Basic ICD-10-CM Documentation and Coding

Effective date: October 1, 2015

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Objectives

- Overview on what is ICD-10-CM
- Changes from ICD-9-CM to ICD-10-CM
- Importance of coding and documentation
- The impact of ICD-10-CM implementation on clinic operations and revenue
- How to implement dual coding to identify and eliminate documentation gaps
- Steps to implement now to reduce financial impact of ICD-10-CM

What is ICD-10-CM?

- The international Classification of Diseases, 10th Edition, Clinical Modification (ICD-10) is the update of diagnoses and sign and symptom codes developed by the World Health Organization (WHO)
- Each world government is responsible for adapting the ICD-10 to suit its own country's needs
- Under Federal Regulation, covered entities are required to implement the new code set for electronic transactions for dates of service no sooner than October 1, 2015

What are the benefits of ICD-10?

- With more specificity there will be a reduction in added queries from other health plans and better tracking of diagnosis processes

- According to the American Health Information Management Association (AHIMA) the following are benefits:
  - Greater coding accuracy and specificity in identifying health conditions
  - Reduced coding errors
  - Higher quality information for measuring and tracking healthcare utilization, quality of patient care and improve safety
  - Improves ability to track and respond to international public health threats

What are some ICD-10 Changes?

- Increased number of codes
  - We will go from 14,000 codes to approximately 69,000 codes (with the potential to add up to 140,000)
- All codes will have full descriptions
- ICD-10 provides more specific data
  - More specific anatomical locations, environmental impacts, functional impairments, etc.
- Expanded injury codes
- Updated diabetes codes
- New structure will accommodate the addition of new codes
- Greater overall specificity
- Increased documentation- All codes must be supported by clinical documentation

ICD-9-CM and ICD-10-CM Comparison

ICD-9-CM	ICD-10-CM
- 3-5 characters in length	- 3-7 characters in length
- Approximately 14,000 codes	- Approximately 69,000 available codes
- First digit may be alpha (E or V) or numeric; digits 2-5 are numeric	- Digit 1 is alpha; digits 2 and 3 are numeric; digits 4-7 are alpha or numeric
- Limited space for adding new codes	-Flexible for adding new codes
- Lacks detail	-Very specific
- Lacks laterality	- Has laterality (i.e., codes identifying right vs. left)
- Lacks trimester detail	- Specifies 1st, 2nd, 3rd trimester

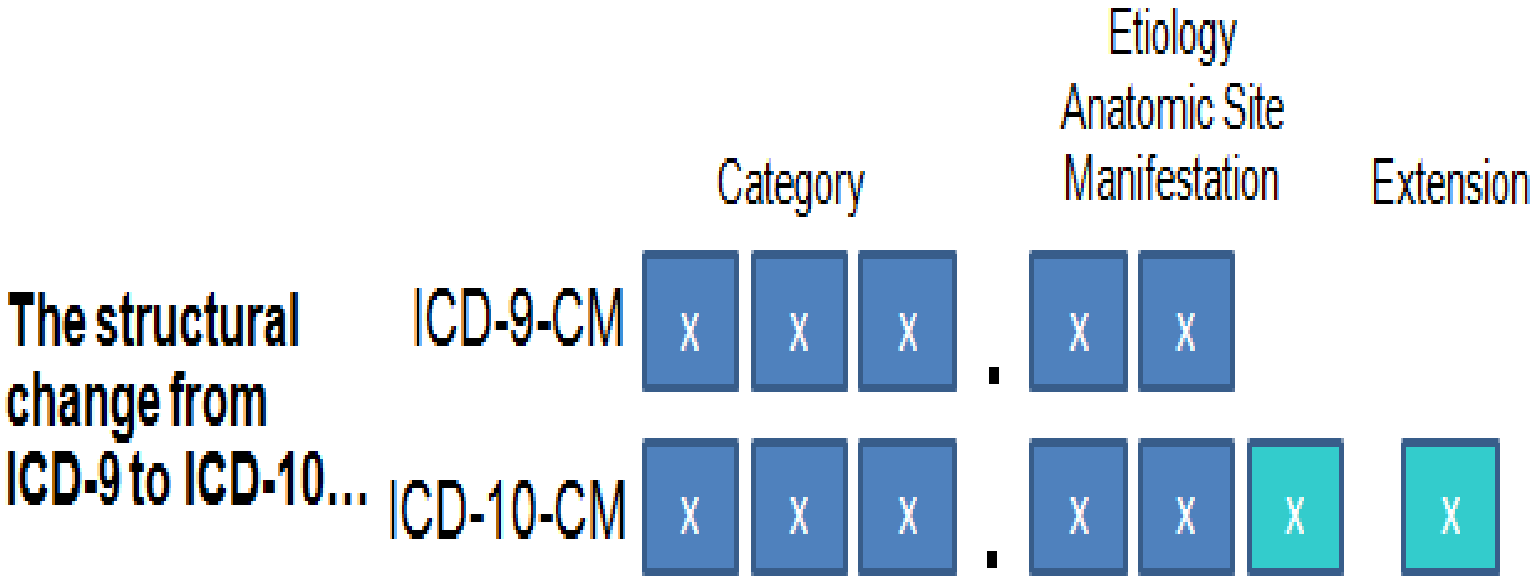
Organization/Structure Changes and New Features

