Ms. Grider is a Senior Manager with Blue Consulting with over 30 years of experience in coding, reimbursement, practice management, billing compliance, accounts receivable, revenue cycle management, and compliance across many specialties. Her specific areas of expertise include medical documentation reviews, accounts receivable analysis and coding and billing education. She holds the following certifications: CPC, CPC-I, CPC-H, CPC-P, CPMA, CEMC, CPCD, COBGC, CCS-P, and CDIP. She is an AHIMA Approved ICD-10 Trainer.

Her background includes many years of practical experience in reimbursement issues, procedural and diagnostic coding, and medical practice management. She has provided testimony for the National Committee on Health Care Vital Statistics on ICD-10 implementation and is considered an ICD-10 expert in the country. She developed the education and training for ICD-10 Implementation for Physicians and Payers for the American Academy of Professional Coders, and the ICD-10 Implementation Training for the Indiana Hospital Association. She served in 2009-2012 on the ICD-10 Stakeholders Committee in Washington, DC advising CMS and HHS of the challenges with ICD-10 implementation.

Ms. Grider is the author of many coding publications for the American Medical Association including Principles of ICD-9-CM Coding, Coding with Modifiers and Medical Record Chart Auditor. She is also the author of the ICD-10-CM Implementation Guide, Making the Transition Manageable, Principles of ICD-10-CM and the Principles of ICD-10-CM Workbook. She holds multiple certifications with the American Academy of Professional Coders as well as the CCS-P credential with the American Health Information Management Association. Her professional affiliations include: the American Academy of Professional Coders, the Indianapolis Chapter of the American Academy of Professional Coders of which she was the founder and President from 1996-2003; past President of the American Academy Professional Coders National Advisory Board; member of the American Health Information Management Association, Healthcare Finance Management Association, and the Workforce for Electronic Data Interchange. Ms. Grider was named one of the Top 10 Health Information Management Professionals in 2009.
Introduction

• The buzz word now is “specificity”, and it will take a solid team of well-trained professionals from HIM and clinical staff to ensure that physician documentation contains the details needed to code accurately in all healthcare settings.
• One of the most significant problems with ICD-10 implementation is the physician/practitioner documentation.
• Reimbursement in all settings begins with the practitioner’s documentation. Without it services cannot be provided to the patient.
• The question all hospitals, physicians, practitioners must ask is will the documentation be sufficient to support the expansion of the codes in ICD-10? In most cases the answer to this question is “no”!

What You Will Learn

• What is the importance of Clinical Documentation Improvement (CDI)
• Why now is the right time to begin a CDI program
• Identify sufficient ICD-10 documentation
• Understand how to identify ICD-10 clinical documentation deficiencies.
• Identify ICD-10 training specific to your organization needs
• Tips to prevent an interruption in revenue due to lack of specificity in the coding or documentation when ICD-10 is implemented
Introduction

• For the past 30 years, the healthcare industry has been using a system of diagnoses and procedure codes called the International Classification of Diseases, 9th Revision, Clinical Modification, or ICD-9-CM (Vol. 1, 2, and 3).

• These codes have been used since the late 1970’s and have become outdated, fail to reflect current medical terminology and practice,

• Do not provide sufficiently detailed information needed for health research and statistical analysis

Diagnoses and Procedure Coding

• ICD-9-CM currently has approximately 7,000+ codes and had jumped to 68,847 in ICD-10-CM in 2012

• The number of procedure codes have increased
  – Currently, there are approximately 4,000 ICD-9-CM procedure codes and this will increase to approximately 87,000 + ICD-10 PCS codes

• There will be concern within the health plan about historical data and how to do diagnoses and procedure data analysis when two systems exist
Documentation Challenges

- Data in other countries not consistent
  - There is not data to indicate physician productivity is affected; this is the unknown
- Reason:
  - Other countries that have implemented ICD-10 are single payment systems
    - US is a multi-payment system
  - Number of Codes used in the US are far greater
- Good preparation and training is key to reducing productivity losses

Productivity Impacts

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- Reason:
  - Other countries that have implemented ICD-10 are single payment systems
    - US is a multi-payment system
  - Number of Codes used in the US are far greater
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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 both conditions exist may code both)
- New – Laterality
- New – Coding pregnancy trimesters
- New – Glasgow coma scale
- New – Functional quadriplegia

Highlights of ICD-10-CM Differences

- 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

- Reference terminologies such as SNOMED-CT® 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
  - SNOMED is a work of clinical terminology
  - Main purpose: coded representation of meaning used in health information

ICD-10-PCS

- Mnemonic Key for the ICD10 components of the medical/surgical sections:
  - Suzy Buys Root Beer at Dairy Queen
- 1st character – Section
- 2nd character – Body system
- 3rd character – Root operation
- 4th character – Body part
- 5th character – Approach
- 6th character – Device
- 7th character – Qualifier
DOCUMENTATION & QUALITY

