May 2015

ICD-10 for Infectious Disease

UConn Health

Just himagine what we can accomplish together.

Introduction

Dr. Frank Turner

ICD-10 Implementation Physician Advisor

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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 assignment
  - Identify the importance of physician documentation and coding
  - Discuss the importance behind the query writing process and Physician response.

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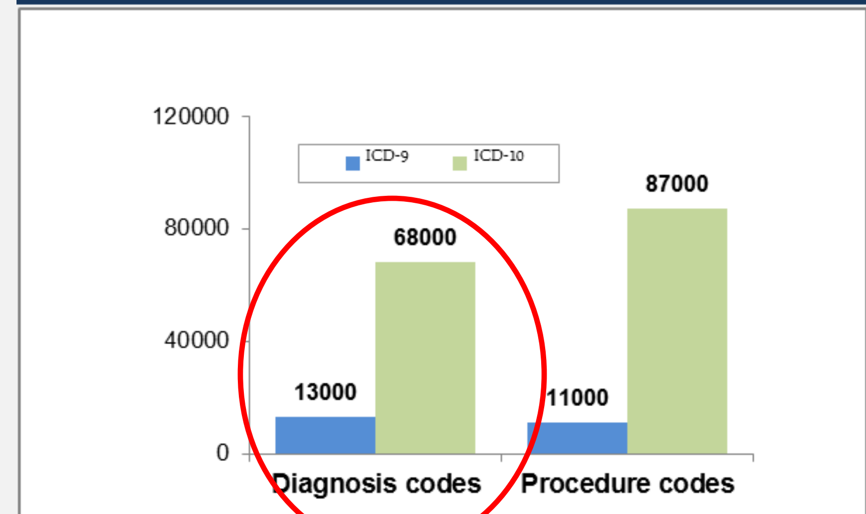
Changes to Diagnosis Codes

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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Considerations

- ICD-10 requires collaboration, collaboration and more 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 classification language and physician clinical documentation

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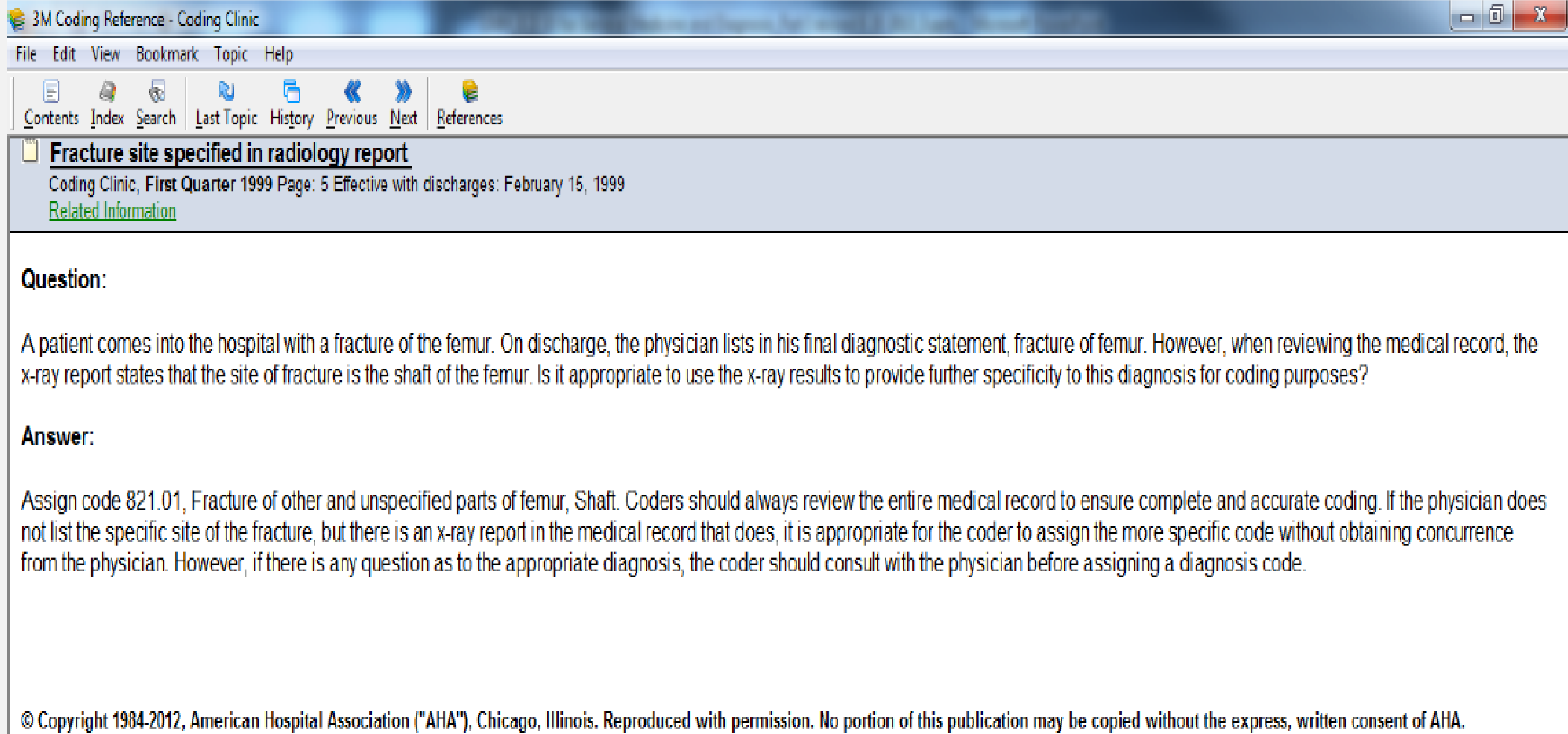
Challenges: Coding Specificity