- More categories for diseases and other health-related conditions
- Clinical modifications offer a higher level of specificity
  - Laterality (left vs. right)
  - Additional character and extensions for expanded detail
- Combines etiology and manifestations, poisoning and external cause, or diagnosis and symptoms into a single code

Structure and Format

- Same hierarchical structure as ICD-9-CM where the first three characters are the category of the code and all codes within the same category have similar traits
- Differences are seen in the organization of ICD-10-CM

ICD-9-CM and ICD-10-CM Code Structure



Picture from http://www.nhrmc.org/awareness

ICD-10-CM Codes and Mandate

- The change in the format and the increased clinical granularity of the ICD-10-CM codes will have an immense impact with providers in that it will require significant increase in Clinical Documentation to support the assignment of all the ICD-10-cm codes

Importance of Documentation

- Documentation in the health record is one of the central elements in patient care, coding, billing, and an effective compliance plan
- It has to be accurate, consistent, and complete in order to be translated into the data and information necessary to ensure clinical quality, substantiate medical necessity, and/or determine the most appropriate reimbursement
- It is the foundation that providers use to make decisions regarding patient's healthcare

Importance of Coding

- Accurate coding paints a picture
- Accurate coding tells the patient's story
- Who's telling the story
- How are they telling the story
- Documentation and coding go hand in hand

Documentation

- ICD-10-CM has greater specificity in codes of many diseases, disorders, injuries, other conditions, and even signs and symptoms
- Some conditions do not require changes in information that is captured
- Codes may also capture a disease and related conditions
- There is greater granularity in order to capture information such as type of patient encounter (Initial, subsequent follow-up care, sequela or complication)
- **NOTE**: Coders CANNOT interpret clinical information nor make the assumption of any cause and effect relationship

Greater Specificity and Detail

- 34,250 of all ICD-10-CM codes are related to the musculoskeletal system
- 17,045 of all ICD-10-CM codes are related to fractures
- 10,582 of fracture codes distinguish "right" vs. "left"
- 25,000 **of all** ICD-10-CM codes distinguish "right" vs. "left"

How does this affect providers documentation?