Review the example for a Laparoscopic Appendectomy:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical System</td>
<td>Root Operation</td>
<td>Body Part</td>
<td>Approach</td>
<td>Device</td>
<td>Qualifier</td>
<td></td>
</tr>
<tr>
<td>O</td>
<td>D</td>
<td>T</td>
<td>J</td>
<td>4</td>
<td>Z</td>
<td>Z</td>
</tr>
</tbody>
</table>

- The use of ICD-10-PCS codes changes information required from the medical record
- A Coder may find it difficult to use existing documentation to ensure proper coding
- Root operation based on specific terminology

Clinical Impact of ICD-10

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

Neoplasms

• Coded by anatomic site
• Laterality (if applicable)
• Type of Neoplasm
  – Malignant
  – Benign
  – In situ
  – Uncertain
  – Unspecified behavior
Carcinoma in Situ of Skin

- The fourth and fifth character categories further define the site, etiology, and manifestation or state of the disease or condition
  - D04.0 Carcinoma in situ of skin of lip
  - D04.10 Carcinoma in situ of skin of unspecified eyelid, including canthus
  - D04.11 Carcinoma in situ of skin of right eyelid, including canthus
  - D04.12 Carcinoma in situ of skin of left eyelid, including canthus
  - D04.20 Carcinoma in situ of skin of unspecified ear and external auricular canal
  - D04.21 Carcinoma in situ of skin of right ear and external auricular canal
  - D04.22 Carcinoma in situ of skin of left ear and external auricular canal
  - D04.30 Carcinoma in situ of skin of unspecified part of face
  - D04.39 Carcinoma in situ of skin of other parts of face

Pressure Ulcers

- Coded by:
  - site
  - stage of ulcer
  - Laterality, when appropriate
    - L89.510 Pressure ulcer of right ankle, unstageable
    - L89.511 Pressure ulcer of right ankle, stage 1
    - L89.512 Pressure ulcer of right ankle, stage 2
    - L89.513 Pressure ulcer of right ankle, stage 3
    - L89.514 Pressure ulcer of right ankle, stage 4
    - L89.519 Pressure ulcer of right ankle, unspecified stage
  - Assessment guided by clinical documentation of stage
  - If not indicated, physician should be queried
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

<table>
<thead>
<tr>
<th>Burn of unspecified degree of right axilla</th>
<th>T22.041</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burn of first degree of right axilla</td>
<td>T22.141</td>
</tr>
<tr>
<td>Burn of second degree of right axilla</td>
<td>T22.241</td>
</tr>
<tr>
<td>Burn of third degree of right axilla</td>
<td>T22.341</td>
</tr>
<tr>
<td>Corrosion of unspecified degree of right axilla</td>
<td>T22.441</td>
</tr>
<tr>
<td>Corrosion of first degree of right axilla</td>
<td>T22.541</td>
</tr>
<tr>
<td>Corrosion of second degree of right axilla</td>
<td>T22.641</td>
</tr>
<tr>
<td>Corrosion of third degree of right axilla</td>
<td>T22.741</td>
</tr>
</tbody>
</table>
Fractures

- Documentation required:
  - Anatomic site
  - Laterality
  - Fracture type
  - Displaced or nondisplaced (displaced default)
  - Open or closed
  - 7th character extension required

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
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>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J45</td>
<td>Asthma</td>
</tr>
<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>
### J45 Asthma

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<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>
<tr>
<td>J45.5</td>
<td>Severe persistent</td>
</tr>
<tr>
<td>J45.50</td>
<td>Severe persistent, uncomplicated</td>
</tr>
<tr>
<td>J45.51</td>
<td>Severe persistent with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.52</td>
<td>Severe persistent with status asthmaticus</td>
</tr>
<tr>
<td>J45.9</td>
<td>Other and unspecified asthma</td>
</tr>
<tr>
<td>J45.90</td>
<td>Unspecified asthma</td>
</tr>
<tr>
<td>J45.901</td>
<td>Unspecified asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.901</td>
<td>Unspecified asthma with status asthmaticus</td>
</tr>
<tr>
<td>J45.99</td>
<td>Other asthma</td>
</tr>
<tr>
<td>J45.990</td>
<td>Exercise induced bronchospasm</td>
</tr>
<tr>
<td>J45.991</td>
<td>Cough variant asthma</td>
</tr>
<tr>
<td>J45.998</td>
<td>Other asthma</td>
</tr>
</tbody>
</table>

---

### 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
Hypertension

Essential hypertension I10
Hypertensive heart disease with heart failure I11.0
Hypertensive heart disease without heart failure I11.9
Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease I12.0
Hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease I12.9
Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease I13.0
Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease I13.10
Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease I13.11
Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease I13.2
Renovascular hypertension I15.0
Hypertension secondary to other renal disorders I15.1
Hypertension secondary to endocrine disorders I15.2
Other secondary hypertension I15.8
Secondary hypertension, unspecified I15.9
Elevated Blood pressure reading R30.0

