Learning Objectives

- Recognize basic implementation and ICD-10 readiness phases
- Identify what a coding assessment includes
- Outline the ICD-10 training phase
- List key MS-DRG and coding changes

ICD-10 Basics

- ICD-10 is the abbreviated term used to refer to the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS)
- **ICD-10-CM**: The diagnosis code set that will replace ICD-9-CM Volumes 1 and 2
- **ICD-10-PCS**: The code set of inpatient procedures that will replace ICD-9-CM Volume 3
Basics: Final Regulation for ICD-10

• ICD-9-CM diagnosis code set will be replaced with ICD-10 (including the official coding guidelines) for coding:
  – Diseases
  – Injuries
  – Impairments
  – Other health problems and their manifestations
  – Causes of injury, disease, impairment, or other problems
• ICD-10-CM diagnosis code set will be used in ALL healthcare settings

Basics: Final Regulation for ICD-10 (cont.)

• ICD-9-CM procedure code set will be replaced with ICD-10-PCS (including the official coding guidelines) for inpatient hospital procedure coding
• Procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients reported by hospitals regarding prevention, diagnosis, treatment, and management will use the PCS (Procedural Coding System)
• ICD-10-PCS code set will be used for facility reporting of hospital INPATIENT services only, not replacing CPT

No Impact on Use of CPT® and HCPCS Level II Codes

Background: The ICD-10 Impact

• ICD-10-CM (diagnoses) will be used by all providers in every healthcare setting
  – ICD-10-PCS (procedures) will be used only for hospital claims for inpatient hospital procedures
  – ICD-10-PCS will not be used on physician claims, even those for inpatient visits
  – No impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes
    • CPT only copyright 2012 American Medical Association. All rights reserved
• 2013 ICD-9-CM: 14,567 codes
• 2013 ICD-10-CM (Dx): 69,832 codes
• Increased specificity and complexity

Background: Benefits to ICD-10

• Reduced ambiguity
• Enhanced system flexibility for adding new codes
• Better reflection of current medical terminology and technology
• Expanded detail relevant to ambulatory and managed care encounters
• Incorporation of recommended revisions to ICD-9-CM that could not be accommodated
• HIPAA criteria for code set standards are met (5010)
• Improved collection and tracking of new diseases and technologies
• Space to accommodate future expansion
ICD-10-CM (Diagnosis) Format

- **Extension**: Etiology, Anatomical site, Severity

ICD-10-CM code structure differs from ICD-9-CM in that it consists of three to seven characters, the first digit being an alpha character and second and third digits are numeric; the fourth and fifth digits may be alpha (not case sensitive) or numeric with a decimal after the third character.

Why So Many Diagnosis Codes?

- Greater specificity and detail in all diagnosis codes:
  - 34,250 (50%) of all ICD-10-CM codes are related to the musculoskeletal system
  - 17,045 (25%) of all ICD-10-CM codes are related to fractures
  - 10,582 (62%) of fracture codes to distinguish ‘right’ vs. ‘left’
  - 25,000 (36%) of all ICD-10-CM codes to distinguish ‘right’ vs. ‘left’

ICD-10 Readiness

- Work closely with HIM and the coding professionals
- Gain greater familiarity and readiness when the changes officially go into effect on **October 1, 2014**
- Share information with physicians
- Share information with organizational leaders

ICD-10 Readiness (cont.)

- Prepare by running a report of top 25 pr dx today
  - Review, map to ICD-10, and identify gaps or challenges
- Prepare by running a report of the top 25 2nd dx today
  - Review, map to ICD-10, and identify gaps or challenges
- Prepare by running a report of the top 25 inpatient procedures today
  - Review, map to ICD-10, and identify gaps or challenges
ICD-10 Implementation & Readiness: Multiple-Phases

• Awareness and understanding ICD-10
• Assessment
• Prerequisite education and training
• Assessment
• Code-set education and training
• Go-live
• Post go-live
• Education and training
• Assessment

ICD-10 Education and Training

• Education = the development of knowledge in the mind; learning
• Training = the practice and learning to do a particular act, trade, art, or profession

ICD-10 Education and Training Plan

• Role-based (basic, advanced, expert)
• CDI, coding staff, coding auditors, coding educators and coding management staff
  – PFS/billing
  – Decision support staff
  – CM/UM staff
  – CDI staff
  – Physicians
  – Others
• Assess to determine the needs
• Budget appropriately
• Plan and establish a timeline with milestones

