CMS and AHIMA Webinar: ICD-10 and Clinical Documentation

December 10, 2014
Webinar Schedule

• 12:00 – Introduction and Welcome
• 12:05 – CMS Update
• 12:10 – AHIMA Presentation
• 1:00 – FAQs
• 1:15 – Q&A

For technical assistance, please call: 1-866-213-9007
CMS Update

Denesecia Green
Acting Director, Administrative Simplification Group
Office of E-Health Standards and Services
CMS
AHIMA Presentation
Speakers

• Angie Comfort, RHIA, CDIP, CCS
  – AHIMA
  – Senior Director, HIM Practice Excellence

• Melanie Endicott, MBA/HCM, RHIA, CDIP, CCS, CCS-P, FAHIMA
  – AHIMA
  – Senior Director, HIM Practice Excellence
Evolving Healthcare Environment

• Healthcare providers face a growing number of documentation and coding challenges amidst changing environment
  – Declining reimbursement
  – Federal/state payment reforms and quality initiatives are impacting documentation and coding
  – Increasing demands for greater documentation specificity
  – Coder shortages
  – Recovery Audit Contractor (RAC) audits
  – Fraud and abuse investigations
  – ICD-10 transition
    • Decreased coder productivity
    • Claims denials/rejections
Where Does ICD-10 Fit In?

• Common reliance on complete and accurate data and clinical documentation
  – Meaningful Use
  – Quality reporting
  – Value-based purchasing
  – Hospital-acquired conditions
  – Payment reform
  – Fraud prevention and detection
  – Research

• ICD-10 will improve quality of data necessary to achieve other healthcare initiatives
Documentation Impact on Quality Data

• Coding and sequencing
• Quality measures
• Reimbursement
• Severity-level profiles
• Risk adjustment profiles
• Present on admission reporting
• Hospital-acquired conditions
Increasing Demand for High-Quality Documentation

• High-quality documentation provides more accurate clinical picture of quality of care provided

• Better clinical documentation promotes better patient care and more accurate capture of acuity, severity, and risk of mortality
  • Quality and performance reporting
  • Reimbursement
  • Severity-level profiles
  • Risk adjustment profiles
  • Provider profiles
  • Present on admission reporting
  • Hospital-acquired conditions

• Benefits of better clinical documentation can be realized in advance of ICD-10 transition
Clinical Documentation Challenges

• Ensuring sufficient documentation to support code assignment while allowing providers to document in clinical, not coding, terms

• Need good clinical documentation – not a greater volume of documentation
ICD-10-CM
Documentation Focus Areas for ICD-10-CM

- Disease type
- Disease acuity
- Disease stage
- Site specificity
- Laterality
- Missing combination code detail
- Changes in timeframes associated with familiar codes
Specificity Examples

• **S72.044G** Nondisplaced fracture of base of neck of right femur, subsequent encounter for closed fracture with delayed healing

• **I69.351** Sequelae of cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side

• **T43.621S** Poisoning by amphetamines, accidental (unintentional), sequela

• **M80.011A** Age-related osteoporosis with current pathological fracture, right shoulder, initial encounter for fracture
Specificity Examples (continued)

• **S31.140D** Puncture wound of abdominal wall with foreign body, right upper quadrant without penetration into peritoneal cavity, subsequent encounter

• **T82.6xxA** Infection and inflammatory reaction due to cardiac valve prosthesis, initial encounter

• **Z89.411** Acquired absence of great right toe

• **Z57.0** Occupational exposure to noise

• **Z63.71** Stress on family due to return of family member from military deployment

• **Y38.811A** Terrorism involving suicide bomber, public safety official injured, initial encounter
Seventh Character Determination

• Initial vs. subsequent encounter vs. sequela
  – Injuries
  – Poisoning, adverse effects, and underdosing
  – Most external cause codes (except for place of occurrence, activity or status)
Fractures

- Open vs. closed
  - Gustilo classification of open fractures (I, II, IIIA, IIIB, IIIC)
    - S52 Forearm
    - S72 Femur
    - S82 Lower leg, including ankle

- Displaced vs. nondisplaced
Fractures (continued)