Occlusion and Stenosis of Carotid Artery

- Documentation must include:
  - Laterality
    - Right
    - Left
    - Bilateral
    - Unspecified
  - I65.21 Occlusion and stenosis of right carotid artery
  - I65.22 Occlusion and stenosis of left carotid artery
  - I65.23 Occlusion and stenosis of bilateral carotid arteries
  - I65.29 Occlusion and stenosis of unspecified carotid artery
Diabetes Mellitus

- There are five 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
- 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-9-CM
  - Type 1/type 2 (250.xx)
  - Controlled
  - uncontrolled
  - manifestations
- ICD-10-CM
  - Type 1-E10-E10.9
  - Type 2-E11-E11.9
  - Included in combination code manifestations
  - E10.351-Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema
Diabetes Mellitus

• 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
Ulcers

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

K25.0 Acute gastric ulcer with hemorrhage
K25.1 Acute gastric ulcer with perforation
K25.2 Acute gastric ulcer with both hemorrhage and perforation
K25.3 Acute gastric ulcer without hemorrhage or perforation
K25.4 Chronic or unspecified gastric ulcer with hemorrhage
K25.5 Chronic or unspecified gastric ulcer with perforation
K25.6 Chronic or unspecified gastric ulcer with both hemorrhage and perforation
K25.7 Chronic gastric ulcer without hemorrhage or perforation
K25.9 Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation
## Ulcers

### K26.0 Acute duodenal ulcer with hemorrhage
- K26.1 Acute duodenal ulcer with perforation
- K26.2 Acute duodenal ulcer with both hemorrhage and perforation
- K26.3 Acute duodenal ulcer without hemorrhage or perforation
- K26.4 Chronic or unspecified duodenal ulcer with hemorrhage
- K26.5 Chronic or unspecified duodenal ulcer with perforation
- K26.6 Chronic or unspecified duodenal ulcer with both hemorrhage and perforation
- K26.7 Chronic duodenal ulcer without hemorrhage or perforation
- K26.9 Duodenal ulcer, unspecified as acute or chronic, without hemorrhage or perforation

### K27.0 Acute peptic ulcer, site unspecified, with hemorrhage
- K27.1 Acute peptic ulcer, site unspecified, with perforation
- K27.2 Acute peptic ulcer, site unspecified, with both hemorrhage and perforation
- K27.3 Acute peptic ulcer, site unspecified, without hemorrhage or perforation
- K27.4 Chronic or unspecified peptic ulcer, site unspecified, with hemorrhage
- K27.5 Chronic or unspecified peptic ulcer, site unspecified, with perforation
- K27.6 Chronic or unspecified peptic ulcer, site unspecified, with both hemorrhage and perforation
- K27.7 Chronic peptic ulcer, site unspecified, without hemorrhage or perforation
- K27.9 Peptic ulcer, site unspecified, unspecified as acute or chronic, without hemorrhage or perforation
### Ulcers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K28.0</td>
<td>Acute gastrojejunul ulcer with hemorrhage</td>
</tr>
<tr>
<td>K28.1</td>
<td>Acute gastrojejunul ulcer with perforation</td>
</tr>
<tr>
<td>K28.2</td>
<td>Acute gastrojejunul ulcer with both hemorrhage and perforation</td>
</tr>
<tr>
<td>K28.3</td>
<td>Acute gastrojejunul ulcer without hemorrhage or perforation</td>
</tr>
<tr>
<td>K28.4</td>
<td>Chronic or unspecified gastrojejunul ulcer with hemorrhage</td>
</tr>
<tr>
<td>K28.5</td>
<td>Chronic or unspecified gastrojejunul ulcer with perforation</td>
</tr>
<tr>
<td>K28.6</td>
<td>Chronic or unspecified gastrojejunul ulcer with both hemorrhage and perforation</td>
</tr>
<tr>
<td>K28.7</td>
<td>Chronic gastrojejunul ulcer without hemorrhage or perforation</td>
</tr>
<tr>
<td>K28.9</td>
<td>Gastrojejunul ulcer, unspecified as acute or chronic, without hemorrhage or perforation</td>
</tr>
</tbody>
</table>

### Gastritis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K29.00</td>
<td>Acute gastritis without bleeding</td>
</tr>
<tr>
<td>K29.01</td>
<td>Acute gastritis with bleeding</td>
</tr>
<tr>
<td>K29.20</td>
<td>Alcoholic gastritis without bleeding</td>
</tr>
<tr>
<td>K29.21</td>
<td>Alcoholic gastritis with bleeding</td>
</tr>
<tr>
<td>K29.30</td>
<td>Chronic superficial gastritis without bleeding</td>
</tr>
<tr>
<td>K29.31</td>
<td>Chronic superficial gastritis with bleeding</td>
</tr>
<tr>
<td>K29.40</td>
<td>Chronic atrophic gastritis without bleeding</td>
</tr>
<tr>
<td>K29.41</td>
<td>Chronic atrophic gastritis with bleeding</td>
</tr>
<tr>
<td>K29.50</td>
<td>Unspecified chronic gastritis without bleeding</td>
</tr>
<tr>
<td>K29.51</td>
<td>Unspecified chronic gastritis with bleeding</td>
</tr>
<tr>
<td>K29.60</td>
<td>Other gastritis without bleeding</td>
</tr>
<tr>
<td>K29.61</td>
<td>Other gastritis with bleeding</td>
</tr>
<tr>
<td>K29.70</td>
<td>Gastritis, unspecified, without bleeding</td>
</tr>
<tr>
<td>K29.71</td>
<td>Gastritis, unspecified, with bleeding</td>
</tr>
</tbody>
</table>
Hernia