3M Coding Reference - Coding Clinic

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Fracture site specified in radiology report

Coding Clinic, First Quarter 1999 Page: 5 Effective with discharges: February 15, 1999

Related Information

Question:

A patient comes into the hospital with a fracture of the femur. On discharge, the physician lists in his final diagnostic statement, fracture of femur. However, when reviewing the medical record, the x-ray report states that the site of fracture is the shaft of the femur. Is it appropriate to use the x-ray results to provide further specificity to this diagnosis for coding purposes?

Answer:

Assign code 821.01, Fracture of other and unspecified parts of femur, Shaft. Coders should always review the entire medical record to ensure complete and accurate coding. If the physician does not list the specific site of the fracture, but there is an x-ray report in the medical record that does, it is appropriate for the coder to assign the more specific code without obtaining concurrence from the physician. However, if there is any question as to the appropriate diagnosis, the coder should consult with the physician before assigning a diagnosis code.

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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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Documentation for Diagnosis

Requirements for Detailed Documentation for Diagnoses	
Acuity	Acute, chronic or both
Specific site	Femur trochanteric – apophyseal, greater trochanter, intertrochanteric, lesser trochanter
Laterality	Right, left, bilateral
Specific type of fractures	Displaced/non-displaced fractures, transverse, oblique, spiral, comminuted, segmental
Etiology of diagnosis	Fracture/dislocation due to – pathological, recurrent, fatigue, age-related, osteoporosis
Link must be established between manifestations and underlying diseases	Osteomalacia – puerperal, senile, due to malabsorption or malnutrition, aluminum bone disease, drug induced
Non-pressure skin ulcers	Site, laterality and depth of tissue involvement

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Documentation for Diagnosis (cont.)

Requirements for Detailed Documentation for Diagnoses	
Complications of care	Intraoperative, postoperative, mechanical malfunctions, Infections (device vs. wound)
Injury details	Place of occurrence, activity causing the injury; accident details
Episode of care	Initial treatment, subsequent treatment (for routine or delayed healing), sequela
Drug reactions/interactions/adverse reactions	Poisoning (accidental/intentional/assault/undetermined), adverse effect, underdosing (due to financial hardship, age-related)
Degree of severity	Mild, moderate, severe, e.g., Malnutrition: mild, moderate, severe

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Diagnosis Documentation Examples

Clinical Examples – Documentation Improvement

Laterality

- ICD-10-CM introduces laterality to the diagnosis classification system. Many providers already document which side of the body the disease or injury occurred, but it is now a required data element with ICD-10-CM.

