Ten things you need to know about ICD-10—and tell your physicians

Summary: The sky is falling, the sky is falling! ICD-10 is coming, and the world as we know it is doomed! That’s what some in the healthcare industry would have you believe, at least. But in truth, the hysteria created by the proposed ICD-10 changes has caused unneeded stress and resistance among healthcare providers. The following white paper helps to alleviate that stress by providing 10 things your physicians should know to help you and them hit the ground running.

To recap, the previously proposed ICD-10 implementation of October 1, 2013, was delayed to October 1, 2015. Now, with the April 14 permanent repeal of the Sustainable Growth Rate formula—a bipartisan passage that, notably, contained no ICD-10 delay language—it appears as though ICD-10 will finally be implemented as the nation’s coding system.

Although healthcare providers have reacted to the ICD-10 delay in different ways, for the most part health information management (HIM), CDI, and coding professionals have been busy learning the core knowledge and competencies needed to implement the upcoming system changes.

While some believe the coding guidelines will be the biggest difficulty in converting to ICD-10, the No. 1 aspect to focus on is clinical documentation practices. There will be significant changes required in documentation, and providers must adhere to these changes to avoid coding errors, compliance issues, and unpaid claims that could impact reimbursement and/or quality of care.

Physician documentation reflects severity of illness (SOI) and risk of mortality (ROM). Therefore, specificity in documentation is vital in order to support the assigned codes, length of stay and resource utilization, complication rates, medical necessity, and overall quality of care delivered. Hospital reimbursement is based on the assigned codes and their sequencing, which in turn is based on provider documentation; therefore, physicians must be familiar with the basic documentation requirements and changes to the coding guidelines.

Physician education should begin with the basics. Physicians do not need to know the new ICD-10-CM diagnosis codes or ICD-10-PCS surgical codes. They only need to know the basic components and the specificity and detail related to their personal scope of work.

To avoid stress and resistance, start with the top documentation requirements in ICD-10. I recommend the following steps:

- Update your query forms to include specific ICD-10 documentation clarification requests (a sample query for myocardial infarction [MI] is provided at the end of this white paper)
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- Create tip sheets by specialty and make them available on the EMR
- Distribute pocket cards and post signs in key documentation areas of the hospital
- Provide lunch-and-learn or evening educational seminars

The top 10 things that physicians need to know about ICD-10 are as follows:

1. **Laterality.** Ask physicians to specify right, left, or bilateral when appropriate, or quadrant when applicable.

2. **Episode of care.** Ask physicians to document:
   - Initial/active encounter. Examples of “active” treatment include surgical treatment, emergency department encounter, or treatment by a physician.
   - Subsequent encounter:
     1. For routine healing or aftercare
     2. For delayed healing
     3. Nonunion or malunion of fracture
   - Encounter for sequela (follow-up). Physicians must document the original injury and current sequela. An example is scar revision (sequela) of burn.

3. **Stage of disease.** Physicians must document the following elements:
   - Acute
   - Chronic
   - Subacute
   - Exacerbation (note that this may no longer translate to acute or chronic, so the physician must document “acute exacerbation”)
   - Condition, such as guarded, serious, or critical (this supports medical necessity)
   - Severity of asthma, including intermittent or persistent and mild, moderate, or severe (intrinsic or extrinsic)

4. **Specific anatomy.** Examples include the following:
   - Vessel of heart or brain, etc.
   - Lobe of lung, etc.
   - Location of stroke and/or hemorrhage (e.g., intracerebral, subarachnoid, subdural). This should also include the exact area (e.g., cortical, subcortical, basilar, vertebral, etc.).
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5. **Associated or related conditions.** Examples include the following:
   
   A) Diabetes mellitus Type 2 with manifestation such as nephropathy, angiopathy, gangrene, etc.
   
   B) Malignancy with associated anemia
   
   C) Atherosclerosis of coronary bypass graft with unstable angina
   
   D) Ulcerative colitis with obstruction
   
   E) Right hip fracture due to osteoporosis
   
   F) Hemorrhage secondary to gastric ulcer

6. **Type, location, and acuity of MI and vessel involved (acute myocardial infarction defined as < 4 weeks old).** Examples include the following:
   
   A) STEMI vs. non-STEMI, etc.
   
