Introduction

- Today’s session will include
- Documentation challenges with ICD-10-CM
  - With documentation examples
Coder Productivity Impacts

- Data in other countries generally consistent
  - Australia and Canada reported a loss in coder productivity in the first 6 months of using ICD-10. After 6 months coder productivity levels were at the same or nearly the same as pre-implementation
  - US ICD-10 CM and PCS is different than the Canada and Australia versions, we therefore don’t know the full impact on coder productivity
  - Many experts in the US are concerned that it may take as long as a year for productivity to rebound

Other Considerations

- There is no data to indicate physician productivity is affected
- Number of codes used in the US are far greater and therefore there may be additional impacts
- Good preparation, education, training and tools are key to reducing productivity losses
- Payer and other perspectives on coding specificity
  - Too early to know if there will be specific audits for lack of specificity
  - At the NCVHS Stakeholder meeting in December of 2009 there were concerns voice of the potential for audits for non-specified codes (this was a BCBS hosted event)
  - We will be learning more as this evolve
Highlights of ICD-10-CM Differences

• New – placeholder “x” if the code only has 4 or 5 characters, but needs a 7th character (e.g., initial/subsequent/sequela to injury), use an “x” in the blank spaces
• Different – Exclude1 (never code it here) and Exclude2 (not included, if he has that code it separately)
• New – Laterality
• New – Coding pregnancy trimesters
• New – Glasgow coma scale
• New – Functional quadriplegia

Additional Observations and Challenges

• The addition of information relevant to ambulatory and managed care encounters
• Expanded injury codes in which ICD-10-CM groups injuries by site
• Diabetes codes include over 210 choices
• Creation of combination diagnosis/symptom codes which reduced the number of codes needed to fully describe a condition
• The length of codes being a maximum of seven characters as opposed to five digits in ICD-9-CM
• Challenges for OB/GYN with codes beginning with letter “O” which can be confused with number “0”
  – Potential keying errors which could lead to claim denials
How Coding Is Mapped in the EHR

- Terminologies such as SNOMED-CT® / KP CMT are “input” systems and codify the clinical information captured in an EHR during the course of patient care
- Clinical translations are mapped to the ICD-10 code

Clinical Impact of ICD-10

- Adequate documentation of clinical observations during patient examinations or procedures ‘
  – essential to deriving the proper ICD-10 coding of that diagnosis or procedure
- Impact of ICD-10 on clinician's medical workflow often overlooked in assessments
- Insufficient documentation and resulting improper coding can impact patient history
Neoplasms’

- Coded by anatomic site
- Laterality (if applicable)
- Type of Neoplasm
  - Malignant
  - Benign
  - In situ
  - Uncertain
  - Unspecified behavior
Documentation

- Laterality
- Type of neoplasm
- Primary of secondary—malignancy
- Benign
- Insitu

Example

- A patient is diagnosed with a neoplasm of the right canthus
  - This Code requires laterality
- D04.11 Carcinoma in situ of skin of right eyelid, including canthus
  - D04.11 Carcinoma in situ of skin of right eyelid, including canthus
  - Laterality and type of Cancer determines diagnosis code
Diabetes Mellitus

- Over 210 codes to identify
- Documentation must include:
  - Type of Diabetes (1 or 2)
  - Manifestations
  - Other mitigating factors

Diabetes Mellitus

- There are six diabetes mellitus categories in the ICD-10-CM. They are:
  - E08 Diabetes mellitus due to an underlying condition
  - E09 Drug or chemical induced diabetes mellitus
  - E10 Type I diabetes mellitus
  - E11 Type 2 diabetes mellitus
  - E13 Other specified diabetes mellitus
  - E14 Unspecified diabetes mellitus
- Note: All the categories above (with the exception of E10) include a note directing users to use an additional code to identify any insulin use, which is Z79.7. The concept of insulin and noninsulin is a component of the diabetes mellitus categories in ICD-10-CM.
Diabetes Mellitus
ICD-10-CM

• Documentation Requirements:
  – Type
  – Body System Affected
  – Complication or manifestation
  – If type 2 DM, if long term insulin use

• Elimination:
  – Dual Diagnoses Coding
  – Controlled versus Uncontrolled—No Longer Captured in ICD-10-CM

Mapping Diabetes

An Example of One ICD-9-CM code being represented by Multiple ICD-10-CM Codes

The industry expects that mapping ICD-9 and ICD-10 codes will be a complex task
Diabetes with Manifestation

- A 60 year old patient presents with Type 1 diabetes has a chronic left heel ulcer with muscle necrosis due to the diabetes.

