ICD-10-CM Coding and Documentation

Adult Day Health Care Council

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Presented by:

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Previously, Karen was the Medical Record Administrator, HIPAA Privacy and Security Officer, and EMR System Administrator at Van Duyn Home and Hospital, a 513-bed skilled nursing facility in Syracuse, NY.

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Objectives:

• Review the recent legislative delay
• Review differences between ICD-9 and ICD-10
• Review 2014 coding guidelines
• Review current documentation practices and how coding is affected
• Review common diagnoses within the adult day health care arena and identify how we can improve our documentation
• Review the process for completing organization-specific gap analysis for coding and related documentation

Current Status

• On April 1, 2014, H.R. 4302, the Protecting Access to Medicare Act of 2014 was signed into law.
• This bill delays ICD-10-CM/PCS implementation until at least October 1, 2015. This was done after legislators rushed the bill through both the US House of Representatives and Senate.
Reasons for changeover to from ICD-9-CM to ICD-10-CM

• ICD-9-CM is a 30 year old system
  – Antiquated
  – Most of the rest of the world already using ICD-10
  – Running out of categories
  – Need for more specificity
  – HIPAA Compliance

From CMS: ICD-10 Overview

Benefits and Opportunities of ICD-10-CM

• Measuring the quality, safety, and efficacy of care;
• Reducing the need for attachments to explain the patient’s condition;
• Designing payment systems and processing claims for reimbursement;
• Conducting research, epidemiological studies, and clinical trials;
• Setting health policy;
• Operational and strategic planning;
• Designing health care delivery systems;
• Monitoring resource use;
• Improving clinical, financial, and administrative performance;
• Preventing and detecting health care fraud and abuse; and
• Tracking public health and risks.
Varying changes by Clinical Areas

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractures</td>
<td>747</td>
<td>17099</td>
</tr>
<tr>
<td>Poisonings and Toxic Effects</td>
<td>244</td>
<td>4662</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>292</td>
<td>574</td>
</tr>
<tr>
<td>Diabetes</td>
<td>69</td>
<td>239</td>
</tr>
<tr>
<td>Bleeding Disorders</td>
<td>26</td>
<td>29</td>
</tr>
<tr>
<td>Mood related Disorders</td>
<td>78</td>
<td>71</td>
</tr>
<tr>
<td>Hypertensive Disease</td>
<td>33</td>
<td>14</td>
</tr>
</tbody>
</table>

Source: CMS ICD-10 Clinical Documentation

Example: Reason for changeover to ICD-10-CM

- Fracture of wrist
  - ICD-9-CM coding
    - Patient fractures left wrist. And month later, fractures right wrist
    - ICD-9-CM does not identify left versus right –requires additional documentation
  - ICD-10-CM coding describes
    - Left versus right
    - Initial encounter, subsequent encounter
    - Routine healing, delayed healing, nonunion, or malunion

- There are 2466 codes for fracture of femur alone

From CMS: ICD-10 Overview
Structural Changes in ICD-10-CM

ICD-9-CM Code Format

- Category
- Etiology, anatomic site, manifestation

ICD-10-CM Code Format

- Category
- Etiology, anatomic site, severity
- Extension

From AHIMA:
ICD-10-CM Primer

ICD-10-CM Diagnoses Codes

- Are 3–7 digits;
- Digit 1 is alpha;
- Digit 2 is numeric;
- Digits 3–7 are alpha or numeric (alpha characters are not case sensitive); and
- A decimal is used after the third character.

Examples:
- A78 – Q fever;
- A69.21 – Meningitis due to Lyme disease; and
- S52.131A – Displaced fracture of neck of right radius, initial encounter for closed fracture.
New Features within ICD-10-CM

• **Laterality (Left, Right, Bilateral)**
  – C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast;
  – H16.013 – Central corneal ulcer, bilateral; and
  – L89.012 – Pressure ulcer of right elbow, stage II.