- Diagnosis codes range from K40.00-K46.9
  - Documentation required
    - Site of hernia
    - Laterality when appropriate
    - If gangrene or obstruction is present
    - If condition is recurrent
  - Categories:
    - Inguinal (K40.0-)
    - Femoral (K41.0-)
    - Umbilical (K42.0-)
    - Ventral (K43.0-)
    - Diaphragmatic (K44.0-)
    - 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 in ICD-10-CM the following is necessary:
  - Trimester (usually located within the code)
  - Gestational condition or pre-existing
  - Type of complication
  - Risk

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervision of pregnancy with history of ectopic or molar pregnancy,</td>
<td>O09.10</td>
</tr>
<tr>
<td>unspecified trimester</td>
<td></td>
</tr>
<tr>
<td>Supervision of pregnancy with history of ectopic or molar pregnancy,</td>
<td>O09.11</td>
</tr>
<tr>
<td>first trimester</td>
<td></td>
</tr>
<tr>
<td>Supervision of pregnancy with history of ectopic or molar pregnancy,</td>
<td>O09.12</td>
</tr>
<tr>
<td>second trimester</td>
<td></td>
</tr>
<tr>
<td>Supervision of pregnancy with history of ectopic or molar pregnancy,</td>
<td>O09.13</td>
</tr>
<tr>
<td>third trimester</td>
<td></td>
</tr>
</tbody>
</table>
### Diabetes in Pregnancy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O24.0111</td>
<td>Pre-existing diabetes mellitus, type 1, in pregnancy, first trimester</td>
</tr>
<tr>
<td>O24.0112</td>
<td>Pre-existing diabetes mellitus, type 1, in pregnancy, second trimester</td>
</tr>
<tr>
<td>O24.0113</td>
<td>Pre-existing diabetes mellitus, type 1, in pregnancy, third trimester</td>
</tr>
<tr>
<td>O24.0119</td>
<td>Pre-existing diabetes mellitus, type 1, in pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>O24.12</td>
<td>Pre-existing diabetes mellitus, type 1, in childbirth</td>
</tr>
<tr>
<td>O24.13</td>
<td>Pre-existing diabetes mellitus, type 1, in the puerperium</td>
</tr>
<tr>
<td>O24.311</td>
<td>Unspecified pre-existing diabetes mellitus in pregnancy, first trimester</td>
</tr>
<tr>
<td>O24.312</td>
<td>Unspecified pre-existing diabetes mellitus in pregnancy, second trimester</td>
</tr>
<tr>
<td>O24.313</td>
<td>Unspecified pre-existing diabetes mellitus in pregnancy, third trimester</td>
</tr>
<tr>
<td>O24.319</td>
<td>Unspecified pre-existing diabetes mellitus in pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>O24.32</td>
<td>Pre-existing diabetes mellitus, type 2, in childbirth</td>
</tr>
<tr>
<td>O24.33</td>
<td>Pre-existing diabetes mellitus, type 2, in the puerperium</td>
</tr>
</tbody>
</table>

### Gestational Diabetes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O24.410</td>
<td>Gestational diabetes mellitus in pregnancy, diet controlled</td>
</tr>
<tr>
<td>O24.414</td>
<td>Gestational diabetes mellitus in pregnancy, insulin controlled</td>
</tr>
<tr>
<td>O24.419</td>
<td>Gestational diabetes mellitus in pregnancy, unspecified control</td>
</tr>
<tr>
<td>O24.420</td>
<td>Gestational diabetes mellitus in childbirth, diet controlled</td>
</tr>
<tr>
<td>O24.424</td>
<td>Gestational diabetes mellitus in childbirth, insulin controlled</td>
</tr>
<tr>
<td>O24.429</td>
<td>Gestational diabetes mellitus in childbirth, unspecified control</td>
</tr>
<tr>
<td>O24.430</td>
<td>Gestational diabetes mellitus in the puerperium, diet controlled</td>
</tr>
<tr>
<td>O24.434</td>
<td>Gestational diabetes mellitus in the puerperium, insulin controlled</td>
</tr>
<tr>
<td>O24.439</td>
<td>Gestational diabetes mellitus in the puerperium, unspecified control</td>
</tr>
</tbody>
</table>
### Other Pre-existing Diabetes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O24.811</td>
<td>Other pre-existing diabetes mellitus in pregnancy, first trimester</td>
</tr>
<tr>
<td>O24.812</td>
<td>Other pre-existing diabetes mellitus in pregnancy, second trimester</td>
</tr>
<tr>
<td>O24.813</td>
<td>Other pre-existing diabetes mellitus in pregnancy, third trimester</td>
</tr>
<tr>
<td>O24.819</td>
<td>Other pre-existing diabetes mellitus in pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>O24.82</td>
<td>Other pre-existing diabetes mellitus in childbirth</td>
</tr>
<tr>
<td>O24.83</td>
<td>Other pre-existing diabetes mellitus in the puerperium</td>
</tr>
</tbody>
</table>