- **Completeness:** In order to accurately code the visit and the reason the patient came in, important information may be missing.
- **Clarify:** An issue involving a patient diagnosis without indication of cause or suspected cause.
- **Consistency:** This would involve conflicting information in the record, especially when you have more than one physician seeing the patient
- **Precision**: Is directly related to specificity

ICD-10-CM Documentation Requirements

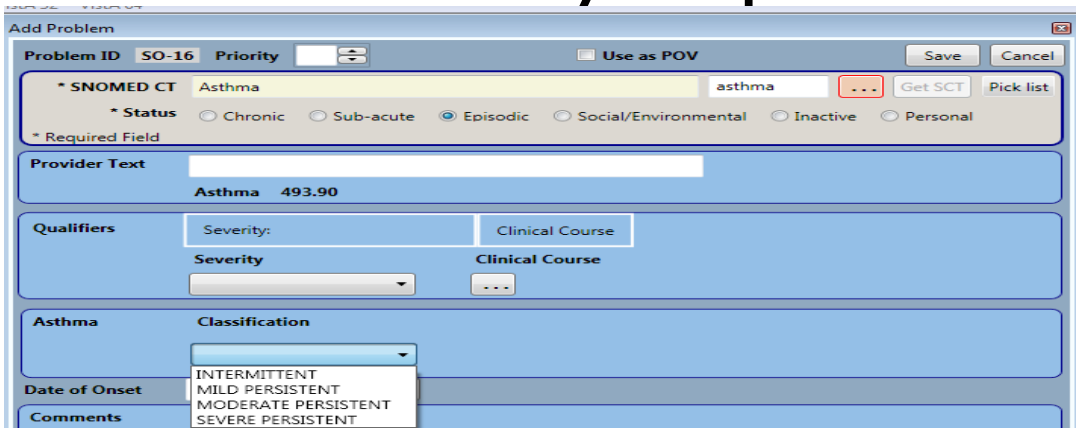
- ICD-10 will dramatically change the documentation provided by clinicians
  - Increased need for Specificity
  - Required to document:
    - Laterality
    - Dominance
    - Stages of Healing
    - Weeks in Pregnancy
    - Episodes of Care
    - Increased Detail and Codes for Patient Accidents, Fractures, etc.
    - Tobacco exposure

Laterality

- This will be the biggest change
- Providers will need to state which side (left or right) when an injury or neoplasm has occurred
- Areas for laterality include:
  - Joint pain
  - Joint effusion
  - Injury
  - Fractures
  - Sprains
  - Tears, meniscus, cruciate ligament
  - Dislocations
  - Arthritis
  - Cerebral infarction
  - Extremity atherosclerosis
  - Pressure ulcers
  - Cancers, neoplasm (breast, lung, bones, etc.)
  - Arthritis
  - Ears and Eyes

Scales

- Measurement scales for ICD-10-CM Include:
  - Asthma severity classification scale of:
    - Intermittent
    - Mild persistent
    - Moderate persistent
    - Severe persistent
- SNOMED has already helped with this



Seizures and Poisoning

- General and Focal Seizures
  - General seizures will need to specify the type of seizure the patient is having and to identify if the seizure is intractable or non-intractable
- Poisoning
  - Substance related to adverse effect must be identified and documented
  - It is also **important** to state, indicate, or document if the medications were taken as prescribed

Stages of Healing

- This indicates what stage of care the physician has rendered to the patient
- This is captured by assigning an appropriate seventh character
  - Example:
    - A= Initial encounter
    - D= Subsequent encounter
    - S= Sequela (Late effect)
- Fractures have further breakdowns regarding stages of healing for open and closed fractures
  - Documentation shall include:
    - Routine
    - Delayed
    - Nonunion
    - Malunion

Weeks in Pregnancy

- The biggest change for pregnancy is for documentation of conditions/complications of pregnancy
- The provider will need to specify the trimester in which the condition occurred
- Not only do you need to document the weeks, you need to give the days as well
  - Example: 14 weeks, 0 days

Other Granularities

- Dominant verses non-dominant side for all paralytic syndrome codes
- Document whether the condition is initial or recurrent for diseases of the eye and adnexa and diseases of the respiratory system
- Relief or non-relief (intractable versus non-intractable) especially for headaches and migraines
- For a concussion documentation needs to include if the patient suffered a loss of consciousness
- Acute and/or chronic must be included in patient's condition