ICD-10 Education/Training: Determine Workforce Impact

• Identify the work groups/employee’s level of impact
• High level: Coding staff, coding auditors, coding educators, coding management
• Medium: CDI, case mgmt, UR, billing/PFS (depending), contracting, decision support/reporting physicians – depending on your EHR or your current workflows
• Low: Admitting/registration (depending)
• None: Housekeeping
CDI Prerequisite With Health Sciences: Brush Up

- Solid foundation of medical terminology, anatomy, pathophysiology, and surgical procedures will help ease the transition to ICD-10-CM/PCS
- Which body part was involved, where it's located, what approach the surgeon used, and what type of root operation was performed
- Medical terminology
- Anatomy/physiology
- Disease process

CDI Physician Queries

- Inventory current queries
  - Review current forms/templates
- Policy and procedure review and revision
- Generate a report on the volume and type/dx of your current CDI querying
  - Assess and make revisions
- Develop new query for ICD-10 specifics; diagnosis and procedure
  - Asthma; coma; open fracture
- Engage physician community
  - Involve and include CDI concurrent query
- Follow AHIMA Practice Brief and guidance non-leading and compliant

Identify and Develop Internal Instructors or Trainers

- Different setting may have a different need
  - Hospital inpatient PCS
- Years of experience
- Public speaker/presenter
- Comfortable addressing questions
- Programs: academy and/or boot camps available to get started

Multiphase & Multiyear

- Time is running out …
Documentation

- Some problems with documentation now will remain with ICD-10
- If an initial thought was of the presence of pneumonia but the clinical course and findings did not truly support it, the physician must be SURE to document that it was RULED OUT.
- Documentation is a legal representation of the care and services provided
- Documentation is the cornerstone to disease and treatment information
  - Aids in clinical decision making
- Documentation can and will demonstrate the quality of care
- Documentation is needed for payment
- Documentation is a compliance necessity

Documentation (cont.)

- The rules for documentation are not changing with ICD-10
- ICD-10 may require increased clinical documentation in some areas, however ...
- The documentation guidelines in ICD-9-CM are very specific even today
- The ICD-9-CM codes have not kept up with the documentation requirements because they may not be specific enough and documentation requirements do not keep up with the codes
- With ICD-10, for the first time … a clinical classification system that is sophisticated enough, and specific enough, to keep up with the changes in medicine and with regulations

Documentation

- Comorbidities
- Manifestations
- Etiology/causation
- Complications
- Detailed anatomical location
- Sequelae
- Degree of functional impairment
- Biologic and chemical agents
- Phase/stage
- Lymph node involvement
- Lateralization and localization
- Procedure or implant related
- History & physical
- Consultation
- Operative report or procedure note
- Discharge summary
- Progress notes
- Physician orders
- Physician visit/encounter note
- Nursing notes
- Physical therapy, occupational and speech therapy notes
- Other clinical notes
- Disability qualification and summary

Documentation (cont.)

- We need greater specificity even TODAY and with ICD-10 (this is not new)
- Surgical or inpatient procedure documentation
- Orthopedic and cardiac
  - Granularity
- Details there today but just not coded
  - ICD-9-CM did/does not capture these specifics
- Some details may be found in other documents within the medical record
Documentation (cont.)

- Estimates: 15% to 20% more specificity – maybe?
- Example: A patient diagnosed with malignant hypertension and Stage V chronic renal disease is admitted to the critical care unit. The patient is now in acute renal failure with acute cortical necrosis.
- First-listed diagnosis: I12.0 hypertensive chronic kidney disease with Stage V chronic kidney disease or end-stage renal disease.
- Second-listed diagnosis: N18.5 chronic kidney disease, Stage V.

Documentation (cont.)

- The word “documentation” is mentioned over 70 times in the ICD-10-CM guidelines document.
- Querying is referred to over 20 times in the guidelines document
- Specific statements:
  - The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.
  - The instructions and conventions of the classification take precedence over guidelines.

Documentation Presents Risks

- The physician uses symbols: plusses, minuses, up arrows, down arrows.
- In the clinical situation, it is incumbent on coders to seek clarification if that “Na” with an up arrow means hypernatremia or something else, such as sodium levels returning to normal.
- If the “Hgb” with a down arrow and a level of 6.8 grams indicate that the transfusion was for anemia, what was the cause of the anemia, if that’s indeed what was meant?
- Does “ETOH” with a plus mean the patient is alcoholic, an alcohol abuser, drinks socially, or had a positive blood alcohol level? There are codes for many of these, and no code should be assigned to others.

