ICD-10: ACTION PLAN FOR DOCUMENTATION ASSESSMENTS

INTRODUCTIONS
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Objectives
- Define Documentation Assessment(s)
- Review best practice methods
- Discuss action plan based on results
- Review common areas for ICD-10 documentation challenges
- Discuss the future of documentation and data

What is Clinical Documentation?
“Clinical documentation should be as complete and specific as possible and include information such as level of severity, specificity of anatomical sites involved, and etiology of symptoms.”

- AHIMA Practice Brief: Guidance for Clinical Documentation Improvement Programs

Documentation and ICD-10

Increased Documentation Needs for ICD-10
More Codes
More Specific
More Details
Polling Question

Have you conducted any type of documentation assessments at your facility?
- Yes
- No
- Undecided

What is a Documentation Assessment?

- What is a Doc Assessment?
  - Process that allows review and discovery of documentation issues than may exist for ICD-10
- Why is it Important?
  - Helps define needs specific to your organization

Why Documentation Assessments?

- Challenges continue to grow
- Getting ahead of the documentation curve
- Determination and planning
- Gauge changes in documentation processes needed in ICD-10

What is the Process?

Documentation Assessment Process

- Review of top 25 dx/px codes or MS-DRG
- Assess of the current level of specificity & quality of physician clinical documentation practices
- Determine results/create action plan
  - Provide insight into how ICD-9-CM codes will map to ICD-10-CM/PCS & how changes will affect your current high-volume/dollar cases
  - Provide details on documentation gaps within the organization
  - Provide education for providers, CDI, or coding staff

Documentation Assessment Steps

Step 1:
Run a list of your top diagnoses and procedure codes (MS-DRGS) for review:
- Suggest top 15:25
- Determine reporting timeframe
- Determine report tool to utilize

Step 2:
Analyze data for review selection:
- What areas make sense to review i.e., hypertension?
- What areas are best to focus on?
- Do you have adequate selection of physicians in your organization?
- Narrow down list and potentially add areas that may not be the top but do have documentation challenges for ICD-10
Documentation Assessment Steps

**Step 3:**
Perform the Review
- What diagnoses or procedures have adequate documentation?
- What diagnoses or procedures lacked documentation for coding?
- What nonspecific codes had to be assigned?
- What diagnoses or procedures were not codeable based on lack of documentation?

**ICD-10 Documentation Opportunities**

<table>
<thead>
<tr>
<th>Diagnosis or Procedure Category</th>
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<th># of Documentation Opportunities Identified</th>
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<tr>
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<td>25</td>
<td>10</td>
</tr>
<tr>
<td>Carotid Artery Stenosis</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory Failure</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>Ulcer</td>
<td>22</td>
<td>1</td>
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Documentation Assessment Steps

**Step 4:**
Review Results/Results Reporting
- Review results
- Identify trends
  - Physician
  - Diagnosis
  - Procedure
  - Specific Areas:
    - Laterality
    - Trimester

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**Determine Recommendations**

**ICD-10 Documentation Assessment (53 Records Reviewed)**
- 18 diagnoses lacked detail for specificity in ICD-10 code assignment
- Several records were identified to have potential financial opportunity due to changes in the classification system and related ICD-10-CM Official Guidelines for Coding and Reporting

**Recommendations**
- Create organizational-wide ICD-10 General Awareness Campaign
- Create queries for sutures and debridement
- Perform an additional Clinical Documentation Assessment subsequent to physician/provider education

**Documentation Findings/Challenges**
Documentation Assessment Steps

Step 5: Action Plan
- What will the data be utilized for?
- How can you build this information into education plans?
- Who should be engaged in results?
- Are follow up assessments needed?

Utilize Results
- It is important to utilize your outcome to determine:
  - Additional education opportunities
    - Physicians
    - CDI
    - Coders
  - Process changes
    - New Queries
    - Review of specific areas
    - Engaging CDI

Validate Education
- Important to plan activities that will validate education- Is there follow up needed?

Utilize your Resources

Create Champions:
- Face-to-face physician education
- Integrate documentation education into current practices
- Rework queries/forms
- Develop additional education collateral and printable documents

Considerations

Things to Consider
- What are you going to review?
- When are you going to conduct documentation assessments?
  - During Education and Training
  - Post Education and Training
  - During any Dual/Parallel coding
  - Post ICD-10 Go Live
- Do you include financial outcomes?
- What are you going to do with your outcomes?
Financial Analysis Review Results

- **Sufficient Documentation**: Claim recoded with adequate documentation
- **Insufficient Documentation w/o Impact**: Missing documentation such as laterality, acute/chronic, initial vs. subsequent, etc., but claim able to be recoded
- **Insufficient Documentation w/Impact**: Claim missing documentation needed to assign correct diagnoses and procedures
- **Potential Coding Issues**: Incorrect coding of principal diagnosis and/or procedure codes.