• **Combination Codes For Certain Conditions and Common Associated Symptoms and Manifestations**
  – K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding;
  – E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema; and

Exclusion Notes

• **Excludes 1** – Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).
  – Example: **Q03** – Congenital hydrocephalus.
    • Excludes 1: Acquired hydrocephalus (G91.-).

• **Excludes 2** – Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions).
  – Example: **L27.2** – Dermatitis due to ingested food.
    • Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)...
Where to begin for coding purposes

• Identify the current “coders”
• Start identifying common diagnoses for your organization
• Review how the diagnoses are currently documented
• Identify missing documentation that could cause difficulty with code assignment

Diabetes Mellitus (E08–E13)

Three types of diabetes: Type 1, Type 2, and secondary
• Coding guideline C.4.a states: “Assign as many codes as needed to describe all complications of disease”
• Coding guideline C.4.a.1 states: “Diabetes not mentioned as Type 1 or Type 2, will be coded as E11.- Type 2”
• Coding guideline C.4.a.3 states: “If documentation does mention type and insulin is used, code as E11.-, Type 2 diabetes”
Type 2 Diabetes

- E11.2- Type 2 Diabetes with kidney complications
  - E11.21 Type 2 Diabetes with diabetic nephropathy
  - E11.22 Type 2 Diabetes with chronic renal kidney disease
    » Use additional code to identify stage of chronic kidney disease (N18.1-N18.6)
- E11.3- Type 2 Diabetes with ophthalmic complications
- E11.4- Type 2 Diabetes with neurological complications
- E11.5- Type 2 Diabetes with circulatory complications

Z79.4: Long-Term Use of Insulin

- Need to develop program-specific guidelines as to when to code long-term use of insulin
- Use of insulin is inherent in coding of E10.-, Type 1 diabetes; however, coding Z79.4 will help with data queries
- Patients with Type 2 diabetes may routinely require insulin, so code Z79.4, long-term (current) use of insulin, should be considered
- Generally, code long-term care drug use if over 1 month and expected to be renewed
Diabetes Mellitus—Documentation Concerns

• Who is documenting diabetes and how?
• Are you getting complete documentation from referring providers?
• Form(s) prompt staff to document Type 1 or Type 2?
• Form(s) prompt staff to list all diabetes-related complications?

Hypertension (I10–I15)

• Hypertension is coded to I10 when it is not complicated
  – Hypertensive heart disease (I11.-): Physician must indicate causal relationship
  – Hypertensive chronic kidney disease (I12.-): ICD-10 assumes causal relationship automatically
• Transient hypertension is coded to R03.0, elevated blood pressure without diagnosis of hypertension, when a definitive diagnosis of hypertension has not been made
Myocardial Infarctions (I21–I24)

- Myocardial infarction is considered acute if less than 4 weeks from time of onset (reference: coding guideline C.6.e.1)
  - Residents admitted within 4 weeks of onset for continual treatment should be coded as acute
  - Residents admitted after 4 weeks of onset for continual treatment should be coded with appropriate aftercare code
- Subsequent myocardial infarctions are coded as I22.
- Healed or old MIs no requiring treatment are coded as I25.2

Circulatory Disorder—Documentation Concerns

- Form(s) indicate site of myocardial infarction(s)?
- Form(s) indicate age of myocardial infarction(s)?
- Form(s) differentiate between high blood pressure readings and confirmed diagnosis of hypertension?
- Form(s) indicate hypertension and related complications?
Cerebrovascular Disorders (I60–I68)

- Care must be used to distinguish between a new or current cerebrovascular event (I60–I68) from a previous event (I69.-)
- Terms “stroke” or “CVA” should be further specified to indicate a hemorrhage, infarction, thrombosis, embolism, occlusion, or stenosis
- Current stroke or CVA would be coded to I63.9, cerebral infarction, unspecified

CVA With Residuals (I69.-)/Previous CVA

- ICD-10 removes the definitive time frame for a condition to be considered a late effect of a condition
- Previous CVA with residuals treated at a different level of care should be coded as CVA with residuals upon admission
- I69 delineates the cause of the previous event (hemorrhage versus infarction, or unspecified)
- Z86.73 = history of TIA and cerebral infarction without residual deficits
Neurological Deficits: Dominant/Nondominant Side