Documentation Assessment

- All healthcare settings: The importance for the hospital data is great. The importance for the physician’s professional billing is massive.
- The importance for evaluation of quality of care delivered to the patient is enormous.
- For example: The specificity of which side of the brain was the stroke, which vessel got occluded, which portion of the brain was the bleed, and if the hemiparesis was on the patient’s dominant or nondominant side will have a great influence on post-hospital care and which modalities of treatment will be covered.
Documentation Assessment

- Plan an assessment on the quality of medical record documentation
  - 100 to 200 charts (depending on resources and cost)
- What are your top physician queries today?
  - Talk with the HIM and CDI departments
  - Review that list
- Evaluate samples of various types of medical records to determine whether documentation supports level of detail found in ICD-10
  - Need someone who knows or is certified in ICD-10 coding

Documentation Assessment (cont.)

- Step to take: Report most frequently used diagnosis codes
  - % of not otherwise specified (NOS) and not elsewhere classified (NEC) codes
- Procedure terminology will be impacted
  - Especially with orthopedics
- Report most frequently used inpatient procedure codes
- Conduct an audit or assessment to identify specific documentation gaps
  - You may already have this with CDI
  - Conduct some ICD-10 coding on current inpatient procedures

Documentation Assessment (cont.)

- Discuss and share the findings or results
- Implement documentation improvement strategies where needed
- BUT … Nonspecific codes are still available in ICD-10 when necessary

Documentation Assessment (cont.)

- Random or target certain areas or specialties
  - Chest pain
  - Pneumonia
  - Heart failure
  - Asthma
  - Fractures
- Emergency room documentation also should be reviewed
Documentation Assessment Scoring and Prioritization: Sample

- RED – Represents the highest level of priority that has the most direct relation to the strategic category. The scoring range that determines the high-priority range is based upon an organization’s own policy, timelines, and goals.

- YELLOW – Represents a medium level of priority that has somewhat of a direct relation to the strategic category. The scoring range that determines the high-priority range is based upon an organization’s own policy, timelines, and goals.

- GREEN – Represents a low level of priority that has little to no direct relation to the strategic category. The scoring range that determines the high-priority range is based upon an organization’s own policy, timelines, and goals.

Documentation Assessment (cont.)

- Use external or internal resources
- Findings should track and trend ICD-10 code level detail
  - Categorize by specialty, ICD-10 chapter, or body system
  - Medical and surgical
- Recommendations and timeline
- Share findings with medical staff

What tools and processes are you using to educate your physicians?

- Percentage of respondents:
  - 5%: Performance improvement data via data analytics
  - 17%: Performance improvement data via data analytics
  - 20%: ICD-10 documentation audits
  - 17%: One or more of the above
  - 42%: None, unsure, or data not applicable

ICD-10 Monitor
Talk Ten Tuesday
January 22, 2013

“Working now to improve clinical documentation for ICD-10 should be a primary focus of every hospital’s ICD-10 transition plan,” said Sandeep Wadhwa, MD, chief medical officer and vice president, coding and reimbursement for 3M Health Information Systems
**Coding Assessment**

- A coding assessment is needed; may have been completed
  - Talk to the HIM director
- Can also provide insight into documentation issues
- Sample 20 records per coding staff member
- External or internal resources
- HIM will lead this effort
- Share findings with CDI

**ICD-10 Training Phase**

- Code set education and training
  - Basic overview
  - Key differences with ICD-10
  - Crosswalk current ICD-9-CM issues to ICD-10 codes
  - Documentation challenges
  - MS-DRG or other payment system impacts

**Education: MS-DRG Changes**

- There will be some changes in MS-DRGs
- There could be increases and decreases in relative weight
- Specific wording/language will impact the ICD-10 code(s)
- Some MS-DRG changes will come from coding guidelines revisions
- Determine physician query changes

**Case Example: Pneumonia Patient With NSTEMI MI (Two Weeks Ago)**

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM/PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>486 Pneumonia</td>
<td>J18.9 Pneumonia</td>
</tr>
<tr>
<td>410.72 Subendocardial infarction, subsequent episode of care</td>
<td>I21.4 Non-ST elevation (NSTEMI) myocardial infarction (MCC)</td>
</tr>
<tr>
<td><strong>MS-DRG 195</strong> Simple pneumonia without CC/MCC RW 0.7096</td>
<td><strong>MS-DRG 193</strong> Simple pneumonia with MCC RW 1.4796</td>
</tr>
</tbody>
</table>
### Case Example: Pressure Ulcer With Gangrene