### Unspecified Diabetes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O24.911</td>
<td>Unspecified diabetes mellitus in pregnancy, first trimester</td>
</tr>
<tr>
<td>O24.912</td>
<td>Unspecified diabetes mellitus in pregnancy, second trimester</td>
</tr>
<tr>
<td>O24.913</td>
<td>Unspecified diabetes mellitus in pregnancy, third trimester</td>
</tr>
<tr>
<td>O24.919</td>
<td>Unspecified diabetes mellitus in pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>O24.92</td>
<td>Unspecified diabetes mellitus in childbirth</td>
</tr>
<tr>
<td>O24.93</td>
<td>Unspecified diabetes mellitus in the puerperium</td>
</tr>
</tbody>
</table>
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 documentation is necessary:
  - Hyperthyroidism or hypothyroidism
  - Cause of condition
  - With or without goiter
  - With or without thyrotoxicosis crisis or storm

Example

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital hypothyroidism with diffuse goiter</td>
<td>E03.0</td>
<td>Thyrotoxicosis with toxic single thyroid nodule without thyrotoxic crisis or storm</td>
<td>E05.10</td>
</tr>
<tr>
<td>Congenital hypothyroidism without goiter</td>
<td>E03.1</td>
<td>Thyrotoxicosis with toxic multinodular goiter with thyrotoxic crisis or storm</td>
<td>E05.21</td>
</tr>
<tr>
<td>Atrophy of thyroid (acquired)</td>
<td>E03.4</td>
<td>Thyrotoxicosis from ectopic thyroid tissue without thyrotoxic crisis or storm</td>
<td>E05.30</td>
</tr>
<tr>
<td>Hypothyroidism, unspecified</td>
<td>E03.9</td>
<td>Thyrotoxicosis, unspecified with thyrotoxic crisis or storm</td>
<td>E05.91</td>
</tr>
</tbody>
</table>
7th character Extension

- S31.623A-Laceration with foreign body of abdominal wall, right lower quadrant with penetration into peritoneal cavity, initial encounter
- 7th character extender used with a laceration code. Note that in ICD-10-CM, the entire code description is written out
  - A Initial encounter
  - D Subsequent encounter
  - S Sequelae

Tobacco Abuse/Addiction

- Tobacco abuse/addiction 6th character sub classification
  - 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
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 provide
  • and assess quality of care

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
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, or utilization of diagnosis codes and/or MS-DRG’s
    • Review the most common diagnosis codes used and frequency

Frequency Reports

• Most billing software is capable of running a frequency reports of the most used procedures and diagnosis codes
• This is helpful for reviewing diagnosis code utilization in the practice
Performing an ICD-10-CM Readiness Audit

• Provider either have staff that conduct audits in your organization 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 when implemented

Example

• The physician documented a diagnosis of GERD (no other information in the assessment or in the history to support further defining the condition

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>530.81 Gastroesophageal reflux</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10-CM K21</td>
<td>K21.0 Gastroesophageal reflux with esophagitis</td>
</tr>
<tr>
<td></td>
<td>K21.9 Gastroesophageal reflux without esophagitis</td>
</tr>
</tbody>
</table>
Example

- A patient with irritable bowel syndrome was treated by his family physician in outpatient clinic. The patient was experiencing symptoms of diarrhea particularly following meals. The physician prescribed medication to the patient during the encounter. The documentation in the assessment indicated IBS without further elaboration.

ICD-9-CM  564.1 Irritable bowel syndrome

ICD-10-CM  K58 Irritable bowel syndrome

  K58.0 Irritable bowel syndrome with diarrhea
  K58.9 Irritable bowel syndrome without diarrhea

Sample Audit Tool

<table>
<thead>
<tr>
<th>Chart #</th>
<th>MR #</th>
<th>Documented Diagnosis Description</th>
<th>ICD-9-CM Documented</th>
<th>ICD-10-CM Diagnosis Documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4567</td>
<td>GERD</td>
<td>530.81</td>
<td>Cannot report without more information</td>
</tr>
<tr>
<td>2</td>
<td>12345</td>
<td>IBS</td>
<td>564.1</td>
<td>Cannot report without more information</td>
</tr>
</tbody>
</table>
Sample Report

Physician Name: John Doe, MD
Date of Audit: 10/20/200x

Reviewer (Auditor): Mary Ellen Ellis CPC, CPC-H

Number of medical records reviewed month of October, 200x: 20
Number of medical records documented the appropriate ICD-9-CM code: 100%
Number of medical records support documentation for ICD-10-CM: 20%
Number of medical records lacking documentation specificity to support ICD-10-CM: 80%

How Do You Solve the Documentation Problem?

