Clinical Documentation Guidance for ICD-10-CM/PCS - Retired

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Organizations were well on their way to an October 1, 2014 implementation of ICD-10-CM/PCS when Congress passed H.R. 4302, the Protecting Access to Medicare Act of 2014. This bill contained a section stating that the Department of Health and Human Services (HHS) could not adopt the new code set until at least October 1, 2015. Although this one-year delay will impact every organization and provider differently, now is the time to refocus organization efforts on clinical documentation. The delay offers some breathing room to evaluate current programs, implement new programs, or strengthen good processes.

Moving from one code system to another was never expected to be easy. With the vast majority of new codes, the documentation for determining the correct code will typically be found within the health record. When used to its full potential, ICD-10-CM/PCS will provide greater detail and a more accurate description of severity of patient illnesses. Organizations with an active and productive clinical documentation improvement (CDI) program may be better prepared for the transition. This Practice Brief outlines documentation guidance for accurate code assignment in ICD-10-CM/PCS.

Rejuvenating CDI Efforts and Strategies for ICD-10-CM/PCS

Successful CDI programs most likely contain physician involvement, familiarity with queries, and an understanding of CDI's impact on other measures. While physician advisors, case managers, nursing staff, or CDI specialists do not need to be experts in code assignment, having a basic understanding of ICD-10-CM/PCS documentation requirements will be important for a smooth transition to the new code set.

Because correct code assignment directly impacts appropriate reimbursement, severity of illness reporting, quality measures, and physician/hospital report cards, correct use of ICD-10-CM/PCS will be a direct reflection of accurate and correct clinical documentation.

Despite numerous differences between the ICD-9-CM and ICD-10-CM/PCS classification systems, some things will remain the same:

- Members of the four "Cooperating Parties" responsible for the ICD-10-CM/PCS and ICD-9-CM Coding Guidelines, which includes AHIMA, the American Hospital Association, the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics, will continue to approve the official set of rules which supplement the official conventions and instructions provided with the code sets used for reporting diagnosis and procedure codes. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes is required by the federal regulation 45 CFR 162.1002 Medical Data Code Sets. No changes will be made to the group of Cooperating Parties.
- The Cooperating Parties will continue to approve coding advice in a quarterly publication by the American Hospital Association. The transition has been made from *Coding Clinic for ICD-9-CM* to a new quarterly publication, *Coding Clinic for ICD-10-CM and ICD-10-PCS.*
- The uniform hospital discharge data set (UHDDS) definition for a principal diagnosis continues to be defined as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- The UHDDS definition for other diagnoses continues to be defined as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded."
- Combination codes will be used to classify two diagnoses, a diagnosis with an associated secondary manifestation, or a diagnosis with an associated complication.
- Queries should continue to be placed on the health record when unclear, ambiguous, or missing documentation is identified.
- Present on admission (POA) indicators will continue to be submitted on claims forms.
- Hospital-acquired conditions (HAC) will continue to impact reimbursement.

- MS-DRGs will continue to drive inpatient prospective payment system methodology and reimbursement.
- Complication and co-morbidity codes will continue, along with a list of CC and MCCs.

Documentation Assessment Identifies Problem Areas

Documentation assessment can be conducted alongside ongoing ICD-10-CM/PCS education or implementation efforts. Conducting gap analyses to determine strengths and weaknesses will be beneficial for identifying additional problem-prone areas.

Steps to take for this process include:

1. Identify the top 5-10 surgeries

    a. Map to ICD-10-PCS
    b. Define the documentation requirements
    c. Identify documentation weaknesses
    d. Develop documentation improvement

2. Identify the top 5-10 MS-DRGs

    a. Map to principal diagnosis and/or procedures to ICD-10-CM/PCS
    b. Review MCC/CC list
    c. Define documentation requirements
    d. Identify documentation weaknesses
    e. Develop documentation improvement

Clinical Documentation Affects MS-DRG Assignment

Below is an example of how clinical documentation will affect code assignment, MS-DRG assignment, and relative weight associated with payment.