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM/PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>707.05 Pressure ulcer, buttock</td>
<td>E96 Gangrene NEC</td>
</tr>
<tr>
<td>707.23 Pressure ulcer, stage III (MCC)</td>
<td>L89.303 Pressure ulcer of unspecified buttock, stage II (MCC)</td>
</tr>
<tr>
<td>785.4 Gangrene (CC)</td>
<td></td>
</tr>
<tr>
<td>MS-DRG 592 Skin ulcers w/MCC</td>
<td>MS-DRG 299 Peripheral vascular disorders w/MCC</td>
</tr>
<tr>
<td>RW 1.4753</td>
<td>RW 1.4072</td>
</tr>
</tbody>
</table>

### Coding Guideline Change: Neoplasm and Anemia

- Educate on changes in guidelines
- ICD-9-CM
  - When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate anemia code (such as code 285.22, anemia in neoplastic disease) is designated as the principal diagnosis and is followed by the appropriate code(s) for the malignancy
- ICD-10-CM
  - When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, Anemia in neoplastic disease)

### Coding Guideline Change: Atherosclerotic Coronary Artery Disease and Angina

- ICD-10-CM has combination codes for atherosclerotic heart disease with angina pectoris. The subcategories for these codes are I25.11, atherosclerotic heart disease of native coronary artery with angina pectoris, and I25.7, atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris
- When using one of these combination codes, it is not necessary to use an additional code for angina pectoris. A causal relationship can be assumed in a patient with both atherosclerosis and angina pectoris, 
  - unless the documentation indicates the angina is due to something other than the atherosclerosis

### POA Guideline

- As stated in the Introduction to the ICD-10-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures
- The importance of consistent, complete documentation in the medical record cannot be overemphasized
- Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not
**POA Guideline (cont.)**

- These guidelines are not a substitute for the provider’s clinical judgment as to the determination of whether a condition was/was not present on admission. The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.
- Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.
- If at the time of code assignment the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification.
- The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.

**CDI: ICD-10 Documentation OB/Pregnancy Tips**

- The provider’s documentation of “weeks” may be used to assign appropriate ICD-10 code for trimester.
- **Definition of trimesters:**
  - First: Less than 14 weeks, 0 days
  - Second: 14 weeks, 0 days to less than 28 weeks, 0 days
  - Third: 28 weeks until delivery
- **Note:** Gestational diabetes – needs specification of diet controlled or insulin controlled. If both diet and insulin controlled, the ICD-10 code for insulin controlled will be assigned.

**CDI: How Can You Prepare?**

- Begin adding the following to physician documentation templates & queries
  - **Side of dominance**
    - Left, right, or ambidextrous (defaults to right)
  - **Laterality**
    - All paired organs or structures
  - **Ordinality**
    - Is this the initial or a subsequent visit for the complaint?
    - Are these symptoms the sequela of the initial event?
CDI: Incorporate Into Query Templates

• Improvement in capture of coma
• Glasgow Coma Scale
  – Need a score from each of the three assessment areas, NOT a total score
  • Eye opening
  • Verbal response
  • Motor response
• Improvement in capture of open fracture complexity
• Gustilo Open Fracture Classification
  – I, II, III, IIIA, IIIB, or IIC

CDI: How Can You Prepare?

• Incorporate the following scales into documentation templates or queries
  – National Heart, Lung and Blood Institute (NHLBI) asthma severity classification scale
  • Intermittent
  • Mild persistent
  • Moderate persistent
  • Severe persistent