Example Documentation

- Provider documentation
  - 20 year old male came into the office with complaints of ear pain for 3 days. Upon exam, the tympanic membrane looks erythematous and bulging.
    - H66.90- Otitis media, Unspecified, unspecified ear
- More specific documentation
  - 20 year old male who works as a dealer in the smoking section of the casino came into the office with complaints of right ear pain for 3 days.
    - H66.91- Otitis media, unspecified, right ear
    - Z57.31- Occupational exposure to environmental tobacco smoke

Documentation

- If providers are not currently documenting to the level of specificity to report the clinical condition, they will be impacted by an increase in time for each visit and potentially less patients seen with a result of a decrease in productivity

DIABETES

ICD-10-CM Documentation and Coding for Diabetes Mellitus

- Diabetes Mellitus ICD-10
  - Combination codes
  - No longer classified as controlled or uncontrolled
  - Inadequately, out of control or poorly controlled coded by type with hyperglycemia
  - More than 200 codes
- ICD-9 has about 59 codes

Structural difference in ICD-9-CM vs. ICD-10-CM

ICD-9-CM	ICD-10-CM
- 249 Secondary Diabetes Mellitus	- E08 Diabetes mellitus due to underlying condition - E09 Drug or chemical induced diabetes mellitus - E13 other specified diabetes
- 250 Diabetes Mellitus	- E10 Type 1 diabetes mellitus - E11 Type 2 diabetes mellitus
- 648.0 Diabetes mellitus complicating pregnancy, Childbirth, and the puerperium	- O24 Diabetes mellitus pregnancy, childbirth, and the puerperium
- 775.1 Neonatal diabetes mellitus	- P70.2 Neonatal diabetes mellitus

Types of Diabetes Mellitus

- There are five diabetes mellitus types (categories)
  - Diabetes Mellitus due to an underlying condition
  - Drug or chemical induced diabetes mellitus
  - Type 1 diabetes mellitus
  - Type 2 diabetes mellitus
  - Other specified diabetes mellitus

Documentation Requirements for Diabetes Mellitus

1. Identify the type or cause of diabetes mellitus
   - Type 1
   - Type 2
   - Due to drug or chemical induced
   - Due to underlying condition
   - Other specified diabetes mellitus, which includes:
     - Due to genetic defects of beta-cell function
     - Due to genetic defects in insulin action
     - Postpancreatectomy
     - Post procedural
     - Secondary diabetes not elsewhere classified

Documentation Requirements for Diabetes Mellitus (continued)

2. Identify the body system affected and any manifestations/complications:
   - No complications
   - Ketoacidosis
     - With coma
     - Without coma
   - Kidney complications
     - Diabetic nephropathy
     - Chronic kidney disease
     - Other diabetic kidney complication

Documentation Requirements for Diabetes Mellitus (continued)- Affected Body Systems

- Ophthalmic complications
  - Diabetic retinopathy
    - Mild nonproliferative
      - With macular edema
      - Without macular edema
    - Moderate nonproliferative
      - With macular edema
      - Without macular edema
    - Severe nonproliferative
      - With macular edema
      - Without macular edema
    - Proliferative
      - With macular edema
      - Without macular edema
    - Unspecified
      - With macular edema
      - Without macular edema
    - Diabetic cataract
    - Other diabetic ophthalmic complication

Documentation Requirements for Diabetes Mellitus (continued)- Affected Body Systems

- Neurological complications
  - Amyotrophy
  - Autonomic (poly) neuropathy
  - Mononeuropathy
  - Polyneuropathy
  - Neuropathy
  - Other specified neurological complication
  - Unspecified neurological complication
- Circulatory complications
  - Peripheral angiopathy
    - With gangrene
    - Without gangrene
- Other specified circulatory complications