• Instructional notes indicate:
  – Fracture not indicated as displaced or nondisplaced should be coded to displaced
  – Fracture not indicated as open or closed should be coded to closed

• Subsequent encounters
  – Routine vs. Delayed healing
  – Nonunion
  – Malunion
Examples of Fracture Terms

- Salter-Harris Types I, II, III, and IV
- LeFort I, II, and III
- Avulsion
- Wedge compression
- Stable and unstable burst
- Zone I, II, and III
- Barton’s
- Smith’s
- Greenstick
- Transverse
- Oblique
- Spiral
- Comminuted
- Segmental
- Torus
- Maisonneuve’s
Pathological Fractures

• Documentation will need to include:
  – Exact location of fracture
    • Site
    • Laterality
  – Etiology of fracture
    • Osteoporosis
    • Neoplastic disease
    • Other specified
    • Unspecified
  – Encounter type
  – Current fracture and/or personal history
Myocardial Infarction

• Does the patient require continued care for acute myocardial infarction (AMI)?
  – Is it within 4 weeks time frame?
  – **New concept:** Has the patient suffered a NEW AMI within the 4 week time frame of the initial AMI?

• Is the myocardial infarction old or healed not requiring further care?
Asthma

• Mild, moderate, severe
• Intermittent, persistent
• Uncomplicated, exacerbated, status asthmaticus
Obstetrics

• Trimester
• Number of Weeks of gestation
• Multiple gestation complication – 7th character for which fetus was affected
• Pre-Existing Conditions vs. Due to Pregnancy
• Diabetes – Diet controlled, insulin controlled or unspecified control
Urosepsis

- Alphabetical Index – code to condition
  - Generalized sepsis?
  - Urine contaminated by bacteria, bacterial by-products, or other toxic material but without other findings?
- ICD-10-CM no longer defaults to urinary tract infection
Adverse Effects, Poisoning, Underdosing and Toxic Effects

• Combination codes that include the substances related to adverse effects, poisonings, toxic effects and underdosing, as well as the external cause
  – Will require knowing intent: accidental, intentional self-harm, assault, undetermined
Underdosing

• Taking less of a medication than is prescribed by the provider or manufacturer
  – Noncompliance or complication of care codes are used with underdosing code to indicate intent, if known
ICD-10-PCS
All 7 characters of an ICD-10-PCS code are required to code.
Are all of them documented today?
ICD-9-CM Suture of Artery: One code 39.31

ICD-10-PCS Repair of Artery: 195 codes

<table>
<thead>
<tr>
<th>Approach</th>
<th>Body Part</th>
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<tbody>
<tr>
<td>0-Open</td>
<td>Abdominal Aorta</td>
</tr>
<tr>
<td>3-Percutaneous</td>
<td>Common Carotid Artery</td>
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<tr>
<td>4-Percutaneous Endoscopic</td>
<td>Radial Artery</td>
</tr>
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<td></td>
<td>...</td>
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<tr>
<td></td>
<td>...</td>
</tr>
<tr>
<td></td>
<td>65 Different Arteries</td>
</tr>
</tbody>
</table>
ICD-10-PCS Documentation Considerations

- **Root Operation**
  - Provider documentation must describe the surgery in detail in order for the coder to select the appropriate root operation

- **Approach**
  - No defaults for unspecified approach

- **Specific body part**
  - Laterality (e.g. right ovary, left ovary, or bilateral ovaries; no default for unspecified ovary; same for fallopian tubes)
  - Greater granularity (vessels, muscles, nerves)
ICD-10-PCS Coding Guidelines

• If the documentation is incomplete for coding purposes, the physician should be queried for the necessary information.

• It is the coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions.

• The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.
Challenging Root Operations Where Documentation is Important

• Resection vs. Excision
  – All or a portion of a body part removed
    • Example: Lymph nodes – a few nodes or entire lymph node chain?

• Extirpation vs. Fragmentation
Challenging Root Operations Where Documentation is Important (continued)

• Occlusion vs. Restriction
  – What is the objective, completely close (Occlusion) or partially close (Restriction)?