- Diagnosis code(s):
  - E10.622-Type 1 diabetes mellitus with other skin ulcer
    - A note underneath the code identifies to “Use additional code to identify site of ulcer
  - Secondary diagnosis: L97.423-non-pressure chronic ulcer of left heel with necrosis of muscle

Diabetic Foot Ulcer

- The reference in ICD-10-CM
- Diabetes, with foot ulcer references to the code E10.621 in the tabular list.
  - E10.621 Type 1 diabetes mellitus with foot ulcer

- Instructional Notes
  - Use additional code to identify site of ulcer (L97.4-, L97.5-)
  - Drug or Chemical induced diabetes (E09), Type 1 (E10), Type 2 (E11), or Other Specified diabetes (E13).
Diabetic Foot Ulcer

- Since the instructional notes indicate an additional code must be reported to identify the site of the foot ulcer, reference in the Tabular list L97.4- to L97.5-.
  - L97.41 Non-pressure chronic ulcer of right heel and midfoot
  - L97.411 Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin
  - L97.412 Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed
  - L97.413 Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle
  - L97.414 Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone
  - L97.419 Non-pressure chronic ulcer of right heel and midfoot with unspecified severity

Arthritis

- Documentation required:
  - Type of arthritis
  - Location (anatomy)
  - Laterality
Example

- **Example:** A physician diagnosed a patient with rheumatoid arthritis of the right ankle and foot who also has rheumatoid polyneuropathy.

Correct Coding

- M05.571 Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot.
- M05.57 Rheumatoid polyneuropathy with rheumatoid arthritis of ankle and foot
  - Rheumatoid polyneuropathy with rheumatoid arthritis, tarsus, metatarsus and phalanges
- M05.571 Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot
- M05.572 Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot
- M05.579 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified ankle and foot
Signs/Symptoms

• A patient is admitted to observation care from the emergency room with precordial (chest) pain. The ER physician decides to keep the patient overnight to rule out a myocardial infarction.

• Since the physician does not specifically diagnose the condition when the patient is admitted to observation care, the encounter is coded using signs and/or symptoms the patient is experiencing.
  • Alphabetic Index: pain → precordial (region) R07.2
  • Tabular List: R07.2 → Precordial pain
  • Correct code: R07.2

Burns

• Information necessary in documentation:
  – Burn or corrosion
  – Depth of burn (first, second, third degree, etc)
  – Extent burn or corrosion
  – Agent
  – Burn codes used for thermal burns except sunburns that come from heat source
    • Fire
    • Hot appliance
  – Corrosions burns due to chemicals
  – 7th character required
    • A Initial encounter
    • D Subsequent encounter
    • S Sequela
Example

- A patient who has Type 1 diabetes mellitus is treated for a second-degree burn on her left knee which radiated down to her ankle. The patient was burned when a hot skillet fell and hit her left knee causing the burn. She was in her kitchen when the injury occurred.