Documentation Requirements for Diabetes Mellitus (continued)- Affected Body Systems

- Arthropathy
  - Neuropathic
  - Other arthropathy
- Skin complication
  - Dermatitis
  - Foot ulcer
  - Other skin ulcer
  - Other skin complication
- Oral complications
  - Periodontal disease
  - Other oral complications
- Hypoglycemia
  - With coma
  - Without coma
- Unspecified complication

Quality in Documentation

- Many payers, including Medicare, have quality measures in place to determine if quality and cost effective care is provided to the patient. It is imperative that diabetes and any associated conditions be documented in the health record

Diabetes and Insulin Usage

- If the patient has long term or current use of insulin be sure to provide documentation

Example Documentation

- Provider documentation
  - A 55 year old female patient presents to the office for management of her diabetes.
    - E11.9- Type 2 diabetes mellitus without complications
- More specific documentation
  - A 55 year old female patient presents to the office for management of her diabetes type 2, which is well controlled by insulin
    - E11.649- Type 2 diabetes mellitus with hypoglycemia without coma
    - Z79.4- Long term (current) use of insulin

Specifics for Use, Abuse, and Dependence

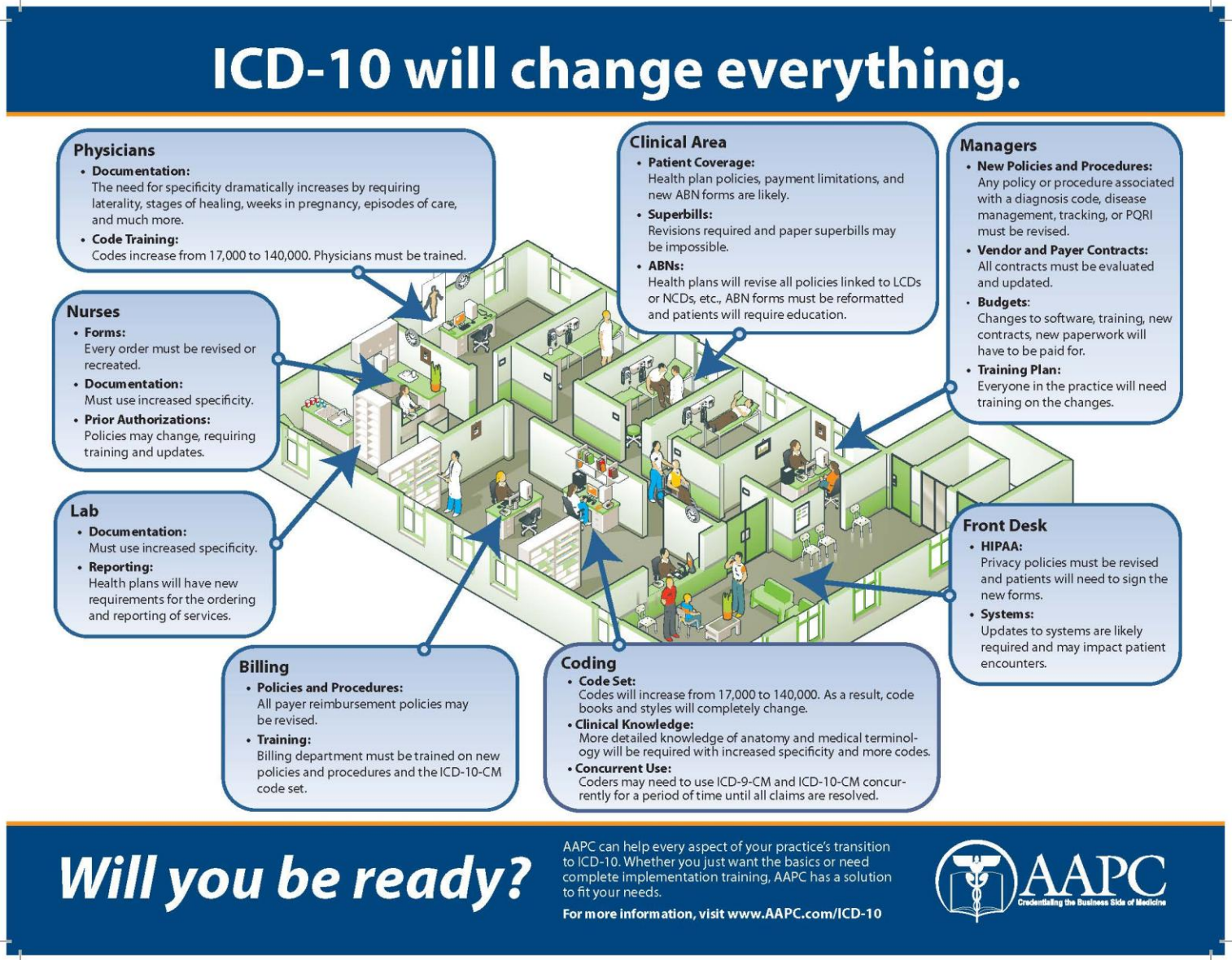
- Alcohol and substance use, abuse and dependence are further broken down to uncomplicated, in remission, intoxication, delirium, perceptual disturbance, withdrawal, psychotic disorder with delusions, hallucinations, persisting amnestic disorder, persisting dementia, anxiety disorder, sexual dysfunction, and sleep disorder
- Nicotine use and dependence are categorized by type of tobacco products:
  - Cigarettes, chewing tobacco, E-cigarettes, and other tobacco products
  - Further broken down by uncomplicated, in remission, and withdrawal
- Inhalants use, abuse and dependence are further broken down by uncomplicated, in remission, intoxication delirium, mood disorder, psychotic disorder, delusions, hallucinations, dementia, and anxiety disorder