Documentation	**MS-DRG**	**FY 2014 Relative Weight**
Shortness of breath	204, Respiratory Signs and Symptoms	0.6780
Shortness of breath due to acute respiratory failure	189, Pulmonary Edema and Respiratory Failure	1.2184

Common ICD-9 Documentation Issues May Remain for ICD-10

CDI programs assist organizations and providers by supporting a standard of clear and complete documentation in the health record at the time of discharge. The program can be tailored to meet the needs of the organization or provider and require strong collaborative teams. The best place to start is by analyzing current high volume services, MS-DRGs, or claims. There are specific documentation issues today that are problematic, which may continue through to ICD-10-CM/PCS. Areas that CDI specialists may want to review and prepare for include:

- Acute Myocardial Infarction
- Asthma
- Cerebrovascular Disease
- Coma

- Diabetes
- Fracture
- Orthopedics
- Pregnancy
- Pressure Ulcer
- Respiratory Failure

Documenting Acute Myocardial Infarction

The term acute myocardial infarction (MI) is somewhat nonspecific. MIs are often differentiated as an ST segment elevated MI (STEMI) or a non-ST segment elevated MI (NSTEMI). ICD-10-CM allows for a differentiation between a STEMI and NSTEMI. MIs can then be further specified by identifying the location, such as the left main coronary artery. The classification of MIs changes in ICD-10-CM. The I22 category includes AMIs, which occurs within four weeks of a previous AMI. Category I21 is for AMIs specified as acute or with a stated duration of four weeks (28 days) or less from the onset.

Documentation Tips: Focus clinical documentation on identifying the date of onset of the MI and duration from onset of MI along with the type, anatomic location, and consequences of the MI.

Documenting Asthma

ICD-10-CM combines intrinsic or extrinsic asthma into one category, so CDI specialists will no longer need to clarify these conditions. The new codes are based on the severity of the asthma. Documentation supporting mild intermittent, mild, moderate, or severe persistent asthma will be needed. Providers should clearly document the relationship between asthma and chronic obstructive bronchitis or chronic obstructive pulmonary disease when applicable.

Documentation Tips: Focus clinical documentation on the severity of asthma and relationship to other diseases when applicable.

Documenting Cerebrovascular Diseases

The cerebrovascular disease codes found in ICD-10-CM categories I60-I69 are more specific than the cerebrovascular diseases codes found in ICD-9-CM. This section includes codes for nontraumatic cerebrovascular hemorrhage and cerebral infarction due to various types of occlusion or stenosis. The ICD-10-CM codes provide greater specificity regarding the type of cerebrovascular disease and precise location of the disease.

The ICD-10-CM category for late effects of cerebrovascular disease is I69, Sequelae of cerebrovascular disease. The sequela codes provide greater specificity in laterality and type of cerebrovascular disease that caused the sequela.

Documentation Tips: Focus documentation on specific type of hemorrhage or infarction, artery affected, and laterality. Providers can also specify occlusions or stenosis to an artery and laterality.

Documenting Coma

One noticeable difference between ICD-9-CM and its ICD-10-CM counterpart is that the latter incorporates the Glasgow Coma Scale (GCS), a neurological scale that captures a patient's conscious state for initial and subsequent assessment. When the individual components (eye response, verbal response, and motor response) are all documented, code assignments are based on the components. In addition, a seventh character is required to denote when the scale was recorded (i.e., in the field or upon arrival to the emergency department).

Documentation Tips: For trauma centers this documentation will be found in the emergency department and/or trauma record. It can also be found on ambulance run sheets. Focus documentation on ensuring that all components of the GSC scale are completed, and that the seventh digit accurately reflects when the scale was recorded.

Documenting Diabetes

In ICD-10-CM most diagnoses of diabetes are classified to one of five categories of codes: E08 Diabetes mellitus due to underlying condition, E09 Drug or chemical induced diabetes mellitus, E10 Type 1 diabetes mellitus, E11 Type 2 diabetes mellitus, and E13 other specific diabetes mellitus. Most of the diabetes codes in ICD-10-CM are combination codes which contain the type of diabetes and associated manifestation or complication.

In ICD-9-CM the fifth digit of the codes for diabetes mellitus and secondary diabetes mellitus provided information on whether or not the diabetes was controlled or uncontrolled. In ICD-9-CM, the term "poorly controlled" required clarification from the provider. In ICD-10-CM, poorly controlled is indexed to the applicable type of diabetes with hyperglycemia code. Diabetes documented as controlled, out of control, or poorly controlled are cross-referenced in the ICD-10-CM index to codes for the specific type of diabetes with hyperglycemia.

Documentation Tips: Focus documentation on the type or etiology of diabetes, body system affected, and any complications affecting that body system.

