March 2015

ICD-10 for General Medicine

UConn Health

Just himagine what we can accomplish together.

Introductions

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Agenda

- After attending this session participants will be able to:
  - Describe the challenges associated with ICD-10 implementation
  - Identify documentation standards necessary for complete and accurate code
  - Identify the importance of physician documentation and coding

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ICD-10 for Physicians

ICD-10 does ***not require a change in how physicians practice medicine or treat patients***.

Rather, it demands more accurate documentation and gives physicians **more diagnostic choices to capture new data to ensure they are paid for the complex work they perform.**

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Future of Documentation

CPT codes **do not** change!

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ICD-10 Documentation for Diagnoses

Requirements for Detailed Documentation for Diagnoses	
Acuity	Stages (I, II, III, IV)
Specific site	Injury details
Laterality	Site, laterality and depth of tissue involvement
Specific type of condition	Drug reactions/interactions/adverse reactions
Episode of care	Site and artery specificity
Link must be established between manifestations and underlying diseases	
Complications of care	
Degree of severity	

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Considerations

- ICD-10 requires collaboration between all members of the clinical and non-clinical healthcare team:
  - Education of CDI/coder staff
  - Template revisions
  - Query revisions

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Challenges

- ICD-10 is a classification system, not a clinical language system:
  - Physician documentation – primarily directed for communication between clinicians.
  - Bridging gaps between coder's classification language and physician clinical documentation.

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Challenges

- Documentation by the physician of specific components of a particular classification (diagnosis code) is required:
  - Test results, labs, x-rays, EKGs, echo reports, path reports, **studies performed for diagnosis are not sufficient documentation for classifying (coding) a disease/injury.**
  - Coders are only allowed to use physician documentation to classify a disease/injury or procedure.

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Importance of Complete Documentation

Accurate Clinical Picture Due to Increased Specificity

Identify Quality of Care Provided

Support Initiatives Aimed at Improving Quality of Care

Justify Medical Necessity

Reducing Costs via Value Based Purchasing

Avoiding Misinterpretation of Diagnosis by Auditors and Coders

Accurate Reflection of Patient Acuity, Outcome and Resources Used for Patient Care

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Consequences of Inadequate Documentation

- Inappropriate Payment for Submitted Claims
- Claim Denials
- Increased Risk of Government Audit, Repayment and Fines

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ICD-10 Documentation Assessment Results

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Methodology

- One hundred (100) records were reviewed during this assessment. The medical records were selected randomly by UConn from the top diagnosis and procedure list determined by the Kforce Healthcare to be high risk areas. The objectives of this analysis were to:
  - Assess the current level of specificity & quality of physician clinical documentation practices
  - Determine how frequently unspecified &/or non-descriptive codes were used in the current ICD-9 system
  - Determine if the documentation required to appropriately assign diagnosis & procedure codes in ICD-10-CM/PCS is present in the medical records reviewed
  - Provide recommendations for documentation improvement

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Diagnoses Reviewed

Diagnoses
Atrial Fibrillation (427.31)
Pain in Limb (729.5)
Diabetes Mellitus (250.00)
Depression (311)
CHF (428.0)
Anxiety (300.00)
Tobacco use disorder (305.1)
UTI (599.0)
Anemia (285.9)
Asthma (493.90)
CAD (414.00)
CKD (585.9)

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Opportunities Identified

Diagnosis or Procedure Category	Number of Diagnoses/Procedures Reviewed	Number of Documentation Opportunities Identified
Atrial Fibrillation (427.31) (Other*)	5	3
Pain in Limb (729.5) (Other*)	3	3
Diabetes Mellitus (250.00)	2	1
Depression (311)(Other*)	4	4
CHF (428.0)	4	1
Anxiety (300.00)(Other*)	2	2
Tobacco use disorder (305.1) (Other*)	4	1
UTI (599.0) (Other*)	4	1
Anemia (285.9) (Other*)	2	2
Asthma (493.90) (Other*)	4	4
CKD (585.9) (Other*)	3	3
CAD (414.00)	3	3