Depression

- ICD-9-CM has **ONE** code for depression: 311
- ICD-10-CM **DOES NOT have one** code for depression
- Depression is classified by single or recurrent episode, further broken down by mild, moderate, severe with psychotic features or severe without psychotic features, if remission status is partial or full

Who is affected by ICD-10-CM at your clinic?

- Physician and non-physician practitioners
- Coders and Billers
- Contract Health Services Staff
- Compliance Officer
- Auditors
- Contractors
- Software Vendors
- Patients



http://mrpalsmy.com/2013/01/icd-10-will-change-everything.jpg

What impact will ICD-10 have on your clinic's revenue?

- 20% increase in time required by the provider per patient
- Additional coding staff
- Additional billing staff

Documentation

- If providers are not currently documenting to the level of specificity to report the clinical condition, they will be impacted by an increase in time for each visit and potentially less patients seen with a result of a decrease in productivity

Dual Coding Prior to October 1, 2015

- With the new patch for RPMS EHR there will be a "switch" for ICD-10 in SNOMED to see what the providers and coders can expect
- Coders should begin coding current visits now as if it is October 1, 2015

How to implement now to reduce financial impact

- Weekly provider training with requirements regarding chapter specific documentation
- Build ICD-10 templates to be used now
- Providers, coder(s), and biller(s) are current with their work
- Submit test claims to your payers
- Problem list clean up

Resources for you for ICD-10-CM

- http://www.ihs.gov/icd10/
- http://www.ama-assn.org/ama
- http://cms.gov/ICD10
- http://www.ahima.org/icd10
- https://www.aapc.com/icd-10/
- Jenna Glenn (707) 521-4670
  - Jenna.Glenn@scihp.org

Sources for this Presentation

- http://cms.gov/ICD10
- https://www.aapc.com/icd-10/
- http://mrpalsmy.com/2013/01/icd-10-will-change-everything.jpg
- http://www.nhrmc.org/awareness
- Elizabeth Bitsilly at California Rural Indian Health Board (CRIHB)