- **Over 5,000 diagnoses have a right and left distinction, such as:**
  - Joint pain/effusion
  - Pneumonia
  - Arthritis
  - Otitis Media

- The following are classification examples of when documentation of laterality is required:
  - M25.561 Pain in right knee
  - S52.521A Torus fracture of lower end of right radius
  - L89.011 Pressure ulcer of the right elbow, stage 1

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Pneumonia, organism unspecified ICD-9

Pneumonia and Influenza (480-488)

- 480 Viral pneumonia
- 481 Pneumococcal pneumonia
- 482 Other bacterial pneumonia
- 483 Pneumonia due to other specified organism
- 484 Pneumonia in infections diseases classified elsewhere
- 465 Bronchopneumonia, organism unspecified
- 486 Pneumonia, organism unspecified
- 487 Influenza
- 488 Influenza due to certain identified avian influenza viruses

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Pneumonia, organism unspecified ICD-10

- J18 Pneumonia, unspecified organism
  - J18.0 Bronchopneumonia, unspecified organism
  - J18.1 Lobar pneumonia, unspecified organism
  - J18.2 Hypostatic pneumonia, unspecified organism
  - J18.8 Other pneumonia, unspecified organism
  - J18.9 Pneumonia, unspecified organism

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Long-term Use of Medications ICD-9

V58.6 Long-term (current) drug use

- V58.61 anticoagulants
- V58.62 antibiotics
- V58.63 antiplatelets/antithrombotics
- V58.64 NSAID
- V58.65 steroids
- V58.66 aspirin
- V58.67 insulin
- V58.69 other medications

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Long-term Use of Medications ICD-10

Z79 Long-term (L/T) (current) drug therapy

- Z79.0 Long term use of anticoagulants and antithrombotics/antiplatelets
  - Z79.01 – Anticoagulants
  - Z79.02 – Antithrombotics/antiplatelets
- Z79.1 – non-steroidal anti-inflammatories
- Z79.2 – antibiotics
- Z79.3 – hormonal contraceptives
- Z79.4 – insulin
- Z79.5 – steroids
  - Z79.51 – inhaled steroids
  - Z79.52 – systemic steroids

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Long-term Use of Medications ICD-10

Z79 Long-term (L/T) (current) drug therapy

- Z79.8 Other long term (current) drug therapy
  - Z79.81 – L/T use of agents affecting estrogen receptors and estrogen level
    - Z79.810 – Selective estrogen receptor modulators (SERMs)
    - Z79.811 – Aromatase inhibitors
    - Z79.818 – Other agents affecting estrogen receptors and estrogen levels
  - Z79.82 – L/T use of aspirin
  - Z79.83 – L/T use of bisphosphonates
  - Z79.89 – Other L/T (current) drug therapy
    - Z79.890 – Hormone replacement therapy (postmenopausal)
    - Z79.891 – L/T (current) use of opiate analgesic
    - Z79.899 – Other L/T (current) drug therapy

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Urinary Tract Infection ICD-9

599 Other disorders of urethra and urinary tract

599.0 Urinary tract infection, site not specified

Use additional code to identify organism, such as E. coli

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Urinary Tract Infection ICD-10

Other diseases of the urinary system (N30-N39)

N30 Cystitis

- N30.0 Acute cystitis
- N30.1 Interstitial cystitis (chronic)
- N30.2 Other chronic cystitis
- N30.3 Trigonitis
- N30.4 Irradiation cystitis
- N30.8 Other cystitis
- N30.9 Cystitis, unspecified
  - N30.90 without hematuria
  - N30.91 with hematuria

N39 Other disorders of urinary system

- N39.0 Urinary tract infection, site not specified
  - Use additional codes (B95-B97), to identify infectious agent

