must be supported in the medical record

Documentation Establishes CAUSE-and-EFFECT Relationship

- Type 2 diabetes with diabetic nephropathy
- Anemia due to chemotherapy
- Anemia due to acute/chronic blood loss

Documentation is Always CONSISTENT

- One time mention of diagnosis is not enough for coding purposes
- Treated diagnosis are always
  - **Inpatient** - Assessed throughout the patient's stay - DAILY
  - **Outpatient** - Assessed every visit until resolved
  - **Inpatient or Outpatient** - Cannot be coded from the problem list

Inpatient Case Study

- CHIEF COMPLAINT: Anxious
- Male who presents to the ED for detox. Has been referred by parole office for inpatient detox and eventual placement into rehab. He admits to binge drinking the past two weeks, mainly beers. When he does quit he begins to shake and becomes extremely anxious. Denies seizure activity. His last drink was 10 pm last night.
  - **Review of Systems and Physical Exam all normal**
  - **Uses the problem list in the admission H&P**

Alcohol Withdrawal Protocol

- Nausea/Vomiting
- Anxiety
- Paroxysmal Sweats
- Tactile disturbances
- Visual disturbances
- Tremors
- Agitation
- Orientation and clouding of sensorium
- Auditory disturbances
- Headache

Active Problems on Problem List Date of Encounter June 10, 2013

- **HTN** (added on Feb 25, **1997**)
- Non-compliant to HTN meds (Added on May 30, **1997**)
- **Type 2 Diabetes Mellitus** (Added on April 15, 2005)
- **Asthma** (Added on Nov. 24, 2008)
- **Seasonal Allergies** (Added on Mar 30, 2010)
- **Alcohol Abuse** (added on Mar 30, 2010)
- Noncompliance (Last updated on April 29, 2013)

Day 2: Clinical Assessment by Provider

- Blood pressure: 145/94
- Pain: 0
- Height: Not done while inpatient
- Weight: 267.20 lb
- BMI: 37.8
- Pulse: 65
- Respirations: 18
- Temperature: 97.2
- Last Accucheck: 190
- Lungs clear
- Heart-reg
- Abdomen-soft, nontender
- Extremities-no edema
- Neuro-no deficits

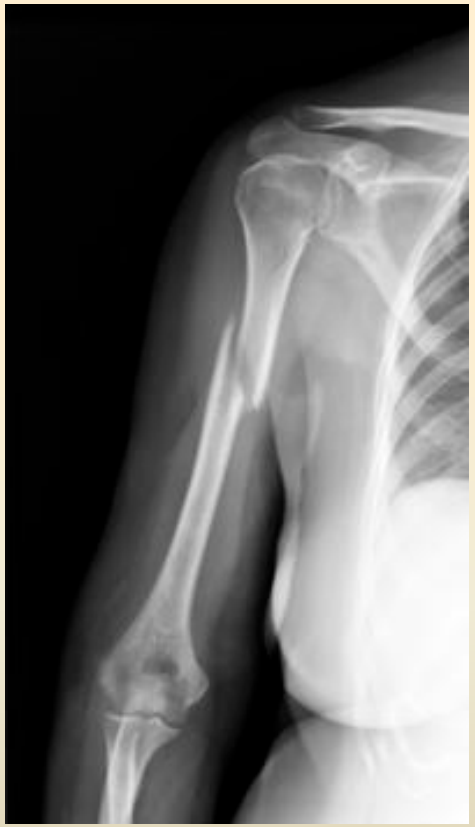
- Assessment/Progress:
  - Alcohol Dependency, detox clinically stable. On AWA protocol with librium
  - DM type 2 uncontrolled
- Doctors Orders/Plan: 1) Continue present management, awaiting rehab placement
- (Present management includes Glipizide PO and Sliding Scale Insulin- information gathered from Medication Administration Record)

New Features of ICD-10

- **Laterality**
- **Combination codes** like: K57.21 Diverticulitis of large intestine with perforation and abscess with bleeding
- **Combination codes for poisoning**: T42.3x2S Poisoning by barbiturates, intentional harm, sequela
- **Obstetric codes** identify Trimester of Care
  - O26.02 Excessive weight gain in pregnancy, second trimester
- **New clinical concepts** like under dosing, blood type, blood alcohol level