• Change vs. Removal vs. Revision
  – Taking out device (Removal)
  – Exchanging device without cutting/puncturing (Change)
  – Correcting malfunctioning, displaced device (Revision)
Challenging Root Operations Where Documentation is Important (continued)

- Amputations: Is the body part identified in sufficient detail to select qualifier?
  - Upper arm and upper leg (portion of the shaft of the humerus or femur amputated)
    - High: Proximal portion
    - Mid: Middle portion
    - Low: Distal portion
  - Foot/Hand
    - Complete or partial?
    - 1st, 2nd, 3rd, 4th or 5th ray?
Challenging Root Operations Where Documentation is Important (continued)

• Amputations: Is the body part identified in sufficient detail to select qualifier? (cont.)
  – Thumb, finger or toe
    • Complete: metacarpophalangeal/metatarsal-phalangeal joint
    • High: Anywhere along the proximal phalanx
    • Mid: Through the proximal interphalangeal joint or anywhere along the middle phalanx
    • Low: Through the distal interphalangeal joint or anywhere along the distal phalanx
Lysis of Abdominal Adhesions

- In the root operation Release, the body part value coded is the body part being freed, and not the tissue being manipulated or cut to free the body part.

- Lysis of intestinal adhesions
  - Small intestine
  - Duodenum
  - Jejunum
  - Ileum
  - Ileocecal valve
  - Large intestine
  - Large intestine, right
  - Large intestine, left
  - Cecum
  - Ascending colon
  - Transverse colon
  - Descending colon
  - Sigmoid colon
Infusions, Chemotherapy and Vascular Access Procedures

• Infusions/transfusions
  – Route of administration (artery or vein, peripheral or central vein)
  – Blood (specific blood and blood products)
  – Other substances (e.g. antineoplastic, destructive agent, thrombolytics, platelet inhibitor, etc.)

• Vascular access devices (e.g. PICC line insertions)
  – Placement site
Documentation Improvement for ICD-10-CM/PCS
ICD-10 Presents New Clinical Documentation Opportunities

- ICD-10-CM/PCS codes are considerably more detailed than ICD-9-CM

Examples:
- Laterality
- Encounter type (initial, subsequent, sequela)
- Anatomical detail
- Type of injury
- Severity
- Approach
Benefits of Clinical Documentation Improvement Program for ICD-10 Transition

• Better documentation to support multiple purposes
• Improved ICD-9-CM coding
• Smoother transition to ICD-10-CM/PCS
  – Collaborative approach to successful transition
  – Fewer coding errors
  – Increased coding productivity
  – Reduced physician queries
  – Fewer claims denials/rejections
  – Opportunity to incorporate documentation details into EHR system
Clinical Documentation Improvement Strategies

- Identify documentation improvement opportunities that could impact various initiatives, including ICD-10, Meaningful Use, value-based purchasing, present on admission and hospital-acquired condition reporting.
- Determine best solution for addressing each documentation gap – one size doesn’t fit all.
  - Examples:
    - Modifications to form or template
    - System prompts
    - Education
    - Workflow or operational process changes
- Prioritize – start with “low hanging fruit” or issues with greatest impact.
Clinical Documentation Improvement Strategies (continued)

• Identify and implement changes in documentation capture processes (such as use of EHR documentation templates and prompts) that would facilitate improvements in clinical documentation practices

• Key to quality care is to focus on capturing quality information at the point of care

• Improving clinical documentation now has immediate benefits
Clinical Documentation Improvement Strategies (continued)

• Educate medical staff

• Demonstrate to physicians the value of high-quality documentation
  – Better clinical documentation promotes better patient care and accurate capture of acuity, severity, and risk of mortality data
Documentation Gap Analysis

• Evaluate medical record samples to determine whether documentation supports level of detail found in ICD-10-CM/PCS

• Sampling techniques could include:
  – Random samples
  – Sampling by clinical specialty
  – Top diagnoses/procedures
  – Top service lines
  – High volume diagnoses/procedures
  – High dollar diagnoses/procedures
  – Diagnostic or procedural categories known to represent documentation problems with ICD-9-CM
Options