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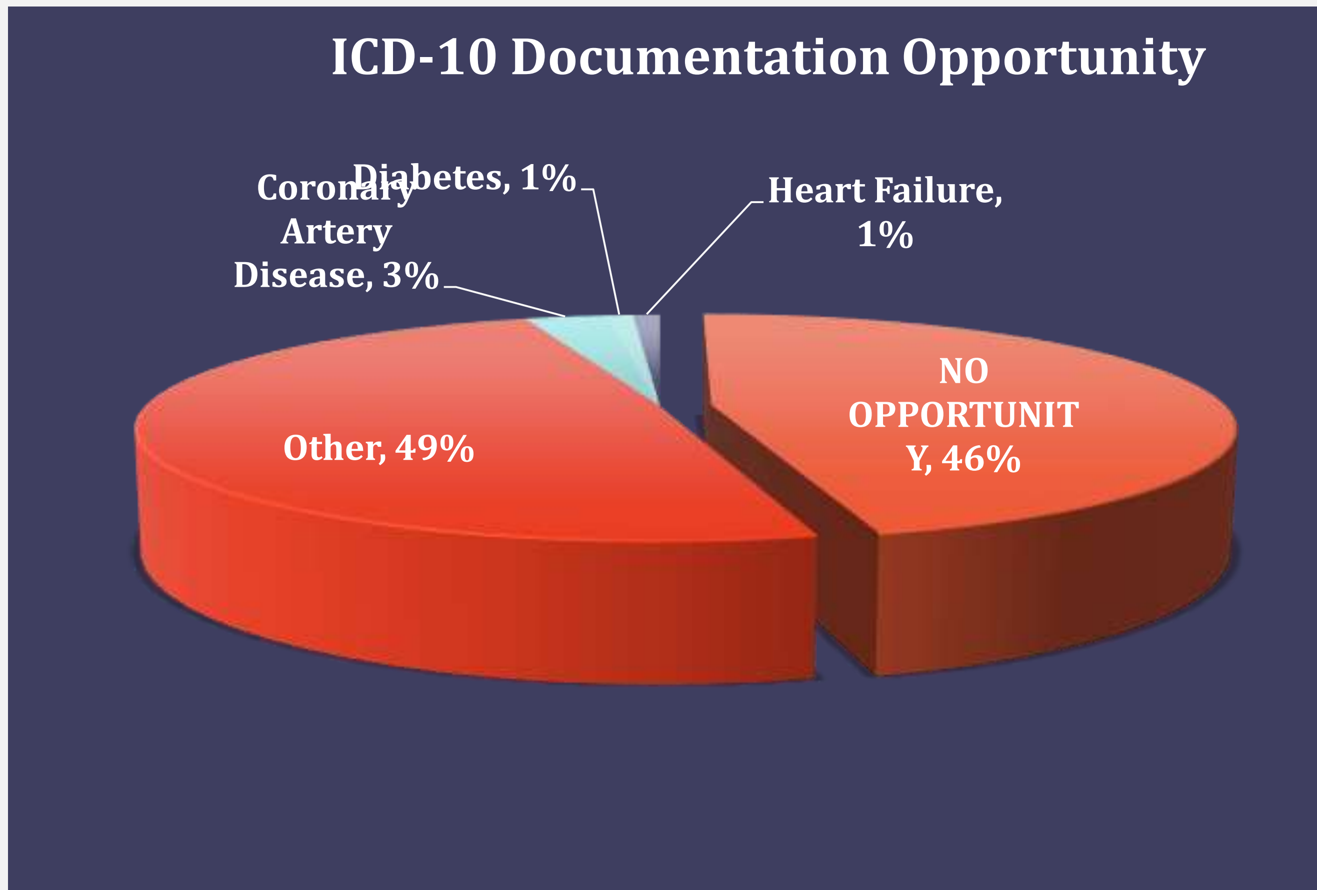
Opportunities Identified



**Note: Multiple documentation opportunities may exist on single medical record account.*

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ICD-10-CM Opportunities

Atrial Fibrillation

- Type specificity
  - Chronic
  - Paroxysmal
  - Persistent
- Typical vs. atypical

Pain in Limb

- Acuity
- Laterality
- Site specificity

Diabetes Mellitus

- Linkage of manifestation to disease
- Type
- Control status
  - Hyper/hypoglycemia
- See table on next slide fur further detail on this diagnosis.