• Educate by showing the comparison between both coding systems
• Show practitioner the documentation requirements for the diagnosis codes that cannot be supported
• 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.
Clinical Documentation Improvement

- Implement a documentation improvement program within the organization and monitor the documentation on an on-going basis to ensure improvement, and identify areas that practitioners still is deficient and needs more assistance
  - These types of audits should be conducted periodically to validate compliance for ICD-10-CM. As with any type of audit, a report summary should be submitted to senior management

Beginning the Process

The following simple steps can help get you started:

1. Run a utilization report that pulls your most frequently used diagnosis codes
2. Run a separate report that can pull patients with those diagnosis codes
3. Use this list to randomly pull charts to begin your documentation audit
4. Utilize the GEMS files to begin mapping your current ICD-9-CM code to an ICD-10-CM code selection. Make sure you validate the codes in the ICD-10 code book(s)
5. Compare your documentation with the code to see if you have documented enough to assign a potential code; if not, begin to work on the documentation aspects moving forward
6. Each quarter revisit this process to make sure you continue to document with the specificity required.
Documentation Audits

- For Hospitals review a minimum of 75 medical records (baseline sampling) and continue every quarter targeting specific MS-DRG’s and/or ICD-9 codes frequently reported
- For physicians review a sample of 5-10 medical records for a baseline sampling
  - Continue each quarter targeting specific diagnosis codes frequently reported

DOCUMENTATION & QUALITY

- In addition in the hospital an analysis of MS-DRGs should be evaluated and mapped from the ICD-9-CM to ICD-10 Data from the Centers for Medicare and Medicaid Services (CMS) (http://www.cms.hhs.gov/ICD10) to determine if a loss of revenue is anticipated
  - MS-DRGs do not map one to one as well as the codes do not map 1:1.
DOCUMENTATION & QUALITY

1. Implement a documentation improvement program within the organization
2. Monitor the documentation on an on-going basis to ensure improvement
3. Identify areas that practitioners still is deficient and needs more assistance
4. As with any type of audit, a report summary should be submitted to senior management

Case Studies
Case Study 1

Preoperative Diagnosis: Bucket-handle tear medial meniscus
Postoperative Diagnosis: **Bucket-handle tear medial meniscus**
Procedure: Arthroscopic partial medial meniscectomy

Indications: This patient is a 17-year old male who tore his **medial meniscus while playing football** at a **high school football** game. The patient is a wide receiver on the team and was tackled resulting in a torn medial meniscus.

Procedure: After induction of general anesthesia, a standard three-portal approach of the knee was evaluated. Mild synovitic changes were noted. The anterior of the medical meniscus had a flap tear which was removed. After all instruments were withdrawn, 4-0 horizontal mattress stitches were used to close the wound and pressure dressings were applied. The patient was awakened and taken to the recovery room in good condition.

Case Study 1

- **ICD-9-CM Codes:**
  - (Procedure) 80.6-Excision of semilunar cartilage of knee (excision of meniscus of knee)
- **Diagnoses:**
  - 717.0 Bucket-handle tear of medial meniscus
  - E849.4-Place for recreation or sport (football field)
  - E00.70-Activity-football (American) Tackle
  - E00.80-Other External Cause Status
Case Study 1

- ICD-10-PCS
  - Must query physician as to which knee is affected cannot code only two choices right knee or left

- Diagnoses:
  - S83.219A--Need to query the physician as to which knee is affected. Can only code **unspecified knee without laterality**
    - S83.211A-right knee
    - S83.212A-left knee
  - W03.xxxA-Tackle in sports
  - Place of Occurrence: Y92.321
  - Status: Y99.8 (other) Recreation or sport not for income (student)

Case Study 2

HPI: Shoulder pain. The patient presents to the ED with **pain**. Occurred suddenly and is now acute. Reports burning pain. Rated as 6/10 in severity right now and 8/10 in severity all the time. This has been ongoing for the past week, but is worse today.


Current Meds: Darvocet N 50 mg

Allergies: Seafood and Amoxicillin


Assessment and Plan: **Pain Joint Shoulder Region.** X-ray shoulder, one view. Prescribe Vicodin for pain and refer to Orthopedic Surgeon for further evaluation.
Case Study 2

- ICD-9-CM Codes:
  - 719.41-Pain joint shoulder region
- ICD-10-CM Codes:
  - M25.211-Pain in right shoulder
  - M25.212-Pain in left shoulder
  - M25.219: Pain In unspecified shoulder
- Need documentation to support laterality

Case Study 3

HISTORY OF PRESENT ILLNESS: Kathryn, a 45-year-old patient who comes in the outpatient clinic for routine follow-up. She has a history of lower extremity deep vein thrombosis in 20xx with subsequent compartment syndrome and fasciotomy. She is on indefinite Coumadin and at this time taking 4 mg daily. She is doing well with no specific complaints. She has had minimal pain 3 on the 0/10 pain scale.