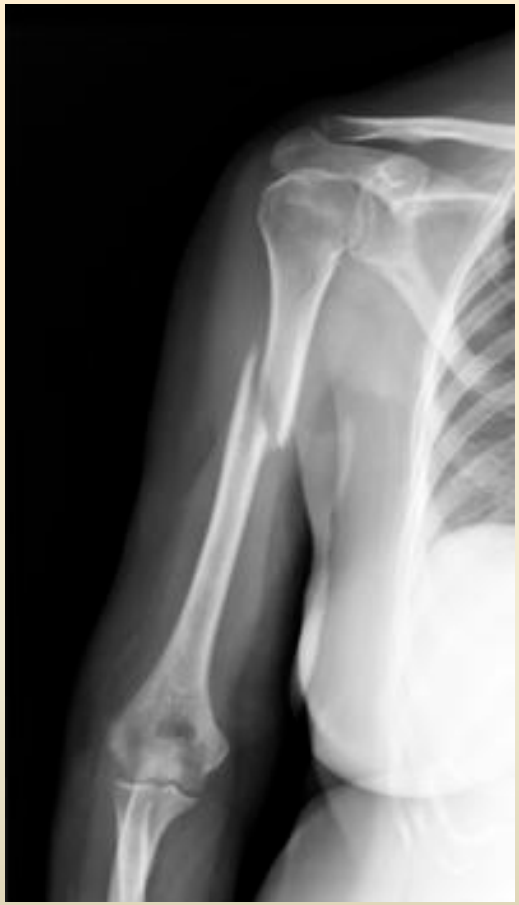
ICD-10 Requires: Specificity

- **BE SPECIFIC**
  - **Location of the fracture**
    - Fracture of ***shaft*** *of the humerus*
      - *S42.30 requires*
      - *specification to the 7th digit*



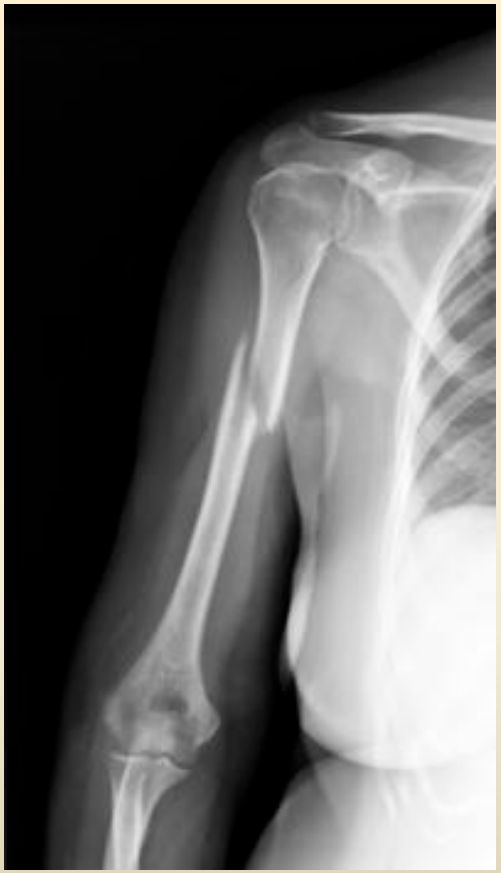
ICD-10 Requires: Laterality

- **Laterality (Left, Right, Bilateral)**
  - **S42.301** Unspecified fracture of shaft of humerus, **right** arm