Documenting Fracture/Orthopedics

In ICD-10-CM approximately 50 percent of all codes are related to the musculoskeletal system, and 25 percent are related to fractures. As such, the need for further clarification is essential to proper code assignment. ICD-10-CM fracture codes can specify the fracture type, such as greenstick, the specific anatomical site, displacement status, laterality, routine versus delayed healing, nonunions, and malunions. Of these new choices, laterality and type of encounter are significant components for the code expansion. Some fracture categories also include a seventh character extension to designate the type of open fracture, based on the Gustilo open fracture classification.

Documentation Tips: Focus documentation efforts on fracture type, laterality, and type of encounter. Review of the radiology reports can assist in determining specificity and, according to *Coding Clinic* First Quarter 2013, it is not necessary to query the physician for inclusion of this information in the progress notes.

Documenting Pregnancy

The majority of codes have a final character identifying the trimester of pregnancy in which the condition occurred. Because certain obstetric conditions or complications occur during certain trimesters, not all conditions include codes for all three trimesters.

ICD-10-CM Chapter 15, Pregnancy, childbirth and the puerperium (O00-O9A) provides an instructional note to "Use additional code from category Z3A, Weeks of gestation, to identify the specific week of the pregnancy."

ICD-10-CM codes provide greater specificity on complications related to multiple gestations. Certain ICD-10-CM categories provide specific codes for cases of multiple gestations to identify the fetus for which the complication applies.

Documentation Tips: Focus documentation on trimester in number of weeks, counted from the first day of the last menstrual period. In cases of multiple gestations where complications affect one or more of the fetuses, identify the fetus for which a complication occurred when possible.

Documenting Pressure Ulcer

ICD-10-CM has combination codes that capture both the location of the pressure ulcer—including laterality—and its associated stage. The current Official Guidelines for Coding and Reporting from CMS do allow code assignment of pressure ulcer stages based on non-provider documentation as long as the provider has documented the existence of the pressure ulcer, and this will continue to hold true once ICD-10-CM is implemented.

Pressure ulcers will continue to be coded once, to the highest degree of specificity. In addition, extensive pressure ulcers can encompass more than one anatomical site. CDI specialists should review provider documentation versus the classification terminology to ensure the correct code is reported.

Documentation Tips: Focus documentation on specific ulcer documentation such as site, laterality, and stage. Reporting extensive ulcers may require multiple codes or a single code for certain contiguous sites as found in the index.

Documenting Respiratory Failure

CDI specialists can assist in identifying a patient who presents to the hospital with difficulty breathing and determining the appropriate diagnosis based on clinical documentation. A diagnosis of "respiratory failure" is indexed to a code in subcategory J96.9, Respiratory failure, unspecified, if it is not specified as acute or chronic. This is different from ICD-9-CM where a diagnosis of "respiratory failure" is indexed to the code for acute respiratory failure unless otherwise specified.

Documentation Tips: Focus documentation on acute, chronic or acute-on-chronic respiratory failure along with hypoxemia or hypercapnia.

CDI Paves the Way for ICD-10 Success

Focusing on clinical documentation improvement should be a key initiative for organizations and providers during this extended period of transition to the ICD-10-CM/PCS code set. Through accurate documentation, coded data can be utilized to make insightful decisions regarding patient treatment, care plans, and strategic decisions. Collaborative insight and support for CDI can result in more detailed, accurate, and higher-quality data, which in turn leads to improved quality reporting, better clinical decision support, and improved patient safety.

Clinical Documentation Affects Specificity for ICD-10-CM

With the transition to ICD-10-CM/PCS, some documentation issues will require capture of new information while others involve updated, modified, and otherwise expanded documentation needs. It's imperative that documentation gaps be filled immediately. In addition physicians, coding professionals, and other clinical staff must continue training in CDI and ICD-10-CM/PCS. Documentation assessment should be a cyclical and ongoing process.
The table below is an example of how clinical documentation will affect specificity in ICD-10-CM diagnostic code assignment.

ICD-9-CM	**ICD-10-CM**
427.31 Atrial Fibrillation	I48.0 Paroxysmal atrial fibrillation I48.1 Persistent atrial fibrillation I48.2 Chronic atrial fibrillation I48.91 Unspecified atrial fibrillation
427.32 Atrial Flutter	I48.3 Typical atrial flutter I48.4 Atypical atrial flutter I48.92 Unspecified atrial flutter

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