Remember to Communication

- You can not overly communicate
- Use results to communicate needs to physicians, coders, and CDI
  - Posters/Collaterals for awareness
  - E-mail Blasts
  - Organization Newsletters
  - Mailbox Stuffers
  - Organization Webinars
  - ICD-10 Website on Intranet

Some Documentation Challenges

- Diabetes Mellitus
- AMI
- CAD with Angina
- Pregnancy
- Cerebral Infarctions
- Injuries
- Fractures
- Respiratory/Vents
- Drug Underdosing
- ICD-10 PCS
  - Total Hip Replacements
  - Debridements
  - Mechanical Ventilations
  - Incision and Debridement

CAD with Angina

In ICD-10-CM CAD/ASHD is specified to:

- Native heart or transplanted heart and with/without angina pectoris
- Type of vessel (native or bypass graft)
- Bypass grafts are further specified by type of graft (vein/artery & autologous/nonautologous biological)
- Four different specifications for type of angina pectoris (unstable angina, angina pectoris with documented spasm, other forms of angina pectoris, and unspecified angina pectoris)

Cerebral Infarction

Cerebral Infarction: Occlusion & Stenosis of cerebral/precerebral arteries resulting in cerebral infarction

- In ICD-10-CM, cerebral infarctions are specified to general site (precerebral or cerebral)
- Vessel with the infarct (carotid, vertebral, basilar, anterior, cerebellar, middle, posterior or other)
- Underlying cause of the occlusion (embolism, thrombosis, stenosis)
- Laterality (left or right)

163.42 I63.421 Cerebral Infarction due to embolism of right anterior cerebral artery

125.711 I25.711 Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm
Diabetes Mellitus

<table>
<thead>
<tr>
<th>ICD-9 CM</th>
<th>ICD-10 CM</th>
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<tr>
<td>Categories 249-250</td>
<td>Categories E08-E13</td>
</tr>
<tr>
<td>4th and 5th digit identify manifestation, complication, or type</td>
<td>Combination codes used to identify manifestation and complication</td>
</tr>
<tr>
<td>Additional code for manifestation</td>
<td>Type of diabetes is separated by categories in ICD-10 (E10 Type 1, E11 Type 2)</td>
</tr>
<tr>
<td>Additional code for insulin dependency V58.67</td>
<td>279.4 used for long term insulin use</td>
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Addition code for manifestation

Drug induced is classified to E09 if it is an adverse effect; if caused by drug poisoning, the drug is coded first with E09 as secondary diagnosis

Inadequately controlled, poorly controlled, out of control are assigned to diabetes by type with hyperglycemia

Myocardial Infarctions

ICD-10-CM Myocardial Infarction

New duration for an "acute" myocardial infarction will be changed from 8 weeks in ICD-9-CM to 4 weeks in ICD-10-CM

Initial vs. Subsequent

- New codes for "subsequent" AMI within 4 weeks of AMI
- Official Coding Guideline: A code from category I22, Subsequent ST elevation (STEMI) and non ST elevation (NSTEMI) myocardial infarction, is to be used when a patient who has suffered an AMI has a new AMI within the 4 week time frame of the initial AMI. A code from category I21. The sequencing of the I22 and I21 codes depends on the circumstances of the encounter.

Myocardial Infarction

Also further specified by:
- Type (STEMI or NSTEMI)
- Site (anterior wall, interior wall, other sites or unspecified)
- Specific artery involved based on site (left main coronary, left anterior descending, other coronary artery, right coronary artery, other left circumflex, other sites, unspecified)

I21.02 ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery

I21.09 ST elevation (STEMI) myocardial infarction involving other coronary artery of anterior wall

ICD-10-CM Pregnancy/Obstetrics

The episode of care is no longer a secondary axis (post partum, ante partum, delivered) instead ICD-10-CM codes are identified by the trimester in which the condition occurred

The trimesters are classified as follows:

- The first trimester less than 14 weeks
- Second trimester 14 weeks to less than 28 weeks
- Third trimester 28 weeks to delivery

