AGENDA

- What is ICD-10’s Greatest Challenge?
- What are Clinical Concepts?
- How do they apply to ICD-10-CM?
- Why are they important?
- How to communicate with providers?
WHAT IS ICD-10’S GREATEST
CHALLENGES?

ICD-10’s Greatest Challenge

• Documentation sufficient to support:
  – Specificity
  – Granularity

Documentation Concepts

• Approximately 21 unique concepts
  – Breaking down ICD-10-CM into concepts
Clinical Concepts

• Type
• Temporal factors
• Caused by/Contributing factors
• Symptoms/Findings/Manifestations
• Localization/Laterality
• Anatomy
• Associated with
• Severity
• Episode
• Remission status
• History of

• Morphology
• Complicated by
• External Cause
• Activity
• Place of Occurrence
• Loss of Consciousness
• Substance
• Number of Gestations
• Outcome of Delivery
• BMI

Specificity

• Laterality
• Temporal Factors
• Anatomic Location
• Other issues

Laterality

• The addition of laterality into the code set is one of the reasons for the increased number of codes in ICD-10-CM.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
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<tbody>
<tr>
<td>370.34 Exposure keratoconjunctivitis</td>
<td>H16.211 Exposure keratoconjunctivitis, right eye</td>
</tr>
<tr>
<td>370.34 Exposure keratoconjunctivitis</td>
<td>H16.212 Exposure keratoconjunctivitis, left eye</td>
</tr>
<tr>
<td>370.34 Exposure keratoconjunctivitis</td>
<td>H16.213 Exposure keratoconjunctivitis, bilateral</td>
</tr>
<tr>
<td>370.34 Exposure keratoconjunctivitis</td>
<td>H16.219 Exposure keratoconjunctivitis, unspecified eye</td>
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</tbody>
</table>
Example A

Patient presents with superficial foreign body in finger of left hand. Piece of glass was removed from finger, antibiotic ointment placed, and Band-Aid put on finger.

S60.459A  Superficial foreign body of unspecified finger, initial encounter

Example B

Patient presents with superficial foreign body in left index finger. Piece of glass was removed from finger, antibiotic ointment placed, and Band-Aid put on finger.

S60.451A  Superficial foreign body of left index finger, initial encounter

Example A

Patient presents with a fracture of the right humeral shaft. Fracture was reduced and cast placed.

S42.301A  Unspecified fracture of shaft of humerus, right arm, initial encounter for closed fracture
Example B

Patient presents with an oblique fracture of the right humeral shaft. Fracture was reduced and cast placed.

S42.331A Displaced oblique fracture of shaft of humerus, right arm, initial encounter for closed fracture

Temporal Factors

- Acute
- Chronic
- Acute on Chronic
- Recurrent

Example A

Joy presents for recheck on her bronchitis. She states she is less short of breath when walking up stairs this week. She says the albuterol is helping her breathing.

J40 Bronchitis, not specified as acute or chronic
Joy presents for a recheck on her simple chronic bronchitis. She states she is less short of breath when walking up stairs this week. She says the albuterol is helping her breathing.

Example B

J41.0 Simple chronic bronchitis

Anatomic Location

Many codes in ICD-10-CM have site specificity, including:

- Fracture coding
- Dislocations
- Pressure ulcers
- Burns and corrosions
- Lacerations
- Open bites

Example A

Jon is brought in by his mother for a recheck of his radial Torus fracture of the right arm. Everything is healing well after 2 weeks. Mom will bring him back next week for possible cast removal.

S52.91XD Unspecified fracture of right forearm, subsequent encounter with routine healing
Example B

Jon is brought in by his mother for a recheck of his distal radial Torus fracture of the right arm. Everything is healing well after 2 weeks. Mom will bring him back next week for possible cast removal.

S52.521D Torus fracture of lower end of right radius, subsequent encounter with routine healing

Other and Multiple Concepts

• In some cases, multiple concepts will be present in the same case (temporal factors, anatomic location, laterality).
• Providers need full education on these areas to ensure that unspecified codes will not be used
  – This will prevent multiple provider queries to receive enough information to assign a code.