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Influenza Vaccine ICD-9

V04 Need for prophylactic vaccination and innoculation against certain diseases (also separate procedure code)

- V04.0 Poliomyelitis
- V04.1 Smallpox
- V04.2 Measles alone
- V04.3 Rubella alone
- V04.4 Yellow fever
- V04.5 Rabies
- V04.6 Mumps alone
- V04.7 Common cold
- V04.8 Other viral diseases
    - V04.81 Influenza
    - V04.82 RSV
    - V04.89 Other viral diseases

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Influenza Vaccine ICD-10

Z23 Encounter for immunization

- Code 1st any routine childhood examination
- NOTE – Procedure codes are required to identify the types of immunizations given

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Septicemia ICD-9

038 Septicemia

- 038.0 Streptococcal septicemia
- 038.1 Staphylococcal septicemia
- 038.2 Pneumococcal septicemia
- 038.3 Septicemia due to anaerobes
- 038.4 Septicemia due to other gram-negative organisms
- 038.8 Other specified septicemias
- 038.9 Unspecified septicemia

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Septicemia ICD-10

A40 Streptococcal sepsis

A41 Other sepsis

- A41.0 Staphylococcus aureus
  - A41.01 – MSSA
  - A41.02 – MRSA
- A41.1 Other specified staphylococcus
- A41.2 Unspecified staphylococcus
- A41.3 Hemophilus influenzae
- A41.4 Anaerobes
- A41.5 Other Gram-negative organisms
- A41.8 Other specified sepsis
  - A41.81 Enterococcus
  - A41.89 Other specified sepsis
- A41.9 Sepsis, unspecified organism

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Septicemia ICD-10

Severe sepsis/organ dysfunction requires the use of an additional "R" code.

R65.2 Severe sepsis

- R65.20 Severe sepsis without septic shock
- R65.21 Severe sepsis with septic shock

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Encephalopathy ICD-9

348.3 Encephalopathy NEC

- 348.30 Encephalopathy unspecified
- 348.31 Metabolic encephalopathy
- 348.39 Other encephalopathy

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Encephalopathy ICD-10

G93 Other disorders of brain

- G93.0 Cerebral cysts
- G93.1 Anoxic brain damage NEC
- G93.2 Benign intracranial hypertension
- G93.3 Postviral fatigue syndrome
- G93.4 Other and unspecified encephalopathy
  - G93.40 Encephalopathy, unspecified
  - G93.41 Metabolic encephalopathy
  - G93.49 Other encephalopathy
- G93.5 Compression of brain
- G93.6 Cerebral edema
- G93.7 Reye's syndrome
- G93.8 Other specified disorders of brain
  - G93.81 Temporal sclerosis
  - G93.88 Brain death
  - G93.89 Other specified disorders of brain
- G93.9 Disorder of brain, unspecified

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Intraoperative and postprocedural complications

Intraoperative and postprocedural complications and disorders of the respiratory system in ICD-10-CM must be specified to be a result of or linked to the procedures performed.

- Intraoperative and postprocedural complications and disorders of respiratory
- system, NEC
- Other intraoperative and postprocedural complications and disorders of respiratory
- system, NEC
- Postprocedural pneumothorax
- Postprocedural respiratory failure
- Postprocedural hemorrhage and hematoma of a respiratory system organ or structure following a procedure
- Following a respiratory procedure
- Following other procedure
- Transfusion-related acute lung injury (TRALI)
- Complication of respirator [ventilator]

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Intraoperative and postprocedural complications

Any conflicting documentation among providers (attending, surgeon, anesthesiologist, consultant, etc.) **requires query for clarification to the attending physician for accurate coding.**

For example, if a patient has a chemical pneumonitis in the postoperative period, it may not be appropriate to classify as postoperative/post-anesthesia chemical pneumonitis.