How it is Coded

- Tabular List: L24.222-Second degree burn of left knee
- When reviewing the tabular list instructions, the instructions indicate a 7th character is required. The choices in category T24 are:
  - The appropriate 7th character is to be added to each code from category T24.
  - A Initial encounter
  - D Subsequent Encounter
  - S Sequela
How it is Coded

- In additional the instruction notes instruct the user to select a code to identify the source, place and intent of the burn.
- Since the patient was injured by a skillet which fell on her knee while she was cooking in the kitchen at home, the following needs to also be reported.
  - What injury occurred and;
  - Place of Occurrence

How it is Coded

- Correct diagnosis code sequence and reporting:
  - First listed diagnosis: L24.222-Second degree burn of left knee
  - Secondary diagnosis: X15.3XXA- Contact with hot saucepan or skillet
  - Tertiary diagnosis: Y92.010 - Kitchen of single-family (private) house as the place of occurrence of the external cause
  - Fourth diagnosis:E10.69 – Type1 diabetes mellitus with other specified complication
Fractures

• Documentation required:
  – Anatomic site
  – Laterality
  – Fracture type
  – Displaced or Nondisplaced
  – Open or closed
  – 7th character extension required

Fractures

• S42.022-Displaced fracture of shaft of left clavicle initial encounter for closed fracture
  – Requires 7th character A for initial encounter
  – S42.022A
  – Site-Left Clavical
  – Laterality-left
  – Initial encounter
Fractures

- Fracture codes require seventh character to identify if fracture is open or closed
- The fracture 7th character extensions are:
  - A Initial encounter for closed fracture
  - B Initial encounter for open fracture
  - D Subsequent encounter for fracture with routine healing
  - G Subsequent encounter for fracture with delayed healing
  - K Subsequent encounter for fracture with nonunion
  - P Subsequent encounter for fracture with malunion
  - S Sequelae
- S42.022-Displaced fracture of shaft of left clavicle initial encounter for closed fracture
  - Requires 7th character A for initial encounter
  - S42.022A

Example

- A patient underwent surgery for an open burst fracture of the first lumbar vertebra which became unstable.
  - First listed diagnosis: S32.012B-unstable burst fracture of first lumbar vertebra
  - Seventh character “B” identifies the initial encounter for the open fracture.
Osteoarthritis

- Osteoarthritis
  - Primary
  - Secondary
  - Traumatic

Laterality

Examples

<table>
<thead>
<tr>
<th>M17.1</th>
<th>Unilateral primary osteoarthritis of knee</th>
</tr>
</thead>
<tbody>
<tr>
<td>M17.10</td>
<td>Unilateral primary osteoarthritis of unspecified knee</td>
</tr>
<tr>
<td>M17.11</td>
<td>Unilateral primary osteoarthritis, right knee</td>
</tr>
<tr>
<td>M17.12</td>
<td>Unilateral primary osteoarthritis, left knee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>M17.2</th>
<th>Bilateral post-traumatic osteoarthritis of knee</th>
</tr>
</thead>
<tbody>
<tr>
<td>M17.30</td>
<td>Unilateral post-traumatic osteoarthritis unspecified knee</td>
</tr>
<tr>
<td>M17.31</td>
<td>Unilateral post-traumatic osteoarthritis right knee</td>
</tr>
<tr>
<td>M17.32</td>
<td>Unilateral post-traumatic osteoarthritis left knee</td>
</tr>
</tbody>
</table>
Chronic Obstructive Pulmonary Disease (COPD)

• Documentation required:
  – Does acute lower respiratory infection exist
  – Does acute exacerbation exist?
    • Chronic obstructive pulmonary disease with acute lower respiratory infection J44.0
    • Chronic obstructive pulmonary disease with (acute) exacerbation J44.1
    • Chronic obstructive pulmonary disease, unspecified J44.9

Chronic Obstructive Pulmonary Disease (COPD)

• Coding Requirements:
  – If an acute lower respiratory infection is present (J44.0)
    • then an additional code should be used to identify the infection, if known.
    • The code set also states that asthma should be coded in addition to these codes, if applicable
  – Other codes that may be reported are for:
    • history of tobacco use (Z87.891)
    • exposure to environmental tobacco smoke (Z77.22)
    • tobacco use (Z72.0)
Asthma

• Documentation for Asthma includes:
  – Severity of disease (mild intermittent, moderate, persistent, etc.)
• Does acute exacerbation exist?
• Does status asthmaticus exist?