Example A

Patricia brings in her daughter for ear pain. Jane is 2 years old and has been pulling at her ears and crying. Patricia noted a fever this morning, so she called to get Jane in to be seen. Upon exam, a bulging, cloudy, immobile tympanic membrane is seen with purulent fluid. Diagnosis: Purulent otitis media.

H66.40 Suppurative otitis media, unspecified, unspecified ear
Example B
Patricia brings in her daughter for ear pain. Jane is 2 years-old and has been pulling at her ears and crying. Patricia noted a fever this morning, so she to get Jane in to be seen. Jane has suffered bouts with acute purulent OM 3 times in the past 5 months. She goes on antibiotics, gets better, then the condition recurs. Upon exam, a bulging, cloudy immobile right tympanic membrane is seen with purulent fluid. Left ear is normal.
Diagnosis: Right recurrent purulent OM.
H66.004 Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear.

Example A
Linda is in today for a follow-up of her atrial fibrillation.
Meds: Cardizem. She states her heart rate is up just a little bit today. No chest pains. No shortness of breath. ECG: AFib with nonspecific ST-T changes.
I48.91 Unspecified atrial fibrillation

Example B
Linda is in today for a follow-up of her persistent atrial fibrillation. Condition present for more than 2 years. Meds: Cardizem. She states her heart rate is up just a little bit today. She is experiencing more frequent symptomatic AFib recurrence with symptoms lasting for 5 days. No chest pains. No shortness of breath. ECG: AFib with nonspecific ST-T changes.
I48.1 Persistent atrial fibrillation
Example A

CHIEF COMPLAINT: Sinus problems. Symptoms include postnasal drainage, sore throat, facial pain, coughing, headaches and congestion. The symptoms are characterized as moderate to severe. Symptoms are worse in the evening and morning.

EXAM: Exam Nose: Intranasal exam reveals moderate congestion and purulent mucus. Exam Facial: There is bilateral sinus tenderness to palpation.

IMPRESSION: Sinusitis

J32.9 Chronic sinusitis, unspecified

Example B

CHIEF COMPLAINT: Sinus problems. The problem began 2 weeks ago and is constant. Symptoms include postnasal drainage, sore throat, facial pain, coughing, headaches and congestion. The symptoms are characterized as moderate to severe. Symptoms are worse in the evening and morning.

EXAM: Exam Nose: Intranasal exam reveals moderate congestion and purulent mucus. Exam Facial: There is bilateral maxillary sinus tenderness to palpation.

IMPRESSION: Acute maxillary sinusitis

J01.00 Acute maxillary sinusitis, unspecified

Fractures

- Contributing factors
- Type
- Underlying conditions
- Anatomic Location
- Complications
- Localization/Laterality
35 year old presented to the emergency department with a painful, right wrist. Upon examination the wrist is swollen and there is pain with palpation of the wrist area with limited grip strength of the right hand. Pain is noted to be in the anatomic snuffbox and upon extension a radial deviation is noted. A **mid third scaphoid fracture** is confirmed by plain film. Fracture is **reduced** in office and patient is placed in a long arm cast.

S62.021A Fracture of middle third of navicular [scaphoid] bone of right wrist, initial encounter for closed fracture

**Documentation Requirements**

- In order to assist providers with clinical documentation improvement, it is necessary that the coder/auditor/educator understand the documentation requirements of the most commonly coded conditions in their specialty.

**Hypertension**

- Type
- Associated complications
- Severity
- Symptoms/Findings/Manifestations
- Temporal factors
- Contributing factors
Congestive Heart Failure

- Type
- Contributing factors
- Temporal factors
- Associated conditions

Example

Subjective: 75 year old female is seen for follow up for chronic hypertensive heart disease. She has been having ongoing shortness of breath and orthopnea. Recent EKG demonstrates findings consistent with cardiomegaly, but not recent change since a prior EKG. Currently she is on Lasix, Lanoxin and Atenolol.

Objective: BP = 175/95; HR = 100. Chest x-ray show mild pulmonary edema. There is 2+ pitting edema in both ankles.