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ICD-10-CM Changes for Diabetes

Condition	New in ICD-10-CM	Description of Change
Diabetes Mellitus (DM)	Poorly controlled, out of control, inadequately controlled and controlled are no longer used in ICD-10-CM	Diabetes must be described by type with hyperglycemia
Gestational Diabetes	Classified to insulin controlled, diet controlled, or puerperal in the OB chapter	If described as puerperal, the diet controlled or insulin controlled component must be described as well
Other specified complications of Diabetes	Expanded to include with neuropathic arthropathy, dermatitis and oral complication including periodontal disease	Documentation of complication relationships to diabetes continues to be an opportunity for improvement
Secondary Diabetes	Specify if due to underlying condition or drug or chemical induced	Documentation must reflect the underlying cause of the DM

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ICD-10-CM Opportunities

Depression

- Type
- Episode
- w/wo psychotic features
  - 311 (Depression), maps to F32.9 (Major depressive disorder, single episode, unspecified)

Anxiety

- Type specificity
  - Panic D/O w/o agoraphobia
  - Generalized
  - Other
  - Unspecified
  - w/wo stress reaction

CHF

- Type
  - Diastolic
  - Systolic
  - Diastolic and Systolic
- Acuity
- See next slide for further detail on this diagnosis.

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Heart Failure

To properly classify heart failure in ICD-10-CM, physicians must specify the ***acuity and type of coronary heart failure:***

- systolic/diastolic or a combination of both
- acute, chronic or acute on chronic

- Cardiac arrest is further delineated as:
  - *Due to underlying cardiac condition*
  - *Other underlying condition*
  - *Cause unspecified*

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Acute Myocardial Infarction

- Acute phase changed from 8 to 4 weeks
- STEMI:
  - Specific site involvement:
    - Anterior
    - Inferior
    - Other/unspecified
  - Specific artery involvement:
    - Left main coronary artery
    - Left anterior descending coronary artery
    - Other coronary artery of anterior wall
    - Right coronary artery
    - Other coronary artery of inferior wall
    - Left circumflex coronary artery
- NSTEMI – No change

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ICD-10-CM Opportunities

Tobacco Use

- Type of nicotine
  - Cigarette
  - Chewing tobacco
  - Pipe
  - Cigar
- Remission
- Dependence

Urinary Tract Infection

No classification for Urosepsis

Query will always be required if “urosepsis” is documented by providers

Anemia

- Type
- Acuity
- Underlying cause

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ICD-10-CM Opportunities

CKD

- Linkage of manifestation to disease
  - E.g. diabetic chronic kidney disease
- Stage

CAD

- Site Specificity
  - native or bypassed vessels
- w/wo angina
  combination codes are utilized in the CAD categories to eliminate necessity for additional code identifying angina (type).

Asthma

- Type
  - mild, moderate, severe
- w/wo status asthmaticus
- w/wo exacerbation
- Episode
  - intermittent
  - persistent
- See following slides for further information on this diagnosis

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Asthma

	Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent
Symptoms	2 or less days per week	More than 2 days per week	Daily	Throughout the day
Nighttime Awakenings	2 X's per month or less	3-4 X's per month	More than once per week but not nightly	Nightly
Rescue Inhaler Use	2 or less days per week	More than 2 days per week, but not daily	Daily	Several times per day
Interference With Normal Activity	None	Minor limitation	Some limitation	Extremely limited
Lung Function	FEV1 >80% predicted and normal between exacerbations	FEV1 >80% predicted	FEV1 60-80% predicted	FEV1 less than 60% predicted

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Asthma

Asthma Scenario

- Patient presents with a history of extrinsic asthma. She is complaining of waking up a couple of nights per week coughing and uses her rescue inhaler on a daily basis. She is sent for a PFT to evaluate her lung volume.