<table>
<thead>
<tr>
<th>J45</th>
<th>Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>J45.2</td>
<td>Mild intermittent asthma</td>
</tr>
<tr>
<td>J45.20</td>
<td>Mild intermittent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.21</td>
<td>Mild intermittent asthma, with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.22</td>
<td>Mild intermittent asthma, with status asthmaticus</td>
</tr>
<tr>
<td>J45.3</td>
<td>Mild persistent asthma</td>
</tr>
<tr>
<td>J45.30</td>
<td>Mild persistent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.31</td>
<td>Mild persistent asthma, with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.32</td>
<td>Mild persistent asthma, with status asthmaticus</td>
</tr>
<tr>
<td>J45.4</td>
<td>Moderate persistent</td>
</tr>
<tr>
<td>J45.40</td>
<td>Moderate persistent, uncomplicated</td>
</tr>
<tr>
<td>J45.41</td>
<td>Moderate persistent with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.42</td>
<td>Moderate persistent with status asthmaticus</td>
</tr>
</tbody>
</table>
Other conditions may be necessary to report in addition to the asthma codes. For example, tobacco dependence (F17) or exposure to tobacco smoke in the perinatal period (P96).

### ICD-10-CM for Conduction Disorders

The ICD-10-CM codes for conduction disorders will vary depending on diagnosis. In order to code conduction disorders in ICD-10-CM the following is necessary:

- Type of disorder
- Site involved

<table>
<thead>
<tr>
<th></th>
<th>ICD-10-CM</th>
<th></th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atrial fibrillation</td>
<td>I48.0</td>
<td>Ventricular fibrillation</td>
<td>I49.01</td>
</tr>
<tr>
<td>Atrial flutter</td>
<td>I48.1</td>
<td>Ventricular flutter</td>
<td>I49.02</td>
</tr>
<tr>
<td>Atrial premature depolarization</td>
<td>I49.1</td>
<td>Re-entry ventricular arrhythmia</td>
<td>I47.0</td>
</tr>
<tr>
<td>Bradycardia</td>
<td>R00.1</td>
<td>Tachycardia</td>
<td>R00.0</td>
</tr>
</tbody>
</table>
Heart Failure

• To code heart failure the following documentation is necessary
  – Site
  – Acute/Chronic/Acute on Chronic
  – Type of failure

<table>
<thead>
<tr>
<th>Left ventricular failure</th>
<th>I50.1</th>
<th>Heart failure, unspecified</th>
<th>I50.9</th>
<th>Unspecified combined systolic and diastolic (congestive) heart failure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unspecified systolic (congestive) heart failure</td>
<td>I50.20</td>
<td>Unspecified diastolic (congestive) heart failure</td>
<td>I50.30</td>
<td>Unspecified combined systolic and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>Acute systolic (congestive) heart failure</td>
<td>I50.21</td>
<td>Acute diastolic (congestive) heart failure</td>
<td>I50.31</td>
<td>Acute combined systolic and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>Chronic systolic (congestive) heart failure</td>
<td>I50.22</td>
<td>Chronic diastolic (congestive) heart failure</td>
<td>I50.32</td>
<td>Chronic combined systolic and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>Acute on chronic systolic (congestive) heart failure</td>
<td>I50.23</td>
<td>Acute on chronic diastolic (congestive) heart failure</td>
<td>I50.33</td>
<td>Acute on chronic combined systolic and diastolic (congestive) heart failure</td>
</tr>
</tbody>
</table>

Example: Heart failure due to hypertension (I11.0)-first listed
Followed by the type of heart failure
Hypertension

- ICD-10-CM code range for hypertension is I10 – I15.9
- In order to code hypertension in ICD-10-CM the following is necessary:
  - Essential or Secondary
  - Causal relationship of other conditions
  - Elevated blood pressure versus hypertension