Assessment: Hypertension – poorly controlled Chronic diastolic congestive heart failure

I11.0 Hypertensive heart disease with heart failure
I50.32 Chronic diastolic (congestive) heart failure

Dermatitis

- Type
- Contributing factors
- Symptoms/Findings/Manifestations
- Anatomical location
- Laterality
Example

**Subjective:** A 24-year-old patient presents due to itchy, red hands. The patient recently started a job at a Chinese restaurant as a chef. He washes his hands often and uses a lot of citrus fruit, ginger, onion, and garlic in the foods he prepares. His symptoms began a few months after beginning his job.

**Objective:** Upon examination, his hands were red and swollen. Vesicles were present on his fingers and he stated that they sometimes crack and bleed.

**Assessment:** Contact dermatitis due to food handling

L24.6 Irritant contact dermatitis due to food in contact with skin

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Hyperthyroidism/Hypothyroidism

- **Type**
- **Contributing factors**
- **Symptoms/Findings/Manifestations**

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Example

- **Subjective:** A 32-year-old female presents with a 5-month Hx of increased sweating and palpitations with weight loss of 25 lbs. On exam, she was nervous and agitated with an obvious, diffuse, non-tender, smooth enlargement of her thyroid, over which a bruit could be heard. She had a fine tremor of her fingers and a resting pulse rate of 150/minute. She had no evidence of exophthalmos. She believes that a maternal aunt had suffered from ‘thyroid disease’.
Objective: Testing showed she had a significant elevation of serum T3 and T4 levels. Measurement of her thyroid-stimulating hormone showed low normal values. Biochemical findings pointed to primary thyroid disease rather than pituitary overactivity. Circulating antibodies to thyroid peroxidase were detected by agglutination. A diagnosis of Graves disease was made. There was no evidence to suggest thyrotoxic crisis or storm.

Assessment: Thyrotoxicosis Diffuse goiter

E05.00 Thyrotoxicosis with diffuse goiter without thyrotoxic crisis or storm

Example

Subjective: 66-yr-old with a history of slowly progressive pain in the left knee. She has noted some enlargement of the knee and considerable crepitance on motion. There has been no significant warmth or redness and symptoms appear confined to that knee. She has difficulty getting out of a chair and can only walk for 2 blocks with a cane. She cannot recall any history of trauma to the knee.
Objective: Exam reveals range of motion limited between 15 and 90 degrees. There is severe crepitance on motion and palpable osteophytes. Minimal effusion is noted. There is moderate genu varus on standing. X-rays demonstrate marked joint space loss particularly in the medial compartment with prominent diffuse osteophytes.

Assessment: Primary osteoarthritis confined to the left knee

M17.12 Unilateral primary osteoarthritis, left knee

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**Headaches**

- Type
- Severity
- Symptoms/Findings/Manifestations
- Association
- Contributing factors
- Temporal factors

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**Example**

**Subjective:** Patient presents with complaint of intermittent headaches. He has had similar headaches for 10 years and comes in now because they used to occur 2-3 times a year and now they are occurring 3-4 times a month. The headaches are so severe that he is unable to work while having one. He describes them as a throbbing pain behind his right eye. The headaches are often associated with nausea and in the last few months he has occasionally vomited with them. Light aggravates his symptoms, but he has no visual symptoms associated with the headaches.

**Objective:** His neurologic exam is unremarkable.

**Assessment:** Chronic Migraine

G43.709 Chronic migraine without aura, not intractable, without status migrainosus

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Sinusitis

- Anatomy
- Temporal factors
- Contributing factors

Example

Subjective: This patient is a 7 year-old female who was seen in the office for discomfort in the maxillary region. For the previous 4-5 years the patient had suffered from chronic sinus problems of a similar type. Symptoms included constant nasal congestion, coughing, and snoring. The patient has been exposed to second-hand smoke from family members.

Objective: An initial exam showed edematous red nasal mucosa and colored nasal discharge. Allergy testing results were negative. A CT scan confirmed bilateral maxillary blockage and bilateral thickening of the mucous membrane.