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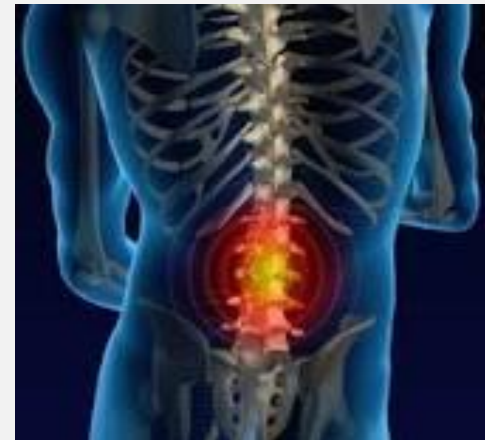
Clinical Examples – Documentation Improvement

Other osteopathies

- To properly classify other osteopathies in ICD-10-CM, physicians must specify the following about the condition:
  - Osteomyelitis
  - Acute hematogenous
  - Other acute
  - Subacute
  - Chronic multifocal
  - Chronic with draining sinus
  - Other chronic hematogenous



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Correct Use of "R" (symptom) Codes

Chapter 18. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)

- Includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions.

- Signs and symptoms pointing rather definitely to a given diagnosis have been assigned to a category in other chapters of the classification.

- In general, categories in this chapter include the less well-defined conditions and symptoms that, without the necessary study of the case to establish a final diagnosis, point perhaps equally to two or more diseases or to two or more systems of the body.

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Correct Use of "R" (symptom) Codes

Chapter 18. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)

- Cases for which no more specific dx can be made even after all facts bearing on the case have been investigated
- Signs and symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined
- Provisional diagnosis in a patient who failed to return for further investigation or care
- Cases referred elsewhere for investigation or treatment before the diagnosis was made
- Cases in which a more precise diagnosis was not available for any other reason
- Certain symptoms, for which supplementary information is provided, that represent important problems in medical care in their own right

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Debility ICD-9

799 Other ill-defined and unknown causes of morbidity and mortality

- 799.0 Asphyxia and hypoxemia
- 799.1 Respiratory arrest
- 799.2 Signs and symptoms involving emotional state
- 799.3 Debility, unspecified
- 799.4 Cachexia
- 799.8 Other ill-defined conditions
- 799.9 Other unknown and unspecified cause

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Debility ICD-10

R53 Malaise and fatigue

- R53.0 Neoplastic (malignant) related fatigue
- R53.1 Weakness
- R53.2 Functional quadriplegia
- R53.8 Other malaise and fatigue
  - R53.81 Other malaise
    - Includes debility NOS, chronic debility, general physical deterioration, malaise NOS, nervous debility
  - R53.82 Chronic fatigue, unspecified
  - R53.83 Other fatigue

R54 Age-related physical debility

- Includes frailty, old age, senescence, senile asthenia, senile debility

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Fatigue ICD-9

780.7 Malaise and fatigue

- 780.71 Chronic fatigue syndrome
- 780.72 Functional quadriplegia
- 780.79 Other malaise and fatigue

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Fatigue ICD-10

R53 Malaise and fatigue

- R53.0 Neoplastic (malignant) related fatigue
- R53.1 Weakness
- R53.2 Functional quadriplegia
- R53.8 Other malaise and fatigue
  - R53.81 Other malaise
  - R53.82 Chronic fatigue, unspecified
  - R53.83 Other fatigue
    - fatigue NOS, lack of energy, lethargy, tiredness

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Dysuria ICD-9

788 Symptoms involving urinary system

- 788.0 Renal colic
- 788.1 Dysuria
- 788.2 Retention of urine
- 788.3 Urinary incontinence
- 788.4 Frequency of urination and polyuria
- 788.5 Oliguria and anuria
- 788.6 Other abnormality of urination
- 788.7 Urethral discharge
- 788.8 Extravasation or urine
- 788.9 Other symptoms involving urinary system

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Dysuria ICD-10

R30 Pain associated with micturition

- R30.0 Dysuria
- R30.1 Vesical tenesmus (feeling of incomplete emptying after unination)
- R30.2 Painful micturition, unspecified

[Painful micturition (dysuria, oliguria)].

[Article in German]

Hochreiter W.