Work Harder

➢ Hire more coders and clinical documentation improvement specialists
➢ Increase volume of physician queries
➢ Conduct intensive, continuous physician training

Work Smarter

➢ Use automation to facilitate coding and documentation (e.g., EHR templates, CAC)
Benefits of EHR Documentation Prompts

- Better clinical documentation to support all initiatives
- Facilitates overcoming language barrier between physicians and coders
- Provides ongoing learning loop for physicians regarding needed documentation elements at the time care is recorded
- Greater coding accuracy, productivity, and coder satisfaction (especially when used in combination with Computer Assisted Coding (CAC) technology)
- Enhanced CAC accuracy
- Reduced compliance risks
- Proper claims payment
- Fewer retrospective provider queries
- Eases ICD-10 transition and provider acceptance
- Allows providers to spend more time on patient care and less time learning ICD-10-CM/PCS
EHR Documentation Templates

• Proper documentation can be facilitated through use of EHR templates and prompts, and data repurposed throughout EHR to support the “collect once, use many” model

• Template: EHR tool utilized for collection, presentation, and organization of clinical data elements

• Prompts: Trigger the provider to provide required or missing documentation
EHR Documentation Templates (continued)

• Use templates only where documentation is not optimal
• Avoid using templates too broadly
• Use default values with extreme caution to avoid inaccurate information
• Do not include coding nomenclature in a template
EHR Documentation Templates (continued)

• Templates should not be too prescriptive, complicated, or time-consuming to use
• Educate physicians on the use of EHR templates
• Establish regular review process to:
  – Maintain master list of templates
  – Ensure template is being used
  – Verify information is still relevant
  – Identify necessary updates
Benefits of EHR Templates

• Better clinical documentation to support all initiatives
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ICD-10 Details to be Added to EHR Templates

- Laterality
- Devices
- Encounter type (initial, subsequent, sequela, routine healing, delayed healing)
- Anatomic details
- Severity
- Disease relationships
ICD-10 Details to be Added to EHR Templates (continued)

• Current condition vs. past history
• Relationship of condition to procedure (postoperative complication?)
• Etiology
• Symptoms/manifestations associated with disease process
• Fracture type (transverse, comminuted, spiral, segmental, etc; displaced vs. non-displaced; open vs. closed; Gustilo classification of open fracture; nonunion or malunion)
ICD-10 Details to be Added to EHR Templates (continued)

• External cause
• Age of acute myocardial infarction
• Route of administration and substance transfused
• Underdosing
• Dominant/Nondominant side (hemiplegia, monoplegia)
ICD-10 Details to be Added to EHR Templates (continued)

• Weeks of gestation
• Identification of fetus in multiple gestations
• Glasgow coma scale
• Causal organism
• Acuity of respiratory failure and presence of hypoxia or hypercapnea
• Type and severity level of asthma
ICD-10 Details to be Added to EHR Templates (continued)

• Traumatic vs. pathologic fracture
• Procedural elements necessary to determine approach and root operation
• Specific body part procedure was performed on (e.g., muscle, tendon, ligament, artery, vein)
• Amputation qualifier – complete, partial, high, mid, low
Conclusion

• Accurate data on severity, risk, quality, and outcomes depends on complete, accurate coding and documentation

• Non-specific documentation results in non-specific code assignments

• ICD-10 should be used to set the “gold standard” for clinical documentation
AHIMA Resources

www.ahima.org

- Clinical Documentation Guidance for ICD-10-CM/PCS
- Using CDI Programs to Improve Acute Care Clinical Documentation in Preparation for ICD-10-CM/PCS
- ICD-10-CM/PCS Implementation Toolkit
- Electronic Documentation Templates Support ICD-10-CM/PCS Implementation
ICD-10-CM/PCS Documentation Tips

www.ahima.org/icd10

Clinical Documentation Improvement

Pneumonia

- Document causative organism (if known)
- Document mechanism:
  - Aspiration
  - Ventilator-associated
  - Radiation-induced
  - Other (specify)
- Document any associated illness:
  - Respiratory failure
  - Sepsis
  - Underlying lung disease
  - Other (specify)
- Document history of tobacco use—present or past
Questions