ICD 10 Documentation Issues for Coders and Documentation Improvement Specialists
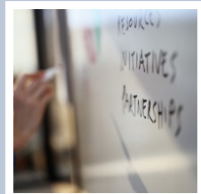
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FHA FLORIDA HOSPITAL ASSOCIATION

Objectives

- Identify the key differences between ICD-9 and ICD-10

- Identify key documentation improvement opportunities for ICD-10

- Discuss the need for the medical staff and their office staff to prepare for ICD-10 to decrease the need for physician queries and assure accurate reimbursement

- Prepare ancillary outpatient departments for ICD-10

- Prevent or decrease RAC denials in under the ICD-10 classification system

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Goals of Documentation Improvement

- Facilitate accurate, complete, and consistent clinical documentation within the health record to support coding and reporting of high-quality healthcare data

- A query is used to clarify and improve documentation of the patient's clinical condition, procedures, and outcomes <u>without consideration to reimbursement</u>

- CDI/Coders should not query the physician only when there is a possibility of increased reimbursement

- Clarify when conditions are present on admission, develop after admission or are a complication

<u>Note:</u> We are seeing denials from all Medicare HMOs and many commercial insurers for both coding and medical necessity issues

Resources

2010 ICD-10-CM is available at
http://www.cdc.gov/nchs/icd/icd10cm.htm or
http://www.cms.hhs.gov/ICD10

- **2010 ICD-10-CM Index to Diseases and Injuries**

- **2010 ICD-10-CM Tabular List of Diseases and Injuries**

  – Instructional Notations

- 2010 Official Guidelines for Coding and Reporting

- 2010 Table of Drugs and Chemicals

- 2010 Neoplasm Table

- 2010 Index to External Causes

- 2010 Mapping "ICD-9-CM to ICD-10-CM" and "ICD-10-CM to ICD-9-CM"

What Does ICD-10 Have to Offer?

- Provides many more categories for diseases and other health-related conditions

- Higher level of specificity

- Combine etiology and manifestations, poisoning and external cause, or diagnosis and symptoms into a single code

- Provides code titles and language that complement accepted clinical practice.

- Potential to reveal more about quality of care and understand complications

- Provide information for clinical decision making and outcome research.
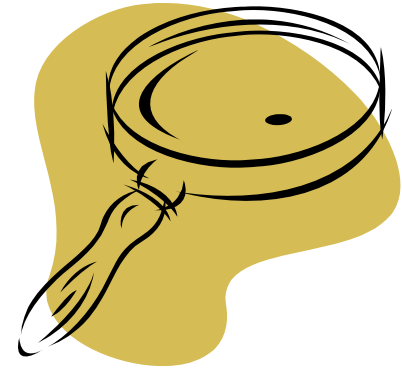
Who Will Use ICD-10?

All reporting/billing health care providers

- **ICD-10-CM**

  - Hospitals, physicians, clinics, laboratory, radiology, psychiatric, rehab, nursing homes etc. <u>All diagnosis codes</u>

- **ICD-10-PCS**

  - Procedures for Hospital Inpatients

  CPT/HCPCS

  - Procedures for Hospital Outpatients, Physician, Laboratory and Radiology Outpatients

Differences Between ICD9 and ICD10

ICD9	ICD10
17 Chapters	21 Chapters
E and V-code Supplemental Classifications	All codes are alphanumeric
Sense organ conditions in Nervous System	Separate Chapters
Antiquated terminology	Current terminology
Injuries by type	Injuries Grouped by site, then type
Complications of Medical Care in 1 Chapter	Complications have been moved to procedure-specific body system chapters
Maximum of 5 characters	Maximum of 7 characters
Partial code titles	Full code titles
	Code Extensions for specificity and laterality
	Dummy placeholder (x)

Format

- Two main parts – Index and Tabular List
- The Index
  - Index to Diseases and Injury
    - Neoplasm Table
    - Table of Drugs and Chemicals.
  - Index to External Causes of Injury

Format

- Tabular List contains categories, subcategories and codes.
- Each character for all categories, subcategories and codes may be either a letter or a number.
- All categories are 3 characters.
- The first character of a category is a **letter**.
- The second and third characters are numbers.
- 3-character category that has no further subdivision is equivalent to a code.
- Subcategories are either 4 or 5 characters.