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential hypertension</td>
<td>I10</td>
</tr>
<tr>
<td>Hypertensive heart disease with heart failure</td>
<td>I11.0</td>
</tr>
<tr>
<td>Hypertensive heart disease without heart failure</td>
<td>I11.9</td>
</tr>
<tr>
<td>Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease</td>
<td>I12.0</td>
</tr>
<tr>
<td>Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease</td>
<td>I12.9</td>
</tr>
<tr>
<td>Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease</td>
<td>I13.0</td>
</tr>
<tr>
<td>Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease</td>
<td>I13.10</td>
</tr>
<tr>
<td>Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease</td>
<td>I13.11</td>
</tr>
<tr>
<td>Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease</td>
<td>I13.2</td>
</tr>
<tr>
<td>Renovascular hypertension</td>
<td>I15.0</td>
</tr>
<tr>
<td>Hypertension secondary to other renal disorders</td>
<td>I15.1</td>
</tr>
<tr>
<td>Hypertension secondary to endocrine disorders</td>
<td>I15.2</td>
</tr>
<tr>
<td>Other secondary hypertension</td>
<td>I15.8</td>
</tr>
<tr>
<td>Secondary hypertension, unspecified</td>
<td>I15.9</td>
</tr>
<tr>
<td>Elevated Blood pressure reading</td>
<td>R30.0</td>
</tr>
</tbody>
</table>
Ulcers

- Information required in documentation:
  - Type of Ulcer
  - Acute or chronic
  - Hemorrhage
  - Perforation
  - Hemorrhage with perforation
  - Without hemorrhage or perforation

Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K25.0</td>
<td>Acute gastric ulcer with hemorrhage</td>
</tr>
<tr>
<td>K25.1</td>
<td>Acute gastric ulcer with perforation</td>
</tr>
<tr>
<td>K25.2</td>
<td>Acute gastric ulcer with both hemorrhage and perforation</td>
</tr>
<tr>
<td>K25.3</td>
<td>Acute gastric ulcer without hemorrhage or perforation</td>
</tr>
<tr>
<td>K25.4</td>
<td>Chronic or unspecified gastric ulcer with hemorrhage</td>
</tr>
<tr>
<td>K25.5</td>
<td>Chronic or unspecified gastric ulcer with perforation</td>
</tr>
<tr>
<td>K25.6</td>
<td>Chronic or unspecified gastric ulcer with both hemorrhage and perforation</td>
</tr>
<tr>
<td>K25.7</td>
<td>Chronic gastric ulcer without hemorrhage or perforation</td>
</tr>
<tr>
<td>K25.9</td>
<td>Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation</td>
</tr>
</tbody>
</table>
Hernia

- Diagnosis codes range from K40.00-K46.9
  - Documentation required
    - Site of hernia
    - Laterality when appropriate (Unilateral-bilateral)
    - If gangrene or obstruction is present
    - If condition is recurrent
  - Categories:
    - Inguinal (K40.0-)
    - Femoral (K41.0-)
    - Umbilical (K42.0-)
    - Ventral (K43.0-)
    - Diaphragmatic (K 44.0-)
    - Other abdominal hernia (K45.0-)
    - Unspecified abdominal hernia (K46.0-)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K40.00</td>
<td>Bilateral inguinal hernia, with obstruction, without gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.01</td>
<td>Bilateral inguinal hernia, with obstruction, without gangrene, recurrent</td>
</tr>
<tr>
<td>K40.10</td>
<td>Bilateral inguinal hernia, with gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.11</td>
<td>Bilateral inguinal hernia, with gangrene, recurrent</td>
</tr>
<tr>
<td>K40.20</td>
<td>Bilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.21</td>
<td>Bilateral inguinal hernia, without obstruction or gangrene, recurrent</td>
</tr>
<tr>
<td>K40.30</td>
<td>Unilateral inguinal hernia, with obstruction, without gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.31</td>
<td>Unilateral inguinal hernia, with obstruction, without gangrene, recurrent</td>
</tr>
<tr>
<td>K40.40</td>
<td>Unilateral inguinal hernia, with gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.41</td>
<td>Unilateral inguinal hernia, with gangrene, recurrent</td>
</tr>
<tr>
<td>K40.90</td>
<td>Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.91</td>
<td>Unilateral inguinal hernia, without obstruction or gangrene, recurrent</td>
</tr>
</tbody>
</table>
Pregnancy