Example

- Assessment: Chronic Maxillary sinusitis, Secondary tobacco smoke exposure
- J32.0 Chronic maxillary sinusitis
- Z77.22 Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)
Overweight and Obesity

- Severity
- Contributing factors
- Association
- Symptoms/Findings/Manifestations

Example

Subjective: A 49-year old AA woman presented for weight loss treatment. She has attempted to lose weight through a variety of diets but has had no meaningful success. She states that she “loves food” and particularly is “addicted to sweets”.

Objective: On exam, she was 64 inches tall and weighed 230 pounds yielding a BMI of 39.5.

Dx: Severe obesity due to excessive caloric intake

E66.01 Morbid (severe) obesity due to excessive calories
Z68.39 Body mass index (BMI) 39.0-39.39, adult

Diabetes Mellitus

- Type
- Pregnancy-related
- Complications
Example
Subjective: 56-year-old obese male with a long history of adult onset diabetes mellitus. He is seen for a follow up evaluation and currently has no new symptoms. He has been dependent on insulin for 10 years and has stage 2 diabetic chronic kidney disease. He does not keep his calories or diet in range.
Objective: Weight = 245. Height = 5'10". Blood glucose = 125. Exam otherwise unremarkable. Calculated BMI = 35.1
Assessment: Type 2 diabetes mellitus with CKD stage 2 Obesity
E11.22 Type 2 diabetes mellitus with diabetic chronic kidney disease
N18.2 Chronic kidney disease, stage 2 (mild)
E66.09 Other obesity due to excess calories
Z79.4 Long term (current) use of insulin

Mood Affective Disorders
- Type
- Temporal factors
- Severity
- Symptoms/Findings/Manifestations
- Remission status

Example
Subjective: 48 year old male with long history of Bipolar disorder currently being treated with lithium carbonate. He presents with a recent symptoms of sleep deprivations, lethargy constipation and general malaise. He states that he feels hopeless. He also state that he feels he is being persecuted and the victim of a government plot to kill him.
Objective: Appears depressed with slow psychomotor function. Physical and neurologic exam is normal
Assessment: Bipolar disorder, severe, Current major depressive manifestations, Paranoid delusions
F31.5 Bipolar disorder, current episode depressed, severe, with psychotic features
Assisting Providers with Transition

• A real emphasis needs to be made with the practitioners to move away from usage of unspecified codes.

• There is a high risk for denial by payers under ICD-10-CM for certain unspecified code usage.

Assisting Providers with Transition

• Template Assessments
  – EMR
  – Paper

• Update where necessary

• Educate on changes with time enough to become familiar with them

Assisting Providers with Transition

• Documentation Assessments
  – Compares current documentation against ICD-10-CM specificity
  – Run by entire practice
  – Run by clinic/facility
  – Run by provider
Assisting Providers with Transition

- Documentation Assessments by Provider
  - Run top diagnosis against recent patient visits
  - Pull 10-15 recent charts with that diagnosis
  - Assign ICD-10-CM code(s)
  - Create a report
  - Meet with provider
  - Re-assess

Documentation Assessment Forms

<table>
<thead>
<tr>
<th>Chart</th>
<th>Patient ID</th>
<th>ICD-10-CM code</th>
<th>ICD-10-CM code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A244893</td>
<td>L25.9</td>
<td>Unspecified contact dermatitis, unspecified cause</td>
</tr>
<tr>
<td>2</td>
<td>J990356</td>
<td>L24.1</td>
<td>Irritant contact dermatitis due to oils and grease</td>
</tr>
<tr>
<td>3</td>
<td>K480353</td>
<td>L23.9</td>
<td>Allergic contact dermatitis, unspecified cause</td>
</tr>
</tbody>
</table>

In ICD-10-CM, in order to assign a code for contact dermatitis to the highest level of specificity, documentation needs to include type and causation.

Denied claims
Pended claims
Medical necessity
Summary

- Understand the unique clinical concepts for your practice/specialty
- Review EMR/EHR to see what additions can be added to assist
- Perform documentation assessments to see where improvements may be needed
- Provide clear concise education on noted weaknesses
- Re-evaluate after implementation

QUESTIONS?