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Asthma

Asthma Documentation Requirements

- Physician (provider) must document if asthma is moderate persistent or some other level. Clinical findings from lung function tests are insufficient to appropriately classify a disease without physician (provider) documentation of the specific classification

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ICD-10 CM

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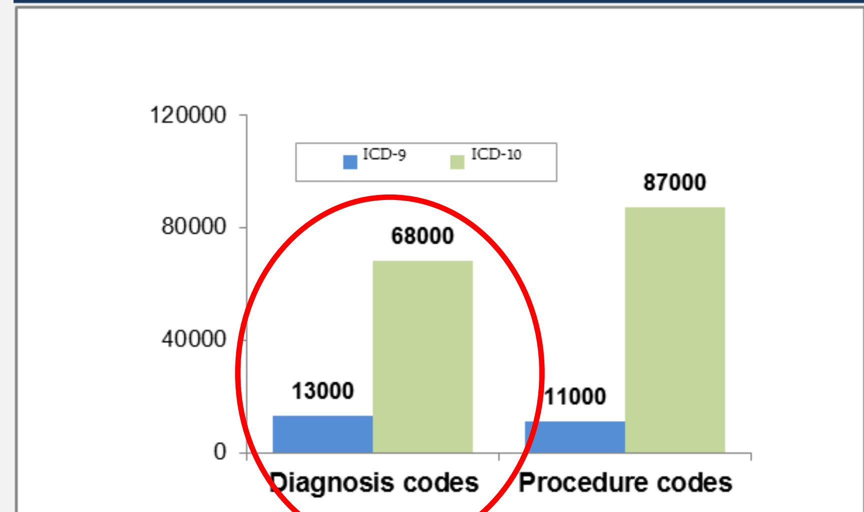
Changes to Diagnosis Codes

The most significant difference between ICD 9 and ICD 10 is the size and composition of the new codes

- ICD 9 is five digits where ICD 10 is 7 alphanumeric characters
- Re-structured classification
- Specificity and detail have been expanded

ICD 10 better describes acuity, complexity and laterality of the patients under your care



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

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Hypertension

- There is only **one** code for hypertension **without manifestations** (benign, malignant, essential, etc…) in ICD-10.
  - The code is I10
- Documentation is required for any relationship between hypertension and other diseases.
  - Hypertensive heart disease- I11
  - Hypertensive chronic kidney disease- I12

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Hypertension ICD-9

- 401 Essential hypertension
  - 401.0 Malignant
  - 401.1 Benign
  - 401.9 Unspecified

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Hypertension ICD-10

- I10 Essential (primary) hypertension
  - Includes high blood pressure, hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
  - Excludes hypertension complicating pregnancy and associated with end organ disease

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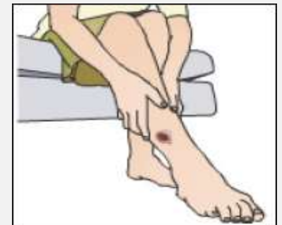
Pressure Ulcers

A patient is admitted with a chronic non-pressure ulcer of the leg.

- In ICD-9-CM Diagnosis, seven (7) codes specify the site of the lower limb.
- **In ICD-10-CM, more than 100 codes are used to delineate:**
  - Site of the chronic non-pressure ulcer
  - Laterality
  - Depth of ulcer of the lower limb (e.g., limited to breakdown of skin, with fat layer exposed, with necrosis of muscle, with necrosis of bone and unspecified severity)



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Pressure Ulcers ICD-10 Code Examples

Pressure Ulcers

L97.10 – Non-pressure chronic ulcer of unspecified thigh

- **L97.101 –** Non-pressure chronic ulcer of unspecific thigh, limited to skin breakdown
- **L97.102 –** Non-pressure chronic ulcer of unspecified thigh, with fat layer exposed
- **L97.103 –** Non-pressure chronic ulcer of unspecified thigh, with necrosis of muscle
- **L97.104 –** Non-pressure chronic ulcer of unspecified thigh, with necrosis of bone
- **L97.109 –** Non-pressure chronic ulcer of unspecified thigh, with unspecified severity