REVIEW OF SYSTEMS: Her diabetes is well controlled. Her fasting blood sugars in the morning have been running 95-110.

PHYSICAL EXAM: GENERAL: Pleasant appearing female in no distress. HEENT: The conjunctiva is pink. Neck is supple. There is no palpable cervical adenopathy, no scleral icterus. CARDIOVASCULAR: Heart had a regular rate and rhythm, with no appreciable murmurs, gallops or rubs. There were no carotid bruits. PULMONARY: Breath sounds were equal bilaterally without crackles or wheezes. EXTREMITIES: Significant fasciotomy scar on her right lateral lower leg. Smaller scar medially. No ankle edema. Her peripheral pulses were strong and intact bilaterally. She had had some numbness of her right toes since the fasciotomy.

LABORATORY DATA: INR by Coagulation Chek in office today was 3.8.

ASSESSMENT AND PLAN: Deep vein thrombosis lower extremity worsening: She will decrease her dose to 3.5 mg daily, as her last three INRs have been elevated. She has a home monitor and emails the results to the office. She will return in 6 months for follow up.
Case Study 3

• **Diagnosis:** Deep vein thrombosis lower extremity worsening and diabetes mellitus

• **ICD-9-CM Coding:**
  – 453.50- Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity

• **ICD-10-CM Choices**
  – I82.501-Chronic embolism and thrombosis of unspecified deep veins of right lower extremity
  – I82-502-Chronic embolism and thrombosis of unspecified deep veins of left lower extremity
  – I82.503-Chronic embolism and thrombosis of unspecified deep veins of lower extremity, bilateral
  – I82-509-Chronic embolism and thrombosis of unspecified deep veins of unspecified lower extremity
  – I82-591-Chronic embolism and thrombosis of other specified deep vein of right lower extremity
  – I82-592-Chronic embolism and thrombosis of other specified deep vein of left lower extremity
  – I82.593-Chronic embolism and thrombosis of other specified deep vein of lower extremity, bilateral
  – I82.599-Chronic embolism and thrombosis of other specified deep vein of unspecified lower extremity
  • **Must query physician for appropriate code**
Case Study 4

• This is a 28 year-old G2 PO, with an estimated delivery date of 3/15/2012 and estimated gestational age of 35 weeks. She presents for induction secondary to gestational DM. The diabetes has been managed well throughout the pregnancy. The patient also has diastasis recti that occurred three weeks ago, which has kept her on bed rest since that time. She was given Pitocin for labor induction and delivered a healthy male 2 hours later.

Case Study 4

• Diagnoses:
  – Gestational DM
  – Diastasis recti
  – Delivery male

• Documentation Missing
  – How gestational DM is controlled
Case Study 4

• Diagnoses:
• O24.42 Gestational DM in childbirth
  – O24.421-Gestational DM in childbirth, diet controlled
  – O24.422-Gestational DM in childbirth, insulin controlled
  – O24.429-Gestational DM in childbirth, unspecified control

• Even though we can report O24.429 for unspecified control the practitioner should be queried.

Case Study 5

This 25 year-old male was admitted as an inpatient through the emergency department after the motorcycle he was driving collided with a deer while driving on State Road 44. The patient was not wearing a helmet and sustained a skull fracture over the left temporal and orbital roof areas with depressed zygomatic arch on the left side. The patient was unconscious in the ED with a GCS score of three. Eyes never open with any verbal response. There was no motor response and the left pupil was fixed and dilated, indicating a cranial injury. Hypoxemia, hypotension, and cerebral edema was noted. The patient was admitted to the ICU with continuous monitoring of percutaneous intracranial pressure. The patient experienced increased periods of apnea and was placed on a ventilator following endotracheal intubation. There has been no improvement in the patient’s status for the past seven days. Brain wave measurement showed no brain wave electrical activity. The decision was made to discontinue life support and the patient expired at 10:40 a.m.
Case Study 5

• Procedure Codes:
  – OBH17EZ-Insertion of device in Trachea (OBH1)
  – 5A1955Z-Performance Respiratory, Greater than 96 consecutive hours
  – 4A103BD-Monitoring, Central Nervous pressure, Intracranial
  – 4A00X4Z-Measurement, Central Nervous, Electrical Activity