ICD-10 Severity of Asthma Classification

<table>
<thead>
<tr>
<th>Type of Asthma</th>
<th>Presentation of Asthma Before (Without) Treatment</th>
<th>Nighttime Symptoms</th>
<th>Lung Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe persistent</td>
<td>- Continuous symptoms</td>
<td>Frequent</td>
<td>FEV1 or PEF ≤ 60% predicted</td>
</tr>
<tr>
<td></td>
<td>- Daily use of inhaler more than 6 times/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Exacerbations 2 or more times/month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate persistent</td>
<td>- Symptoms ≥ 2 times/week</td>
<td>&gt; 1 time/week</td>
<td>FEV1 or PEF ≤ 60% predicted</td>
</tr>
<tr>
<td></td>
<td>- Exacerbations every 3 or more times/week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild persistent</td>
<td>- Symptoms ≥ 2 times/week</td>
<td>≤ 2 times/week</td>
<td>FEV1 or PEF ≥ 60% predicted</td>
</tr>
<tr>
<td></td>
<td>- Exacerbations ≤ 1 time/week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild intermittent</td>
<td>- Symptoms ≥ 2 times/week</td>
<td>≤ 2 times/week</td>
<td>FEV1 or PEF ≥ 60% predicted</td>
</tr>
<tr>
<td></td>
<td>- Exacerbations ≤ 1 time/week</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Learning & Remembering

• The education plan needs to feed your needs.
• Some experts say that people remember:
  • 20% of what they hear
  • 30% of what they see
  • 50% of what they hear and see
  • AND 80% of what they hear, see, and do
  – Very important in educating and teaching
### Remember: Learning Traits

<table>
<thead>
<tr>
<th>Auditory learners tend to...</th>
<th>Kinesthetic learners tend to...</th>
<th>Visual learners tend to...</th>
<th>Tactile learners tend to...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• enjoy reading and being read to.</td>
<td>• be demonstrative, animated, and outgoing.</td>
<td>• have good spelling, note taking, and organizational skills.</td>
<td>• prefer manipulatives when being introduced to a topic.</td>
</tr>
<tr>
<td>• be able to verbally explain concepts and scenarios.</td>
<td>• enjoy physical movement and manipulatives.</td>
<td>• notice details and prefer neatness.</td>
<td>• literally translate events and phenomena.</td>
</tr>
<tr>
<td>• like music and hum to themselves.</td>
<td>• be willing to try new things.</td>
<td>• learn more if illustrations and charts accompany reading.</td>
<td>• tolerate clutter.</td>
</tr>
<tr>
<td>• enjoy both talking and listening.</td>
<td>• be messy in habits and surroundings.</td>
<td>• prefer quiet, serene surroundings.</td>
<td>• be artistic in nature.</td>
</tr>
</tbody>
</table>

### Learn More: Computer Assisted CDI

- CAC or computer assisted coding, may now be computer assisted CDI
- Concurrent electronic review of the medical record
- Huge time saver
- Bridge to ICD-10 and documentation needs
- Talk to your HIM director about this technology

### Go-Live and Post Go-Live Phase

- **October 2012 to October 2013**
  - Prerequisite: Health science refresher
  - Documentation assessment
  - Physician awareness
- **October 2013 to October 2014**
  - Physician education
  - Code-set knowledge
- **October 2014**
  - Go-live plans
  - Reassessment within 2-3 months
- **June 2015**
  - Post-go-live plans
- **December 2015**
  - One year + post implementation
  - Identify needs and ongoing resources

### CDI Professionals – Action Steps

- Be a part of the ICD-10 implementation team
- Secure funding: Check w/HIM
  - Online products and/or consultant services
  - Project management, etc.
- Assess your CDI staff
- Educate your CDI staff with HIM (partner)
- Education and training specifics
  - Medical health science review
  - Coding guidelines
  - Review the specific of ICD-10 code set with HIM
  - Code descriptions and changes
  - Case examples
CDI Professionals – Action Steps (cont.)

- Discuss physician query revisions with your HIM leaders
  - Identify dx and proc targets
- CDI systems, software and reporting
  - Validate readiness of systems/software
  - Inventory and revise reports w/ICD-9 codes
- Provide awareness and “education” to physicians
- Plan for the future: Go-live and post go-live

Clinical Documentation Improvement

- The opportunity is always there
  - Time and commitment
- CDI program can benefit and should be a part of your overall implementation plan and strategy
- Documentation assessment to call out areas for attention in ICD-10
- Revisions to query forms and language
- Work with HIM leadership and coding department
- Engagement of physicians and other clinicians

Summary

- ICD-10 brings greater clinical data to help our healthcare system
- Education and training is essential
- Documentation assessment is critical
- Reviewing and revising current query language and forms is necessary
- Partner with colleagues
- Bridge the gaps and make it fun …

References/Resources

- AHIMA Practice Brief—Physician Query, 2001
- ACDIS – Association of Clinical Documentation Improvement Specialists
- AHIMA ICD-10 home:
- Medical Records Briefing: HCPro March 2013
Thank you. Questions?

In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the workbook.