Source

Urologische Universitätsklinik, Inselspital, Bern.

Abstract

Painful micturition is one of the most common symptoms of urological diseases. The term "dysuria" is descriptive for micturition which the patient perceives as unpleasant.

Abdominal Pain ICD-9

789.0 Abdominal pain

- 789.00 unspecified site
- 789.01 RUQ
- 789.02 LUQ
- 789.03 RLQ
- 789.04 LLQ
- 789.05 periumbilic
- 789.06 epigastric
- 789.07 generalized
- 789.09 other specific site
  - includes multiple sites

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Abdominal Pain ICD-10

R10 Abdominal and pelvic pain

- R10.0 Acute abdomen
- R10.1 Pain localized to upper abdomen
- R10.2 Pelvic and perineal pain
- R10.3 Pain localized to other parts of lower abdomen
- R10.8 Other abdominal pain
- R10.9 Unspecified abdominal pain

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Abdominal Pain ICD-10

R10 Abdominal and pelvic pain

- R10.8 Other abdominal pain
  - R10.81 Abdominal tenderness
    - R10.811 RUQ
    - R10.812 LUQ
    - R10.813 RLQ
    - R10.814 LLQ
    - R10.815 Periumbilic
    - R10.816 Epigastric
    - R10.817 Generalized
    - R10.819 Unspecified site
  - R10.81 Rebound abdominal tenderness
    - R10.821 RUQ
    - R10.822 LUQ
    - R10.823 RLQ
    - R10.824 LLQ
    - R10.825 Periumbilic
    - R10.826 Epigastric
    - R10.827 Generalized
    - R10.829 Unspecified site
  - R10.83 Colic
  - R10.84 Generalized abdominal pain
- R10.9 Unspecified abdominal pain

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Nausea with Vomiting ICD-9

787.0 Nausea and vomiting

- 787.01 Nausea with vomiting
- 787.02 Nausea alone
- 787.03 Vomiting alone
- 787.04 Bilious emesis

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Nausea with Vomiting ICD-10

R11 Nausea and vomiting

- R11.0 Nausea
- R11.1 Vomiting
  - R11.10 Vomiting, unspecified
  - R11.11 Vomiting, without nausea
  - R11.12 Projectile vomiting
  - R11.13 Vomiting of fecal matter
  - R11.14 Bilious vomiting
- R11.2 Nausea with vomiting, unspecified

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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

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

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

- **A**: Initial encounter – when the patient is receiving active treatment/first visit by that physician
- **D**: Subsequent encounter – after the active phase of treatment and when the patient is receiving repeat or routine care for the injury.
- **S**: Sequela is assigned for complication or condition that arises as a direct result of an injury (takes priority for code- if no sequelae, code initial or subsequent)

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Procedure Documentation Examples

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Overview of ICD-10-PCS

- Basic principles used when developing the system were that **no diagnostic information is included** in the procedure description (i.e., no codes for procedures exclusive to aneurysms, cleft lip, strictures or neoplasms, etc.).
- This procedure classification system is only utilized in the **inpatient hospital setting.**

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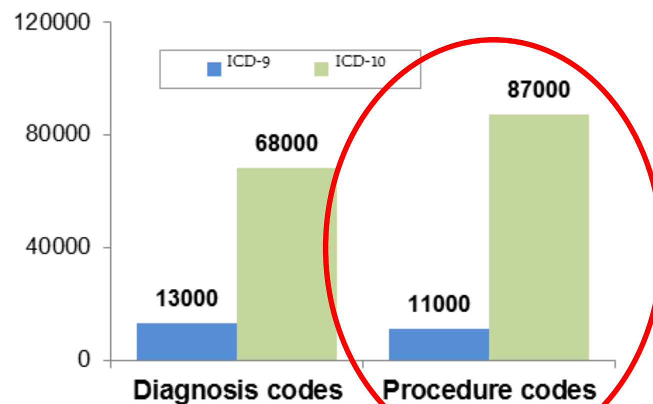
ICD-10-PCS