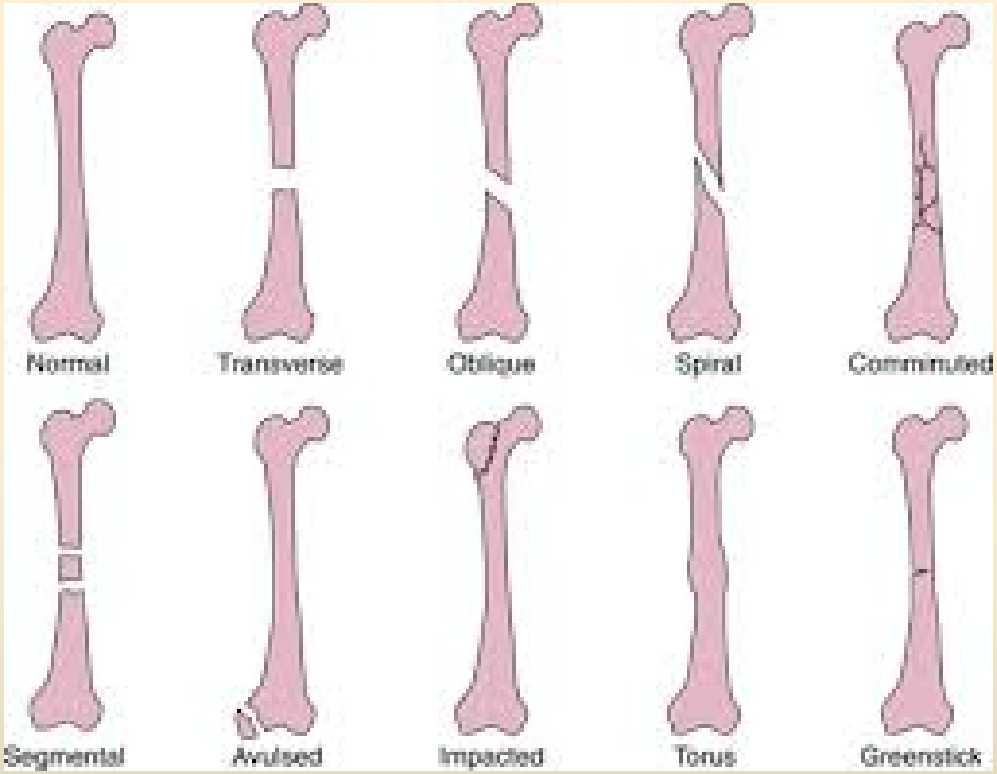


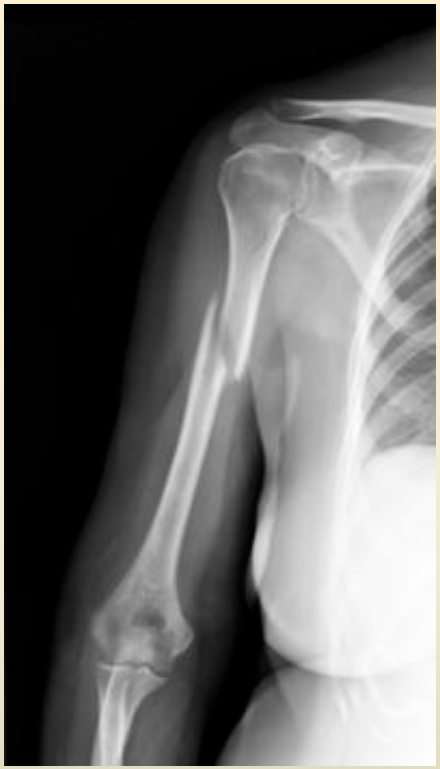
ICD-10 Requires: Clinical Detail

- Greenstick
- Transverse
- Oblique
- Spiral
- Comminuted
- Segmental
- Displaced
- Nondisplaced



ICD-10 Requires: Clinical Detail (cont.)





ICD-10 Requires: Type of Encounter, 7th Digit

- **A**=Initial encounter for **closed** fracture
- **B**=initial encounter for **open** fracture
- **D**=Subsequent encounter for fracture with routine healing
- **G**=Subsequent encounter for fracture with delayed healing
- **K**=Subsequent encounter for fracture with malunion
- **S**=Sequela
- Final Code **S42.341A** Displaced spiral fracture of the humerus, right arm, initial encounter

ICD-10 Requires: Location & Depth

- Example: The local Skilled Nursing facility sends over an elderly lady with a urinary tract infection who has become septic.
- During your admission assessment of the patient you turn the patient over and see that there is stage 2 pressure ulcer on the right lower back.

ICD-10 Requires: Location & Depth (cont.)

L89.132 Pressure ulcer of *right lower back, stage 2*

Was this present on Admission?