Format

- Subcategory characters may be either letters or numbers.
- All codes are either 4, 5 or 6 characters.
- The final character in a code may be either a letter or a number.
- Utilizes dummy place holders, always the letter "x."
- A dummy "x" is used as a 5th character place holder at certain 6 character codes to allow for future expansion.
- Certain categories have applicable 7th character extensions. The extension is required for all codes within the category, or as the notes in the tabular instruct.

Notable Differences

Combination code is a single code used to classify:

- two or more diagnoses, or
- a diagnosis with an associated sign or symptom, or
- a diagnosis with an associated complication

Notable Differences

Laterality

- For bilateral sites, the final character of the codes in the ICD-10-CM indicate laterality.
  - Right side is always character 1
  - Left side character 2
  - Bilateral code is always 3 (when a bilateral code is provided)
  - An unspecified side code is also provided should the side not be identified in the medical record. The unspecified side is either a character 0 or 9 depending on whether it is a 5th or 6th character.

Includes Notes and Inclusion Terms

Includes notes

- The word "Includes" appears immediately under certain categories to further define, or give examples of, the content of the category.

Inclusion terms

- Lists of terms are included under some codes. These terms are some of the conditions for which that code number is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of some of the various conditions assigned to that code.

- The inclusion terms are not necessarily exhaustive. Additional terms found only in the Index may also be assigned to a code.

Excludes Notes

Excludes1

- Type 1 Excludes note is a pure excludes. It means "NOT CODED HERE!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note.

- An Excludes1 is for used for when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

Excludes2

- Type 2 excludes note represents "Not included here".

- An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, from but a patient may have both conditions at the same time.

- When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together.

With and Without

With/without note

- When "with" and "without" are the two options for the final character of a set of codes, the default is always "without."
  - Five-character codes "Without" = 0 in the fifth-position for five-character codes, and
  - "With" = 1 in the fifth-position
  - Six-character codes, "1" represents "with" and "9" represents "without."

Locating a code in the ICD-10-CM

- Alphabetic Index – Reason or Condition
- Instructional notes (mostly in the Tabular)
- Tabular List
- Assign the code to greatest specificity

ICD-10-PCS

The development of ICD-10-PCS had as its goal the incorporation of <u>four</u> major attributes:

- Completeness
- Expandability
- Multiaxial – each character with its own meaning
- Standardized Terminology

General Principles

- Diagnostic Information is not included in the procedure description

- Not Otherwise Specified (NOS) options are restricted

- Limited use of Not Elsewhere Classified (NEC) option

- Level of specificity

ICD-10

- Includes "laterality" in the codes
- All general coding guidelines are the same
- *Coding Clinic* will still be the authority for interpretation
- There are non-specific codes and a code can be assigned for non-specific terminology
- Most non-specific codes are not considered CC/MCCs and many cannot be used as Principal Diagnoses

Unique Procedural Coding System

- All currently performed procedures can be assigned an ICD-10-PCS code

- Frequency of the procedure was not a consideration

- Unique codes describe variations in the procedure

- Does not look like any other procedural coding system

ICD-10-PCS Characteristics

- 7 character alphanumeric codes
- Each character contains up to 34 values
- Letters O and I are not used
- Procedures are divided into sections by general type of procedure
- First character is always the "section"
  - Example: Medical/Surgical = "0"

        Obstetrics – "1"

Index

- No complete procedure codes exist in the Index

- Index is used to identify the proper "Table"

- Tables are used to construct a complete and valid code

- Only characters appearing on the table may be used

Index

- Located procedure code table on an alphabetic lookup

- Codes may be found in the index based on the general type of the procedure

  – Resection

  – Transfusion

  – Fluoroscopy

Index

- Codes may also be located by common procedure names i.e. appendectomy

- The index specifies the first three or four values of the code, followed by three or four periods (e.g., 027....), or directs the user to see another term.