Right, left, unspecified lower limbs with all the above complications are specified in ICD-10-CM

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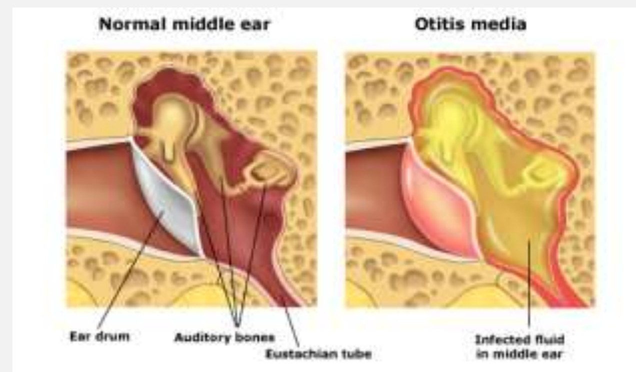
Otitis Media

- In ICD-10-CM for Otitis Media conditions, the physician should specify laterality and type: with effusion or nonpurulent, allergic, catarrhal, exudative, post measles, purulent, secretory, suppurative, etc. as well as acuity (acute or chronic).



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Episodes of Care

- ***ICD-10-CM relies more heavily on categorizing the episodes of care*** for injuries and illnesses. ***Detailed documentation is required***, for example, for fractures:
  - ***Fracture codes in ICD-10 include greater specificity:***
    - Type of fracture
    - Anatomical site
    - Displaced or not
    - Laterality

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Fractures

- Classification also includes episodes of care:
  - Initial
  - Subsequent
  - Sequela
- Gustilo-Anderson is required for some open fractures utilizing a 7th character in the code
- ***Fractures not indicated as open or closed will be classified as a closed fracture***
- ***Fracture modifiers are "displaced"* (default if not further specified) *and "non-displaced"***
- **Fracture cause must be documented**
  - Traumatic or nontraumatic?

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Episodes of Care w/Fractures

Fractures in ICD-10-CM:

- Open Fracture of the Right Wrist, Initial Encounter – S62.101***B***

Character	
A	Initial Encounter/Closed Fracture
B	Initial Encounter/Open Fracture
D	Subsequent Encounter/Fracture Routine Healing
E	Subsequent Encounter for Open Fracture, Type I or II Routine Healing
G	Subsequent Encounter/Fracture Delayed Healing
K	Subsequent Encounter/Fracture Nonunion
P	Subsequent Encounter/Fracture Malunion
S	Sequela

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Fractures/Injuries – General Rule

- Documentation of the initial injury must be consistent for each visit with episode of care information:
  - Each record must stand on its own.
  - Documentation from previous records will not be used / must be re-iterated in current note.
  - No aftercare or follow-up classification for fractures or injuries (V codes in ICD-9-CM Diagnosis) – in ICD-10-CM use “subsequent” code.

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Pathological Fractures

- ICD-10-CM introduces more specificity in the classification of pathological fractures due to osteoporosis.
  - Age related, includes
    - Senile
    - Post menopausal
  - Other, includes
    - Drug induced
    - Idiopathic
    - Post oophorectomy
    - Postsurgical malabsorption
    - Post traumatic

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Open Wounds/Lacerations

Below is an example of the classification differences between ICD-9-CM Diagnosis and ICD-10-CM for an open wound or laceration of the thumb with a foreign body.

ICD-9-CM Diagnosis

- 883.1 Complicated open wound of the finger.

