

# ICD-10 Taskforce Bulletin

A Newsletter from the NCHICA ICD-10 Taskforce

November 2011, No. 1

## Clinical Documentation Challenges with ICD-10-CM

**Golden Rule:** If it's not documented by the physician/provider, it did not happen; therefore, it cannot be coded or billed.

**Objective:** To ensure medical record documentation is documented to the fullest extent possible in order to support the greater specificity afforded in the ICD-10-CM (Clinical Modification) code sets.

With the transition to ICD-10-CM, some documentation issues will require physicians/providers to capture new information; others involve updated, modified and otherwise expanded documentation needs.

ICD-10-CM contains multiple combination codes so the documentation must reflect the association between conditions. For example, ICD-10-CM code K50.814 designates "Crohn's disease of both small and large intestine *with abscess*." The ICD-9-CM equivalent codes would be "555.2 – Regional enteritis, small intestine with large intestine" and "569.5 – Abscess of intestine."

In addition, laterality needs to be documented. For example, ICD-10-CM code M05.271 designates "Rheumatoid vasculitis with rheumatoid arthritis of *right* ankle and foot." The ICD-9-CM equivalent code would be "714.27 – Rheumatoid arthritis with visceral or systemic involvement, ankle and foot."

The following are some of the potential problem areas related to insufficient documentation that physicians/providers need to be aware of so the level of specificity required in the clinical documentation can be better understood:

**Diabetes Mellitus** - ICD-9-CM features 59 codes for diabetes, while ICD-10-CM offers more than 200 codes. The expanded diabetes code set has added a provision of "poorly controlled" to the categories of controlled or not controlled and there are multiple combination codes (e.g., ICD-10-CM code E09.11 designates "Type 1 diabetes mellitus with ketoacidosis with coma").

**Injuries** - ICD-10-CM features an expanded category for injuries. A seventh character extension identifies the encounter type:

- "A" for the initial encounter,
- "D" for the subsequent encounter for fracture with routine healing,
- "G" for subsequent encounter for fracture with delayed healing, and
- "S" for sequela of fracture.

Coding professionals will also need to code the size and depth of the injury under ICD-10-CM which may not be captured in physician documentation. In addition to coding the type of injury, the cause of the injury should be documented and coded as well.

**Drug Under-dosing** – Under-dosing is a new code in ICD-10-CM. It identifies situations in which a patient has taken less of a medication than prescribed by the physician.

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**RED ALERT  
COUNTDOWN**  
**679 Days**  
(As of November 21, 2011)

### ICD-10-CM Training

**Charlotte AHEC ICD-10-CM Training and Implementation Issues for the Provider Office**  
November 30, 2011

<http://my.ncahec.net/education.php?d=a>

**Southeast AHEC ICD-10 Steps to Prepare Your Office**  
December 6, 2011

<http://my.ncahec.net/education.php?d=a>

**NCCHCA's ICD-10 Training**

January 26, 2012

<https://m360.ncchca.org/calendar.aspx>

**North Carolina schools that offer ICD-10 training**

<http://www.nchima.org/services/services.html>

**AHIMA ICD-10 Distance Learning** (Membership not required for classes)

<http://www.ahima.org/continuinged/campus/default.aspx>

### **\*\*ICD-10 Reminders\*\***

**As of October 1, 2013:**

- **ALL** claims will use **ICD-10-CM** diagnosis codes.
- **ICD-10-PCS** will be used for inpatient hospital claims **ONLY**.
- **CPT** code usage will be unaffected.

### **Drug Under-dosing (continued)**

- The medical condition is sequenced first.
- The under-dosing code is listed as a secondary diagnosis.
- The additional code explains why the patient is not taking the medication (e.g., financial reasons). Since this is new, many physicians will not be in the habit of documenting a patient's reasons for under-dosing in the record.

### **Cerebral Infarctions**

- Late effects of stroke are differentiated by type of stroke.
- Combination codes for common etiologies/manifestations are included (e.g., ICD-10-CM code I63.012 designates "cerebral infarction due to thrombosis of left vertebral artery").

### **Acute Myocardial Infarction (AMI)**

- Age definition for AMI has changed to four weeks rather than eight weeks.
- New categories for subsequent AMI and for complications within 28 days of AMI.
- Different terminology is used and laterality is included (e.g., I21.02 designates "ST segment elevation myocardial infarction [STEMI] involving left anterior descending coronary artery").

### **Musculoskeletal Conditions**

ICD-10-CM includes more diagnosis codes related to musculoskeletal conditions. For example, there are eight codes for pathologic fractures in ICD-9-CM, but in ICD-10-CM there are more than 150 codes.

### **Pregnancy**

- Documentation of trimester now required.
  - Counted from first day of last menstrual period.
  - Must document number of weeks.
  - Episodes of care have been deleted.
  - For example, ICD-10-CM code of O15.03 designates "eclampsia in pregnancy, third trimester."
- Obstructed labor codes incorporate reason for the obstruction and code extensions are used to identify specific fetus (1-5) affected by obstetric condition (e.g., ICD-10-CM code O64.1xx2 designates "obstructed labor due to breech presentation, fetus 2").

### **Respiratory/Vents**

Some codes require time frames attached to them, such as the respiratory/ventilator codes, which note if a patient has been on a ventilator for less than 24 consecutive hours, 24-96 consecutive hours, or greater than 96 hours.

**NOTE:** Unspecified codes are still available since there are times when even the clinician does not have the information necessary about the disease process in order to assign a more specific code. But the goal is to ensure the medical record documentation is as comprehensive as it can be to support the greater specificity in the ICD-10-CM code sets to the absolute extent possible. When the specificity is greater, there should be a reduction in payment denials and requests for additional information from payers.

### **What can be done NOW to prepare physicians/providers for the changes that will occur when ICD-10-CM is implemented?**

- Perform Clinical Documentation Assessments. This can involve evaluating samples of various types of medical records to determine whether the documentation supports the level of detail found in ICD-10-CM.
- Documentation improvement strategies can be implemented to address areas where documentation is found to be lacking.
- Designate a physician/provider champion to assist in clinical documentation education and promote the positive aspects of moving to ICD-10-CM.

For tips on talking to your vendor, please see the CMS publication:

#### ***Talking to Your Vendors about ICD-10 and Version 5010: Tips for Medical Practices***

<http://www.cms.gov/ICD10/Downloads/ICD10TalkingtoVendorforMedicalPractices20100409.pdf>

*Content provided by the NCHICA ICD-10 Taskforce. For more information on ICD-10 and to read past Bulletins, visit <http://www.nchica.org/HIPAAResources/icd10.htm>.*