- ***The coder will need to know what the objective of the procedure is to find the appropriate code***

CDI Specialists will assist in determining the "objective" of procedures performed.

Index

- Each table also identifies the first three values of the code (e.g., 027).

- Based on the first three values of the code obtained from the index, the corresponding table can be located.

- The table is then used to obtain the complete code by specifying the last four values.

M/S Root Operations

- Alteration
- Bypass
- Change
- Control
- Creation
- Destruction
- Detachment
- Division
- Drainage

- Excision
- ***Extirpation***
- Extraction
- Fragmentation
- Fusion
- Insertion
- Inspection
- Map
- Occlusion

M/S Root Operations (continued)

- Reattachment
- Release
- Removal
- Repair
- Replacement
- Reposition
- Resection
- Restriction
- Supplement

- Transfer
- Transplantation

Tables

0 Medical and Surgical
2 Heart and Great Vessels
7 Dilation: Expanding an orifice or the lumen of a tubular body part Body Part

Body Part	Approach	Device	Qualifier
0 Coronary Artery, One Site **1** Coronary Arteries, Two Sites **2** Coronary Arteries, Three Sites **3** Coronary Arteries, Four or More Sites	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**4** Drug-eluting Intraluminal Device **D** Intraluminal Device **T** Radioactive Intraluminal Device **Z** No Device	**6** Bifurcation **Z** No Qualifier

Example

Dilation of one coronary artery using an intraluminal device via percutaneous approach

Code: 02703DZ

New Term
"Extirpation"

- Taking or cutting <u>out</u> solid matter, such as a foreign body, embolus or calculus is taken out of a body part without taking out any of the body part.

New Definitions
"Excision" vs. "Resection"

- Cutting out/off without replacement, some of a body part
  - Example: Breast Lumpectomy

- Cutting out/off without replacement, all of a body part
  - Example: Total Mastectomy

Totals by Section

Section	Number
Medical and Surgical	62,123
Obstetrics	338
Placement	864
Administration	1,435
Measurement and Monitoring	326
Extracorporeal Assistance and Performance	43
Extracorporeal Therapies	42
Osteopathic	100
Other Procedures	60
Chiropractic	90
Imaging	2,673
Nuclear Medicine	463
Radiation Oncology	1,929
Rehabilitation and Diagnostic Audiology	1,382
Mental Health	30
Substance Abuse Treatment	59
Total	**71,957**

High Numbers of RAC Denials

- Incorrect Principal Diagnosis Code
  - Coagulopathy (286.X)
  - Symptoms
  - Respiratory Failure
  - Sepsis
  - Unrelated OR Proc.
  - Acute Renal Failure
- Removal of CC/MCC
  - Acute Blood Loss Anemia
  - Acute Forms of HF

- Change in procedure Code
  - Excisional Debridement
  - Transbronchial Biopsy
- Time based codes
  - Critical Care (OP)
  - Respirator
- Ancillary and Diagnostic (LCD/NCDs)

Coagulopathy

ICD-9

- 286.9 - Coagulopathy, unspecified

- 790.92 – Abnormal Coagulation Profile

ICD-10

D68.8, Other specified coagulation defects

D68.9, Coagulation defects, unspecified

R79.1 - Abnormal Coagulation Profile

Coding Clinic Advice

- Patients on "Coumadin" are expected to have elevated clotting time
- 790.92 is used when coagulopathy is due to circulating anticoagulants such as Coumadin
- If improper dosage – poisoning
- Proper dosage – adverse effect

Sepsis, Severe Sepsis, and Septic Shock

- **Sepsis**
  - Assign appropriate code for underlying systemic infection (bacterial, fungal, Candida etc.)
  - If the type of infection or causal organism is not further specified, assign Sepsis, unspecified (038.9/A41.9)
  - A code for SIRS is added in ICD-9, but is not added in ICD-10 unless "severe sepsis or an associated acute organ dysfunction is documented."