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

ICD-10 procedure codes will require additional and significant detail in surgical reporting

- Key ICD-10 characteristics
  - ICD-10 is a "dramatic departure" from current practice
  - Surgical codes lack decimals
  - The new code set will allow for incorporation of new procedures and technologies
  - Terminology is precisely defined and used consistently across all codes

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ICD-10-PCS Chest Tube with Drainage

Patient presents for chest tube placement

ICD-10-PCS

0W9930Z

- Drainage of Right Pleural Cavity with Drainage Device, Percutaneous Approach

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ICD-10-PCS Table

Section	0	Medical and Surgical
Body System	W	Anatomical Regions, General
Operation	9	Drainage: Taking or letting out fluids and/or gases from a body part

Body Part	Approach	Device	Qualifier
0 Head **1** Cranial Cavity **2** Face **3** Oral Cavity and Throat **4** Upper Jaw **5** Lower Jaw **6** Neck **8** Chest Wall **9** Pleural Cavity, Right **B** Pleural Cavity, Left **C** Mediastinum **D** Pericardial Cavity **F** Abdominal Wall **G** Peritoneal Cavity **H** Retroperitoneum **J** Pelvic Cavity **K** Upper Back **L** Lower Back **M** Perineum, Male **N** Perineum, Female	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Drainage Device	**Z** No Qualifier

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Catheter Insertion into Vein

- Procedures require documentation of:
  - Specific vein where insertion performed
    - Right or left internal jugular vein
    - Right or left external jugular vein
  - Approach
    - Open
    - Percutaneous
    - Percutaneous endoscopic
  - Type of device
    - Infusion
    - intraluminal
  - Code examples
    - ICD-9 – 38.93 – venous catheterization.
    - ICD-10-PCS – 05HM33Z – Insertion, internal jugular vein right, percutaneous, infusion device.

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Catheter Insertion

Section	**0**	Medical and Surgical
Body System	**2**	Heart and Great Vessels
Operation	**H**	Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Body Part	Approach	Device	Qualifier
4 Coronary Vein **6** Atrium, Right **7** Atrium, Left **K** Ventricle, Right **L** Ventricle, Left	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Monitoring Device, Pressure Sensor **2** Monitoring Device **3** Infusion Device **D** Intraluminal Device **J** Cardiac Lead, Pacemaker **K** Cardiac Lead, Defibrillator **M** Cardiac Lead	**Z** No Qualifier
P Pulmonary Trunk **Q** Pulmonary Artery, Right **R** Pulmonary Artery, Left **S** Pulmonary Vein, Right **T** Pulmonary Vein, Left **V** Superior Vena Cava **W** Thoracic Aorta	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Monitoring Device, Pressure Sensor **2** Monitoring Device **3** Infusion Device **D** Intraluminal Device	**Z** No Qualifier

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Physician Queries

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Query…why?

A query is a communication tool used to clarify documentation in the health record for accurate code assignment.

The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

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Query…when?

A query is written when the Health record Documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

"A proper query process ensures that appropriate documentation appears in the health record"

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Query…when?

“A proper query process ensures that appropriate documentation appears in the health record”

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Query… answer how?

Queries are generated to elicit more information from the Provider.

- A response is ***necessary*** from the provider to fulfill this process.

- A. ***signature alone on a generated query does not fulfill this requirement***

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Query… answer how?

A Physician response, ***'see notes'*** does not fulfill the request generated by the query.

- The coder has already reviewed the notes and Medical Record Documentation
- ***Although the response may seem 'obvious' coders are only 'reporters'*** of the medical record and ***cannot code a diagnosis*** that is ***not documented by the Provider.***

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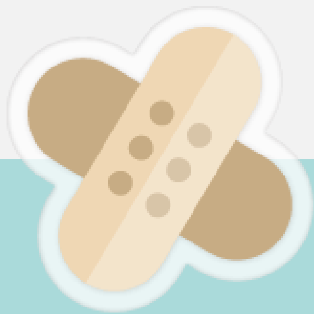

Questions?

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