Coding guideline C.6.a states:

- “Should the affected side be documented, but not specified as dominant or nondominant, and the classification system does not indicate a default, code selection is as follows:
  - For ambidextrous patients, the default should be dominant
  - If the left side is affected, the default is non-dominant
  - If the right side is affected, the default is dominant”

<table>
<thead>
<tr>
<th></th>
<th>Hemiplegia on Left Side</th>
<th>Hemiplegia on Right Side</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident &quot;eats&quot; with left hand</td>
<td>Code as Left Dominant</td>
<td>Code as Right Non-Dominant</td>
</tr>
<tr>
<td>Resident &quot;eats&quot; with right hand</td>
<td>Code as Left Non-Dominant</td>
<td>Code as Right Dominant</td>
</tr>
<tr>
<td>Resident is identified as being &quot;ambidexterous&quot;</td>
<td>Code as Left Dominant</td>
<td>Code as Right Dominant</td>
</tr>
<tr>
<td>Documentation not available identifying which hand resident previously or currently eats with</td>
<td>Code as Left Non-Dominant</td>
<td>Code as Right Dominant</td>
</tr>
</tbody>
</table>

Cerebrovascular Disorders—Documentation Concerns

- Form(s) prompt documentation of all residuals from previous stroke?
- Form(s) allow for collection of previous stroke or TIA without residuals?
- Form(s) indicate dominant or non-dominant side when neuromuscular deficits are present?
Osteoarthritis (M15-M19)

- Primary axis for osteoarthritis
  - Site—whether it involves multiple sites (M15.-, Osteoarthritis) or single joints (M16.- for hips and M17.- for knee)
- Bilateral involvement of single joint is coded to categories M16-M19.
- Codes further specify whether osteoarthritis is primary or secondary (post-traumatic).

Gait Abnormality (R26.-)

- Has been expanded to include:
  - Ataxia R26.0
  - Falling R29.6
  - Paralytic R26.1
  - Spastic R26.1
  - Staggering R26.0
  - Unsteadiness R26.81
  - Walking Difficulty R26.2
Miscellaneous Z-Codes

• Program-specific coding guidelines must indicate when and if the following codes will be used:
  – Do not resuscitate status (Z66)
  – Carrier of infectious diseases (Z22.-)
  – Personal history of neoplasm (Z85.-)
  – Long-term (current) drug use (Z79.-)
  – Acquired absence of limb (Z89.-)
  – Acquired absence of organ (Z90.-)
  – History of falling (Z79.81)
  – Artificial opening status (Z93.-)

Miscellaneous Z-Codes (cont.)

• Program-specific coding guidelines must indicate when and if the following codes will be used:
  – Transplanted organ and tissue status (Z94.-)
  – Presence of cardiac and vascular implants (Z95.-)
  – Presence of other functional implants (Z96.-)
  – Presence of other devices (Z97.-)
Where to begin for coding purposes

- Identify the current “coders”
  - Verify access to coding guidelines
- Start identifying common diagnoses for your program
- Review how the diagnoses are currently documented
  - Where is the documentation obtained from now?
  - How and where is the diagnosis used?
- Identify missing documentation that could cause difficulty with code assignment

Next Steps

- Review the 2014 ICD-10-CM coding guidelines by chapter
- Determine if your program is affected by coding guidelines and how
- Identify top 10–15 most common diagnoses at your program
- Determine common diagnoses affected by coding guidelines and how
- Review ICD-9-CM codes for common diagnoses
- Determine if facility is coding common diagnoses to “unspecified category” in ICD-9
- Review ICD-10-CM codes for common diagnoses
- Determine if ICD-10 codes allow for greater specificity than currently coded
More Information/Resources

- CMS
- CDC
  - General ICD-10-CM information [http://www.cdc.gov/nchs/icd/icd10cm.htm](http://www.cdc.gov/nchs/icd/icd10cm.htm)
- AHIMA
  - ICD-10 General Information [http://www.ahima.org/icd10](http://www.ahima.org/icd10)