ICD-10-CM

- S61.021A Laceration with foreign body of right thumb without damage to nail, initial encounter.
- **Much more descriptive of the injury allowing for reflection of patient acuity, outcome/prognosis, evaluation as well as follow up expectations.**

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Documentation Improvement

- Coders/CDI staff are not permitted to classify diseases from lung function tests only
- For inpatients: possible, probable and suspected conditions are coded as though they exist
- For outpatients: code only to the highest level of certainty

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Pregnancy Complications

ICD-9-CM and ICD-10-CM differences for pregnancy complication:

ICD-9-CM

- 648.03– Diabetes Mellitus in mother complicating pregnancy, antepartum

ICD-10-CM

- O24.912– Unspecified diabetes mellitus in pregnancy, second trimester

- The trimester or number of weeks in which the condition occurred should be coded from physician documentation.
- It's also important to know whether the condition is pre-existing or not.

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Underdosing

Underdosing – new concept in ICD-10

- Taking less of a medication than prescribed by physician or manufacturer's instruction
  - Noncompliance
  - Complication of care

Underdosing – ***Documentation Needed:***

- If a patient is purposely stopping or altering their medication regimen this needs to be documented to provided accurate coding

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Underdosing

These codes also require a 7th digit to identify whether this is:

- Initial encounter
- Subsequent encounter
- Sequela (takes priority for code – if no sequela, code initial or subsequent)

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Underdosing

- Underdosing of drugs specifies documentation of intentional or unintentional underdosing:
  - Intentional underdosing
    - Due to financial hardship
    - Other reasons
  - Unintentional underdosing
    - Age-related debility
    - Other reasons

Separate "Z" code that is submitted alongside the code for underdosing.

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Underdosing/Poisoning ICD-10 Code Examples

Underdosing/Poisoning Coding Examples
T45.511 – Poisoning by anticoagulants, accidental (unintentional)
T45.512 – Poisoning by anticoagulants, intentional self-harm
T45.513 – Poisoning by anticoagulants, assault
T45.514 – Poisoning by anticoagulants, undetermined
T45.515 – Adverse effect of anticoagulants
T45.516 – Underdosing of anticoagulants

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Crohn's Disease

- Classifications now include
  - Without complications
  - With complications
    - Rectal bleeding
    - Intestinal obstruction
    - Fistula
    - Abscess
    - Other or unspecified

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Crohn's Disease Scenario

- Patient presents with a known history of Crohn's disease. He is experiencing abdominal pain and some bloating. A CT scan and colonoscopy are performed to evaluate for obstruction.

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Crohn's Disease

Documentation Requirements

- Physician (provider) must document if obstruction is associated with or caused by the Crohn's disease. Clinical findings from colonoscopy or CT studies are insufficient to appropriately classify a disease without physician (provider) documentation of specific cause and effect relationship.

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Crohn's Disease ICD-10 Code Examples

Crohn's Disease (sm. Intestine, large intestine, both, unspecified)

K50.0 – Crohn's disease of small intestine

- K50.00 – Crohn's disease of small intestine **without complications**
- K50.01 – Crohn's disease of small intestine **with complications**
  - K50.011 – Crohn's disease of small intestine with **rectal bleeding**
  - K50.012 – Crohn's disease of small intestine with **intestinal obstruction**
  - K50.013 – Crohn's disease of small intestine with **fistula**
  - K50.014 – Crohn's disease of small intestine with **abscess**
  - K50.018 – Crohn's disease of small intestine with **other complication**
  - K50.019 – Crohn's disease of small intestine with **unspecified complication**

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Gout

Physician (provider) must document the type and site of the gout in order to get the most specific classification.

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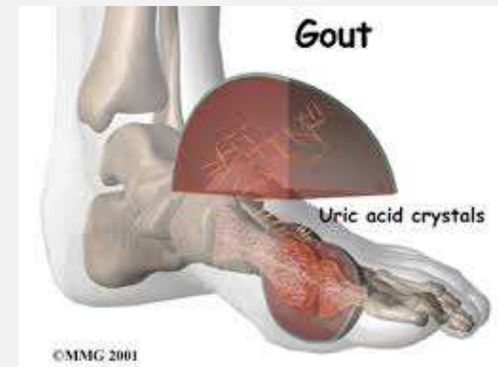
Gout