ICD-10 Codes that Need More Specificity: Inpatient OR Outpatient

- Diabetes **Type**:
  - Type 1
  - Type 2
  - Chemical or drug induced
  - Other: Secondary, post procedure
- Diabetes due to **underlying conditions**; such as:
  - Congenital rubella
  - Cushing's syndrome
  - Cystic fibrosis
  - Malignant neoplasm
  - Malnutrition
  - Pancreatitis and other diseases of the pancreas

ICD-10 Codes that Need More Specificity: Inpatient OR Outpatient

- Diabetes-Complications
  - Ketoacidosis
  - Kidney complications
  - Ophthalmic complications
  - Neurological complications
  - Circulatory complications
- Other specified complications:
  - Arthropathy
  - Neuropathy
  - Skin complications
  - Oral complications
  - Hypoglycemia with /without coma

Documentation Establishes a Cause-and-Effect Relationship Between Two Conditions

Example: Patient admitted with non-healing wound on foot

Clinical Indicators

- A1c=8.6
- Type 2 Diabetes on problem list
- Is this **Type 2 Diabetes with foot ulcer E11.621**

Type 2 Diabetic Foot Ulcer

- **E11.6** Type 2 Diabetes with other specified complications
  - **E11.62** Type 2 Diabetes with skin complications
    - **E11.621** Type 2 Diabetes with Foot Ulcer

Coding Note: Use Additional Code to Identify Site of Ulcer (L97.4-L97.5)

- **L97.4**=Non-pressure chronic ulcer of heel and mid-foot(15 options)
  - **Location**: unspecified, right heel and mid-foot, left heel and mid-foot
  - **Severity** of ulcer
    - Limited to breakdown of skin
    - With fat layer exposed
    - With necrosis of muscle
    - With necrosis of bone
    - Unspecified severity

L97.5 Non-Pressure Ulcer of Other Part of Foot (15 Options)

- **Location Other part of foot**
  - Unspecified
  - Right
  - Left
- **Severity Other part of foot**
  - Limited to breakdown of skin
  - With fat layer exposed
  - With necrosis of muscle
  - With necrosis of bone
  - Unspecified severity

Outpatient Case Study

- 38 year-old Native American female is seen in Ophthalmology for ongoing diabetes related eye problems
- She had onset of **Type 1 Diabetes Mellitus** at age 13
- She has no renal, hepatic, or peripheral vascular involvement, no elevated lipids or triglycerides
- Last A1c was 6.5

Outpatient Case Study (cont.)

- Stable, mild nonproliferative diabetic retinopathy for many years with no visual acuity problems
- She is now four months post-delivery of a healthy baby girl
- During her pregnancy her **retinopathy advanced to moderate nonproliferative**
- **She developed signs of macular edema in her right eye**

Outpatient Case Study (more)

- Fundoscopy performed reveals **stable areas of microaneurysms in left eye and no evidence of macular edema.**
- Exam of **right eye shows microaneurysms and retinal hemorrhage, thickening, and focal edema consistent with macular edema**.
- Near and far visual acuity remains at 20/30 in each eye.
- Patient is advised that she is not a candidate for treatment at this time.
- She is reminded to see her Primary Care provider regularly.
- Return in three months for monitoring of her retinopathy and macular edema.

Diagnosis

- **E10.3 Type 1 Diabetes with ophthalmic complications**
  - **E10.33** Type 1 Diabetes with **moderate** nonproliferative diabetic retinopathy
    - **E 10.331 Type 1 Diabetes with moderate nonproliferative diabetic retinopathy with macular edema**

RECAP of Required Documentation

- Be specific
- Consistent throughout inpatient stay or outpatient encounters
- All cause and effects are connected
- Higher more complex codes are used
- If you treat something, explain why and the patient’s response to treatment

Parting Words...

If YOU didn’t write it....it didn’t happen.

References

- American Health Information Management Association. “Managing an Effective Query Process.” Journal of AHIMA, 79(10):83-88.
- Department of Health and Human Services, CMS, ICD-10-CM Classification Enhancements, April 2013
- Alcohol Withdrawal Protocol and other clinical resources:

http://www.ihs.gov/nc4/index.cfm?module=formsOrgSys

Credits and Contact

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