   B) Anterior wall, etc.
   
   C) Coronary vessel, etc.

7. **Seizure specificity as to type.** Examples include the following:
   
   A) Intractable
   
   B) Petit mal
   
   C) Grand mal
   
   D) If with status epilepticus

8. **Glasgow Coma Scale.** This is used for ICD-10 reporting. Physician documentation needs to include three key elements: eye response, verbal response, and motor response.

9. **Gustilo-Anderson scale for open fractures.** These include Type I, Type II, or Type III.

10. **TNM score for neoplasms or other standardized staging system.** “T” describes the primary tumor site, “N” describes the regional lymph node involvement, and “M” describes the presence of distant metastatic spread (e.g., T3N2M0). Note that physicians must document the pathology results, as ICD-10 guidelines still do not permit coders to report a code from a pathology report.

Not included in the top 10, but equally important, are the following points:

- Urosepsis will no longer have a default code and therefore will not be an approved diagnosis for UTI or sepsis from a urinary source.
- Nicotine dependence takes a more prominent role in ICD-10 with further subcategories for specific tobacco products used and tobacco withdrawal or nicotine-induced disorder.
Stroke documentation should state dominant vs. nondominant side.

Many surgeons currently document lymph node sampling. This is sufficient under ICD-9, but ICD-10 will require greater specificity. When documenting the removal of lymph nodes, it is important to document whether the entire chain of lymph nodes was removed (or the removal was attempted). When an entire lymph node chain is removed, the appropriate root operation is “resection.” When single lymph nodes are removed, the root operation is “excision.” A coder may not use a physician’s documentation of lymph node resection unless the accompanying documentation (entire lymph chain, or similar) is documented by the physician.

Begin your physician education efforts as soon as possible. Once you have explained and addressed the top 10 documentation issues above with your physicians, consider addressing other issues as needs arise. Track documentation deficiencies in your facility and maintain communication with coders to determine what steps should be implemented next. Above all, don’t be afraid of ICD-10. Remember that the sky isn’t falling, and you will have a happy ending to your story.

**Query example**

84-year-old white male with HTN, CAD, DM, and recent inferior MI was admitted for UTI with sepsis. Patient was maintained on home medications of carvedilol, aspirin, and atorvastatin. EKG revealed Q-waves in the inferior leads. Cardiac enzymes were followed, and the patient remained on telemetry. Discharge diagnoses include *E. coli* sepsis and recent MI.

Based on the patient’s clinical presentation, please provide additional information as to the **type, coronary artery** involved, and **acuity** of the MI. Possible diagnoses include, but are not limited to:

**Type of infarction:**
- STEMI (ST elevation)
- NSTEMI (non-ST elevation)
- Other ________________

**Coronary artery involved:**
- Right coronary artery
- Other coronary artery
- Other ________________
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Acuity of MI (specify if known):
- Acute/subacute MI (< 4 weeks old)
- Old or healed MI
- Other ______________________

Other __________________

Unable to determine

ABOUT THE CONTRIBUTOR

Sylvia Hoffman, RN, CCDS, CCDI, CDIP, is president and CEO of Sylvia Hoffman CDI Consulting in Tampa, Florida, and a member of the ACDIS Advisory Board. Previously, Hoffman served as a clinical documentation specialist in a 1,000-bed teaching hospital in Tampa. She worked as an educational consultant for documentation integrity with DocuComp, LLC, and was employed as a senior associate in the Forensic Division at KPMG, providing clinical documentation education and retrospective record reviews for compliance, integrity, and quality throughout the Southeast. Hoffman has 15 years of acute care hospital experience and 10 years of case management experience. She currently serves as an adjunct educator for HCPro in the areas of CDI and ICD-10, teaching boot camps and providing online educational seminars. She is a former president of the Florida ACDIS regional chapter and coauthored the HCPro book The Clinical Documentation Improvement Specialist’s Guide to ICD-10.