- Classifications include:
  - Acute, flare, attack, NOS – M10 (coded M10 if 'chronic gout' not specified)
  - Chronic – M1A
    - Idiopathic – M1A.0
    - Lead-induced
    - Drug-induced
    - Due to renal impairment
    - Other secondary gout
    - Unspecified – M1A.9
    - 6th character for site; 7th character for with or without tophus



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Gout ICD-10 Code Examples

Gout

M10.0 – Idiopathic gout
- M10.00 – Idiopathic gout, unspecified site
- M10.01 – Idiopathic gout, shoulder
  - M10.011 – idiopathic gout, right shoulder
  - M10.012 – idiopathic gout, left shoulder
  - M10.019 – idiopathic gout, unspecified shoulder

M10.1 – Lead-induced gout

M10.2 – Drug-induced gout

M10.3 – Gout due to renal impairment

M10.4 – Other secondary gout

M10.9 – Gout, unspecified

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Alcohol Abuse/Use

- Classifications include
  - Uncomplicated
  - Complications
    - With intoxication
    - Delirium
    - Delusions
    - Hallucinations
    - Anxiety disorder
    - Sexual dysfunction
    - Sleep disorder
    - Unspecified

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Alcohol Abuse/Use

- Physician (provider) must document whether the complication is associated with/due to the alcohol abuse.
  - For example:
    - F10.18 Alcohol abuse with other alcohol-induced disorders
      - F10.180 Alcohol abuse with alcohol-induced anxiety disorder
      - F10.181 Alcohol abuse with alcohol-induced sexual dysfunction
      - F10.182 Alcohol abuse with alcohol-induced sleep disorder
      - F10.188 Alcohol abuse with other alcohol-induced disorder

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Blood Alcohol Level

An additional code from category Y90, Evidence of alcohol involvement determined by blood alcohol level, should be used with a code from F10, Alcohol-related disorders, if the patient's blood alcohol level is recorded.

- Y90 Evidence of alcohol involvement determined by blood alcohol level.
  - Y90.0 Blood alcohol level of less than 20 mg/100ml
  - Y90.1 Blood alcohol level of 20-39 mg/100ml
  - Y90.2 Blood alcohol level of 40-59 mg/100ml
  - Y90.3 Blood alcohol level of 60-79 mg/100ml
  - Y90.4 Blood alcohol level of 80-99 mg/100ml
  - Y90.5 Blood alcohol level of 100-119 mg/100ml
  - Y90.6 Blood alcohol level of 120-199 mg/100ml
  - Y90.7 Blood alcohol level of 200-239 mg/100ml
  - Y90.8 Blood alcohol level of 240 mg/100ml or more
  - Y90.9 Presence of alcohol in blood, level not specified

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STDs

ICD-10-CM has created a range of codes to identify infections with a predominantly Sexual mode of transmission (A50-A64).

- Physician (provider) must document the type of STD and infection.
- It is important to note that human immunodeficiency ***virus (HIV) disease is excluded from this range of codes.***
  - A56.11 Disease, sexually transmitted, chlamydial

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Domestic Violence Coding

- ICD-10-CM has multiple codes each describing type of assault instrument as well as type of encounter such as:

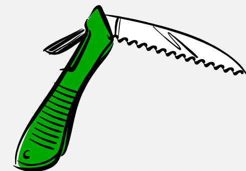
Example:

ICD-9-CM

– E code=E966=Assault by cutting and piercing instrument

ICD-10-CM

– X99.0xxA = Assault by sharp glass, initial encounter;
– X99.0xxD = Assault by sharp glass, subsequent encounter;
– X99.1xxA = Assault by knife, initial encounter;
– X99.1xxD = Assault by knife, subsequent encounter



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Domestic Violence Coding

ICD-10-CM includes whether the maltreatment was ***suspected or confirmed*** and also details if the encounter was ***initial or subsequent:***

- T74.91xA Unspecified adult maltreatment, confirmed, initial encounter;
- T74.91xD Unspecified adult maltreatment, confirmed, subsequent encounter
- T76.91xA Unspecified adult maltreatment, suspected, initial encounter
- T76.91xD Unspecified adult maltreatment, suspected, subsequent encounter