Case 5

• Diagnoses:
  – S02.119A-Fracture traumatic skull, temporal bone
  – S02.402A-Fracture traumatic zygoma
  – S06.1x7A-Injury, intracranial cerebral edema, traumatic
  – R40.2312-Coma, with motor response (none)
  – R40.2112-Coma, with opening of eyes (never)
  – R40.2212-Coma, with verbal response (None)
  – V20.4xxA-Accident, transport, motorcyclist, driver (collision (with) animal traffic (Accident, motorcycle NOS-see accident, transport, motorcyclist)
  – Y92.413-Place of occurrence, State Road
  – Y99.8-Status Other
Case Study 6

This is a 58-year old male who presented for outpatient chemotherapy. He had surgery three months ago for lung cancer and is now undergoing chemotherapy with Taxol and carboplatin, including dexamethasone as part of his chemotherapy and prophylaxis for nausea. He had done very well without outpatient chemotherapy. When he presented today for chemotherapy, he was found to be hypoglycemic. He is a known type 2 diabetic complicated by neuropathy and nephropathy. Due to his blood glucose levels, it was decided to postpone chemotherapy and was admitted as an inpatient to control his diabetes. His internist was contacted to assist with managing the diabetes. He has been on 70/30 insulin, 25 units in the morning and 2 units in the evening for approximately four years. An IV insulin drip was started and he also has q 1 hour Accu-Checks. His hepatomegaly has enlarged from his last exam. There is a potential of fatty infiltration due to poor diabetes control or there may be some involvement with metastatic carcinoma.

Case Study 6 (continued)

Lab Data: Sodium 128, potassium 5.5, chloride 89. BUN 1.3, creatinine 0.8, glucose range 30-460 with final glucose of 210. Calcium 9.4, WBC 9.8, hemoglobin 11.6, hematocrit 34.3, platelets 277,000.

Plan: There is a cyclic nature of his chemotherapy treatment regimen that is likely to produce major shifts in his glucose, along with difficulty in DM control. The patient will need to monitor glucose levels closely. He will be discharged tomorrow and will begin 70/30 insulin regimen at 35 units in the morning with 25 units in the evening. He is to continue chemotherapy next week in the hospital outpatient oncology clinic.

Discharge Diagnoses:
1. Carcinoma of the lung, currently undergoing chemotherapy
2. Type 2 diabetes, with neuropathy and nephropathy
3. Hyperlipidemia
Case 6

• ICD-9-CM
  – 250.42 (DM nephropathy, uncontrolled type 2 and nephropathy
  – 250.62-DM neuropathy uncontrolled type 2 and Diabetic neuropathy
  – 272.4 hyperlipidemia
  – V58.67-long term insulin use

• ICD-10-CM
  – E11.649-Type 2 DM with hypoglycemia
  – E11.21-DM with nephropathy
  – E11.40-DM with neuropathy
  – C34.90 unspecified part of lung
    • Need to query physician as to what part of lung is affected; upper middle lobe, lower lobe
  – E78.5 Hyperlipidemia
  – Z79.4-long term insulin use type 2 patient
Report Excerpt

My Medical Practice
ICD-10 Readiness Documentation Audit
March 8, 20xx

Seventy five (75) patient records of various dates-of-service were reviewed on March 8, 20xx reviewing only diagnosis coding to support medical necessity and the conversion from ICD-9-CM to ICD-10-CM. The patient encounters were reviewed to determine if documentation will support the diagnosis code with the ICD-10 conversion.

The percentage of diagnosis code accurately documented for ICD-10-CM is 77%. The percentage of diagnosis codes that are unspecified or unable to code is 23%.

Documentation Issues
1. Chart 1-Diagnosis code 729.5 pain in limb is documented and reported. In ICD-10-CM the codes are selected based on laterality, left, right and bilateral. The provider also reported 727.51 for a synovial cyst of popliteal space and the codes in ICD-10-CM are based on right, left, and unspecified knee.

Recommendation: Make certain documentation specifies laterality in the assessment and plan of care.

Take Away Advice

• Stay positive when educating physicians and don't expect them to become coders
• Computer assisted coding (CAC) and medical transcription systems can help achieve the documentation needed to create ICD-10 codes
• For the Electronic Health Record-algorhythms can help
Tips

• Gather the physicians for a dinner meeting and prepare a 1 hour presentation on the most common diagnoses and what documentation is required with ICD-9 and then with ICD-10 so they can visually see the difference.

• It might be a good idea to create “flash cards” either on 3 x 5 cards or even electronically to assist in documentation. Take the top most common ICD-9-CM codes per specialty, map them to the ICD-10 codes and create flash cards with the additional documentation required.

Tips

• For inpatient service, run a utilization report on the top 20-25 MS-DRG’s or top diagnosis codes and develop education material based on documentation deficiencies. Prepare a report and educate the practitioners in a group setting for 2 hours and invite their practice administrators/managers to attend.

• Meet with individual physicians whose overall percentage of compliance with ICD-10 is lower than 80% to discuss new documentation requirements.

• Monitor documentation on a quarterly basis after the initial base line assessment and continue to educate and train beyond ICD-10 “Go-Live” as part of compliance.
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