Sepsis

ICD-9	ICD-10
038.9 – Unspecified Septicemia	A41.9 Sepsis, Unspecified
038.42 – Septicemia due to E. Coli	A41.51 Sepsis due to E. Coli
995.91 – Sepsis	
995.92 – Severe Sepsis	R65.20 Severe Sepsis without Septic Shock
785.52 – Septic Shock	R65.21 Severe Sepsis with Septic Shock
584.9 – Acute Kidney Failure, Unspecified	N17.9 Acute Kidney Failure, Unspecified

Case – Physician documents "sepsis due to E. coli UTI." BUN 60 and Creatinine 1.6 on admission, rising to 3.2 two days after admission. MD documents renal insufficiency on admission and ARI 2 days after admission.

"Urosepsis" and Sepsis

- Urosepsis still means Urinary Tract Infection
  - Defaults to code 599.0 in ICD-9
  - No code in ICD-10 (must query)

Bacteremia

- Not synonymous with "Septicemia"
    - Codes to 790.7 in ICD9
    - Codes to R78.81 in ICD10

Both are symptom codes and should not be sequenced as Principal Diagnosis if the site of the infection is known.

"Abnormal Findings on Examination of blood, without diagnosis (R70-R79)"

SIRS

- SIRS due to Non-Infectious Process
  - Trauma
  - Malignant Neoplasm
  - Pancreatitis

SIRS remains a secondary code (R65.10)

Principal Diagnosis - Reason for Admission

"That condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

- Codes for symptoms, signs, and ill-defined conditions are not to be used as principal diagnosis when a related definitive diagnosis has been established.

- When there are two or more interrelated conditions (such as diseases in the same chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

Principal Diagnosis -
Reason for Admission

- In the <u>unusual instance</u> when two or more diagnoses equally meet the criteria for principal diagnosis *as determined by the circumstances of admission, diagnostic workup and/or therapy* provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

Documentation Improvement Opportunity – Clarify early in the admission the focus of treatment, diagnostic workup. Clarify whether conditions were present at the time of admission.

Acute Renal Failure

ICD9	ICD10
584.9 – Acute Kidney Failure, Unspecified (CC)	N17.9 – Acute Kidney Failure, Unspecified
584.8 – Acute Kidney Failure with Other Specified Pathologic Lesion in Kidney (MCC)	N17.8 – Other Acute Kidney Failure

All of the Acute Kidney Failure codes are MCCs except 584.9 – AKF, <u>unspecified</u> which is only a CC (for now)

Abnormal Findings

- Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported <u>unless the provider indicates their clinical significance</u>.

- If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

> Documentation Improvement Opportunity – Seek clarification of significance of "documented" abnormal findings.

Excisional Debridement

ICD9	ICD10
Excisional	Excision
Non-Excisional	Extraction

Problem remains the same. Need to determine whether "excision" took place or simple "extraction."

Excision "Down to"

- "Down to" does not mean including
- Code to the deepest layer <u>included</u> in the debridement
- Assure the description of the procedure specifically identifies intent, instruments, technique and depth
- Intent – "debride" or "drain"?

<u>Coding Clinic</u> references include: 3Q2010, page 11; 3Q2008, 2Q2008.

Excision in ICD-10

Important:
- Site
- Type of Wound
- Stage – i.e. initial or subsequent
- Depth
- Intent

Heart Failure

ICD9	ICD10
Separate codes for Congestive HF & Systolic and/or Diastolic Heart Failure	Combination codes

Note: To assign the correct code in ICD10, Coders and CDI specialists will need to clarify the specific type of heart failure i.e. systolic, diastolic, acute and/or chronic.

Questions?

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