• The ICD-10-CM codes for pregnancy begin with the letter “O”
  – In order to code hypertension in ICD-10-CM the following is necessary:
    – Trimester (usually located within the code)
    – Gestational condition or pre-existing
    – Type of complication
    – Risk

Pregnancy

| Supervision of pregnancy with history of ectopic or molar pregnancy, unspecified trimester | O09.10 |
| Supervision of pregnancy with history of ectopic or molar pregnancy, first trimester | O09.11 |
| Supervision of pregnancy with history of ectopic or molar pregnancy, second trimester | O09.12 |
| Supervision of pregnancy with history of ectopic or molar pregnancy, third trimester | O09.13 |
Gestational Diabetes

O24.410 Gestational diabetes mellitus in pregnancy, diet controlled
O24.414 Gestational diabetes mellitus in pregnancy, insulin controlled
O24.419 Gestational diabetes mellitus in pregnancy, unspecified control
O24.420 Gestational diabetes mellitus in childbirth, diet controlled
O24.424 Gestational diabetes mellitus in childbirth, insulin controlled
O24.429 Gestational diabetes mellitus in childbirth, unspecified control
O24.430 Gestational diabetes mellitus in the puerperium, diet controlled
O24.434 Gestational diabetes mellitus in the puerperium, insulin controlled
O24.439 Gestational diabetes mellitus in the puerperium, unspecified control

ICD-10-CM for Hyperthyroidism and Hypothyroidism

• Most ICD-10-CM codes for hyperthyroidism and hypothyroidism can be found in the E03-E05 code range
• In order to code these conditions in ICD-10-CM the following is necessary:
  – Hyperthyroidism or hypothyroidism
  – Cause of condition
  – With or without goiter
  – With or without thyrotoxicosis crisis or storm
ICD-10-CM for Hyperthyroidism and Hypothyroidism

<table>
<thead>
<tr>
<th>Condition Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital hypothyroidism with diffuse goiter</td>
<td>E03.0</td>
<td>Thyrotoxicosis with toxic single thyroid nodule</td>
</tr>
<tr>
<td></td>
<td></td>
<td>without thyrotoxic crisis or storm</td>
</tr>
<tr>
<td>Congenital hypothyroidism without goiter</td>
<td>E03.1</td>
<td>Thyrotoxicosis with toxic multinodular goiter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>with thyrotoxic crisis or storm</td>
</tr>
<tr>
<td>Atrophy of thyroid (acquired)</td>
<td>E03.4</td>
<td>Thyrotoxicosis from ectopic thyroid tissue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>without thyrotoxic crisis or storm</td>
</tr>
<tr>
<td>Hypothyroidism, unspecified</td>
<td>E03.9</td>
<td>Thyrotoxicosis, unspecified with thyrotoxic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>crisis or storm</td>
</tr>
</tbody>
</table>

Tobacco Abuse/Addiction

- Tobacco abuse/addiction 6th character subclassification
  - 20 choices in ICD-10-CM for nicotine dependence
  - Documentation must include
    - Uncomplicated
    - In remission
    - With withdrawal
    - With other nicotine induced disorders
    - Cigarettes, chewing tobacco, other tobacco products and unspecified
  - Example: F17.211 Nicotine dependence, cigarettes, in remission
**Nicotine Dependence**

- F17.200 Nicotine dependence, unspecified, uncomplicated
- F17.201 Nicotine dependence, unspecified, in remission
- F17.203 Nicotine dependence unspecified, with withdrawal
- F17.208 Nicotine dependence, unspecified, with other nicotine-induced disorders
- F17.209 Nicotine dependence, unspecified, with unspecified nicotine-induced disorders
- F17.210 Nicotine dependence, cigarettes, uncomplicated
- F17.211 Nicotine dependence, cigarettes, in remission
- F17.213 Nicotine dependence, cigarettes, with withdrawal
- F17.218 Nicotine dependence, cigarettes, with other nicotine-induced disorders
- F17.219 Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders

**Other Nicotine Dependence**

- F17.220 Nicotine dependence, chewing tobacco, uncomplicated
- F17.221 Nicotine dependence, chewing tobacco, in remission
- F17.223 Nicotine dependence, chewing tobacco, with withdrawal
- F17.228 Nicotine dependence, chewing tobacco, with other nicotine-induced disorders
- F17.229 Nicotine dependence, chewing tobacco, with unspecified nicotine-induced disorders
- F17.290 Nicotine dependence, other tobacco product, uncomplicated
- F17.291 Nicotine dependence, other tobacco product, in remission
- F17.293 Nicotine dependence, other tobacco product, with withdrawal
- F17.298 Nicotine dependence, other tobacco product, with other nicotine-induced disorders
- F17.299 Nicotine dependence, other tobacco product, with unspecified nicotine-induced disorders
Malignant Neoplasm Breast

- 54 choices for male/female breast
- Documentation must include:
  - Laterality
  - Location
  - Use of an additional code to identify estrogen receptor status
  - Example: C50.422 Malignant neoplasm of upper-outer quadrant of the left male breast

Malignant Neoplasm Breast

- Sixth character sub-classification
  - C50.- Malignant neoplasm of breast
  - C50.1- Malignant neoplasm of nipple and areola
  - C50.2- Malignant neoplasm of upper-inner quadrant of breast
  - C50.3- Malignant neoplasm of lower-inner quadrant of breast
  - C50.4- Malignant neoplasm of upper-outer quadrant of breast
  - C50.5- Malignant neoplasm of lower-outer quadrant of breast
  - C50.6- Malignant neoplasm of axillary tail of breast
  - C50.8- Malignant neoplasm of overlapping sites of breast
  - C50.9- Malignant neoplasm of breast of unspecified site
Mapping Examples

INTERPRETIVE FINDINGS: Exam reveals a stable knee under examination under anesthesia. The video arthroscopy examination reveals smooth articular surfaces throughout the entire knee. He has a lateral meniscus which is normal. His medial meniscus shows a locked bucket-handle medial meniscal tear which underwent excision. The cruciate ligament is intact.

Mapping Example

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>S83.211A</td>
<td>Bucket-handle tear of medial meniscus, current injury, right knee, initial encounter</td>
</tr>
<tr>
<td>S83.212A</td>
<td>Bucket-handle tear of medial meniscus, current injury, left knee, initial encounter</td>
</tr>
<tr>
<td>S83.219A</td>
<td>Bucket-handle tear of medial meniscus, current injury, unspecified knee, initial encounter</td>
</tr>
<tr>
<td>S83.221A</td>
<td>Peripheral tear of medial meniscus, current injury, right knee, initial encounter</td>
</tr>
<tr>
<td>S83.222A</td>
<td>Peripheral tear of medial meniscus, current injury, left knee, initial encounter</td>
</tr>
<tr>
<td>S83.229A</td>
<td>Peripheral tear of medial meniscus, current injury, unspecified knee, initial encounter</td>
</tr>
<tr>
<td>S83.231A</td>
<td>Complex tear of medial meniscus, current injury, right knee, initial encounter</td>
</tr>
<tr>
<td>S83.232A</td>
<td>Complex tear of medial meniscus, current injury, left knee, initial encounter</td>
</tr>
<tr>
<td>S83.239A</td>
<td>Complex tear of medial meniscus, current injury, unspecified knee, initial encounter</td>
</tr>
<tr>
<td>S83.241A</td>
<td>Other tear of medial meniscus, current injury, right knee, initial encounter</td>
</tr>
<tr>
<td>S83.242A</td>
<td>Other tear of medial meniscus, current injury, left knee, initial encounter</td>
</tr>
<tr>
<td>S83.249A</td>
<td>Other tear of medial meniscus, current injury, unspecified knee, initial encounter</td>
</tr>
</tbody>
</table>
Well Visits