- ICD-10-CM also includes the terminology of ***"abandonment"***

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Top 5 New Codes Signs and Symptoms

- Projectile Vomiting
  - Previously vomiting alone (787.03)
  - ICD-10-CM: R11.12
- Anterior chest wall pain
  - Previously chest pain, other (786.59)
  - ICD-10-CM: R07.89
- Somnolence
  - Previously other alteration of consciousness (780.09)
  - ICD-10-CM: R40.0

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Top 5 New Codes Signs and Symptoms

- Repeated falls
  - Previously other symptoms involving nervous and musculoskeletal systems (781.99)
  - ICD-10-CM: R29.6
- Mouth breathing
  - Previously other symptoms involving head and neck (784.99)
  - ICD-10-CM: R06.5

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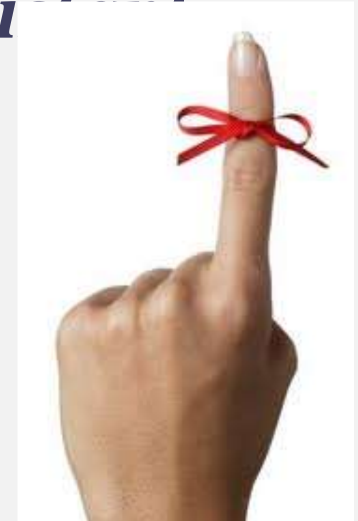
Infections resistant to antibiotics

- Many bacterial infections are resistant to current antibiotics. ***It is necessary to identify all infections documented as antibiotic resi*** The infection must also be identified.

- Code Category Z16 - Resistance to antimicrobial drugs



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Infections resistant to antibiotics

This 78 year old patient is seen for continued follow-up for C.diff colitis. Cultures of the organism have found this infection to be resistant to flagyl. A new drug regimen will be started at this time.

ICD-10-CM

A04.7 Colitis (acute)(catarrhal)(chronic)(noninfective)(hemorrhagic), Clostridium difficule

Z16.39 Resistance, resistant (to), organism(s), to, drug, antimicrobial (single), specified NEC

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Combination Codes for MRSA Infection

Methicillin Resistant Staphylococcus Aureus (MRSA) infections have been revised to include combination codes that *specify the causal organism.*

- A41.02 Sepsis due to Methicillin Resistant Staphylococcus Aureus
- J15.212 Pneumonia due to Methicillin Resistant Staphylococcus Aureus

Providers must specify the causal relationship!

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MSSA and MRSA colonization

- A positive MRSA colonization test might be documented by the provider as ***"MRSA screen positive" or "MRSA nasal swab positive".***
  - Z22.322, Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus
  - Z22.321, Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus

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Obesity

- The following are important documentation tips and strategies for this disease/condition as required by the specificity needed in ICD-10:
  - Include descriptions such as overweight, obesity or morbid obesity due to excess calories, drug-induced obesity, and morbid obesity with alveolar hypoventilation.
  - List the specific drug(s) associated with drug-induced obesity.
  - Detail body mass index (BMI), especially if greater than 40.

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Obesity ICD-9

- 278 Overweight, obesity, and other hyperalimentation
  - 278.0 Overweight and obesity
    - 278.00 Obesity, unspecified (Obesity NOS)
    - 278.01 Morbid obesity
    - 278.02 Overweight

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Obesity ICD-10

- E66 Overweight and obesity
  - E66.0 Obesity due to excess calories
    - E66.01 Morbid (severe) obesity due to excess calories, excludes E66.2
    - E66.09 Other obesity due to excess calories
  - E66.1 Drug-induced obesity
  - E66.2 Morbid (severe) obesity with alveolar hypoventilation
  - E66.3 Overweight
  - E66.8 Other obesity
  - E66.9 Obesity, unspecified (Obesity NOS)

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Summary

- The transition to ICD-10 classification systems on October 1, 2015 will have a significant impact on physician documentation requirements.
- The sessions over the next several months will further prepare you for these requirements.
- Please let us know areas or items that you would like to see further addressed in more detail.

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Questions???

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