Certain codes are further classified with a seventh character extension to identify the fetus in a multiple gestation that is affected by the condition being coded

I26.120 Preterm labor second trimester with preterm delivery third trimester, singleton gestation (fetus identification is not applicable in this case = 7th character of 0)

Injuries & Traumatic Fractures

- Requires documentation of specific anatomical site
- Laterality may be necessary depending on site
- Requires documentation of the type of fracture; displaced or nondisplaced (Displaced is the default if not specified)
- Requires episode of care: initial, subsequent or sequela
**Excisional Debridements**

**Documentation Needed:**
- The type of debridement (i.e. excisional, non-excisional)
- Exact body part
- Deepest layer debrided
- Laterality of the procedure
- In ICD-10-PCS excisional debridement is coded to the root operation "excision" of the specific body part. The skin is no longer combined with subcutaneous tissue when specifying body part.

0HBMXZX: Excision of Right Foot Skin, External Approach
0JBC0ZX: Excision of Pelvic Region Subcutaneous Tissue and Fascia, Open Approach

**Incision and Drainage**

**ICD-9-CM**
- 86.04 Other incision with drainage of skin and subcutaneous tissue
  - Doesn’t differentiate between skin or subcutaneous tissue
  - Doesn’t specify site (e.g. scalp, left arm, buttock, abdomen)

**ICD-10-PCS**
- 0H96X0Z Drainage of Back Skin with Drainage Device, External Approach
- 0H96XZZ Drainage of Back Skin, External Approach
  - Plus 264 other codes specifying location (e.g. Left upper extremity, elbow, abdomen, genitalia, etc.), depth (e.g. skin or subcutaneous tissue) approach (e.g. external, open, percutaneous, percutaneous endoscopic), and drainage device.

**Joint Replacements**

- Joint replacements are classified to upper and lower replacements:
  - Upper joints are those joints above the diaphragm
  - Lower joints are below the diaphragm
- The type of implant used (i.e. ceramic on ceramic, ceramic on polyethylene, metal on metal, metal on polyethylene) will need to be documented
- There is also specificity related to cemented or uncemented prosthetic device
- Documentation of material utilized in the replacement

**Mechanical Ventilation**

- Mechanical ventilation is separated by:
  - less than 24 hours,
  - 24 – 96 consecutive hours and
  - greater than 96 hours
- No longer an unspecified option as to duration of mechanical ventilation

SA195Z2, Respiratory Ventilation Greater than 96 Consecutive Hours
Right hip replacement with cement and metal on polyethylene is classified to code 0SR9029.

The Future…..

- Factors affecting the need for accurate documentation
  - Pay for Performance
  - Value Based Purchasing
  - Core Measures

Readmission Reduction – Key Documentation & Coding

- Complete documentation & coding of secondary conditions for risk adjustment regardless of MCC/CC status
- Accurate assignment of discharge disposition and admission source for acute care hospital transfers

Clinical Process Measures
- Correct assignment of principal diagnosis – AMI, PNA, HF

Outcome Measures
- Complete documentation & coding of secondary conditions for risk adjustment regardless of MCC/CC status
- Accurate documentation & coding of complications
- Accurate documentation & assignment of present on admission (POA) indicator

Multi-Disciplinary Approach

- Clinical Documentation Improvement (CDI) establishes partnership of informal education between CDI Specialists, HIM Professional Coders and Clinical Providers for improved data capture and reporting
- The engagement of all Clinical Providers and exchange of clinical documentation between CDI Specialist and HIM Professional Coders can be a powerful mechanism for performance improvement on quality measures
- Facilities Need to Recognize the Value of a Collaborative Team Approach
- Pay for Performance is Here to Stay
IN SUMMARY

Documentation....Getting it Right!

Delivery of Patient Care (Clinical)

+ Appropriate/Timely Documentation

Accurate Medical Coding (ICD-9 or ICD-10)

All the Right Reasons......

- Reported data is studied & trended
  - Benchmark and assist in improving quality of patient care
  - Improve clinical protocols
  - Develop evidence-based medical practices
  - Provide risk adjustment/severity of illness stratifications
  - Current reimbursement
  - Basis for developing future CMS reimbursement programs

In Summary......

A multi-disciplinary approach for achieving the best quality of clinical data produced by the assignment of the most specific ICD-10 codes based upon complete and accurate clinical documentation will have far-reaching effects within healthcare organizations as well as the entire healthcare delivery system.

QUESTIONS???
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