• Annual physical, well child, GYN exam etc…
• Documentation must include:
  – With abnormal findings
  – Without abnormal findings
  – Example: Z00.01 Encounter for general adult medical examination with abnormal findings (use additional code to identify abnormal findings)

Injury Coding

• Injury Coding
  – Initial encounters generally require three codes
• External cause codes
  – Are used for the length of treatment
  – 7th digit extender changes with stage of healing
• Place of occurrence
  – Used only once at the initial encounter
  – No 7th digit extender
• Activity code
  – Used only once at the initial encounter
  – No 7th digit extender
Example

• CC: Hurt left knee-TV fell on it
  • HPI: Patient hurt her knee and it is bruised and it hurts to walk. She was moving a TV in her bedroom last night and she fell into the TV with her knee causing her to collide with it. Her lower back has been hurting since then as well.
  • A/P: L knee strain
    – Lumbar strain
  • S86.812A—Strain, left knee, initial encounter
  • S39.012A—Strain, Back, initial encounter
  • W18.09xA—Fall striking other object, initial encounter(activity)
  • Y92.013—House, single family home, bedroom (place of occurrence)

Documentation: Compliance and Quality

• In the clinical area, the largest impact to ICD-10-CM implementation is the documentation
  – Since ICD-10-CM is more robust and has up to seven digits of specificity, will documentation currently be in the medical record to support ICD-10-CM on the “Go-live” date?
  – By analyzing the documentation and conducting medical record documentation audits, the impact can be assessed
Documentation

• In recent years medical records have become a tool to document medical histories as well as to provide a method by which:
  – health statistics are tracked
  – acts as a legal document
  – To justify to insurance companies the charges billed on the basis of the medical care provided and to assess quality of care

How to Approach?

• How is ICD-9 currently used in the clinical setting?
  – Random samples should be evaluated
  – Take an in-depth look at the current level of documentation
  – Running a frequency report of the most used procedures and diagnosis codes before you begin
How Do You Begin?

• Take an in-depth look at the current level of documentation in the medical record
  – Review the lack of specificity in the documentation and analyze how to begin the process of improvement
  – Based on the specialty of the practice, review the most common diagnosis codes used and frequency

Perform an ICD-10-CM Readiness Audit

• Practitioners either have staff that conduct audits in your medical practice or routinely have a consultant audit for appropriate documentation and coding
  – Important element of compliance and many practitioners have undergone this process from a comprehensive coding perspective
    • But take a different approach
      – Review the patient chart note to make sure the physician or non-physician practitioner is documenting a complete diagnosis to support an ICD-10-CM code
Performing an ICD-10-CM Readiness Audit

- ICD-10-CM readiness audit
  - different than the typical medical record documentation and coding audit
  - Auditor will assess the documentation and make a determination if:
    1. does the documentation support the current diagnosis reported, and
    2. will the documentation support an ICD-10-CM code(s)?
  - The auditor must be familiar with ICD-10-CM codes and guidelines in order to make this determination

Performing an ICD-10-CM Readiness Audit

- Once the audit has been conducted and analyzed:
  - the organization will have a good assessment of documentation deficiencies
    • will be able to develop a priority list of diagnoses that require more granularity
  - Audit will also help identify practitioners who would benefit from focused training to assist in making sure the practitioner will be able to support medical necessity using ICD-10-CM in 2013
How Do You Solve the Documentation Problem?

- Educate by showing the comparison between both coding systems
- Encourage the practitioner to begin documenting more specifically for ICD-10-CM
- Keep results and comprise a periodic summary
  - This summary should identify the percentage of correct documentation for both ICD-9-CM and ICD-10-CM with recommendation for improving documentation.

Conclusion

- It is evident after reviewing documentation that a lot of work must be completed to get ready for ICD-10-CM
- Audit the diagnosis and inpatient procedure documentation pre and post ICD-10-CM implementation
Questions?

THE COUNTDOWN IS NOW!!!