FAMILY AND INTERNAL MEDICINE

Payers and Providers Partnering for Success

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IMPORTANCE OF DOCUMENTATION

- A significant portion of practice revenues, however, can be attributed to E&M services.
- Neglecting the proper documentation and coding of encounters is a common and costly mistake.
- If the coding for a service is incorrect at the outset, payment may be delayed, reduced, or not forthcoming at all.
- You also stand to increase revenues by learning to code correctly because as often as not, coding errors are "undercode" versus "overcode.“

CHANGES FROM ICD-9 TO ICD-10

- ICD-9-CM codes don't specify laterality.
- In ICD-9-CM, coders are used to V codes and E codes.
- The current V codes will become Z codes in ICD-10-CM.
- The E codes used in ICD-9-CM will fall within the S00-Y99.9 codes in ICD-10-CM.
- ICD-10-CM now captures the side and specific bone or joint.

ICD-10-CM

ICD-10 STRUCTURE & CONTENT

- ICD-10 diagnosis codes have between 3 and 7 characters
- Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of any or all of the 4th, 5th and 6th characters
- Digits 4-6 provide greater detail of etiology, anatomical site and severity
- A code using only the first three digits is to be used only if it is not further subdivided.
- Overall changes with ICD-10-CM:
  - Location
  - Laterality
  - Severity

VARYING CHANGES BY CLINICAL AREAS

Clinical Area	ICD-9 Code	ICD-10 Codes
Fracture's	747	17099
Poisoning and Toxic effects	244	4662
Pregnancy related conditions	1104	2155
Brain Injury	292	574
Diabetes	69	239
Migraine	40	44
Bleeding disorders	26	29
Mood related disorders	78	71
Hypertensive Disease	33	14
End stage renal disease	11	5
Chronic respiratory failure	7	4

ICD-10 BILLING AND CODING

- If you are a provider, then you will need to understand how ICD-10 requires specific documentation that differs from what was sufficient for ICD-9.

- If you are a coder, you must know how to translate the clinical information from the operative report into the ICD-10 system. One incorrect character and your entire claim will be undermined.

- When ICD-9 becomes ICD-10, your fracture codes explode with ultra specific options, meaning providers have to document extensive details to ensure the right diagnosis.

ICD-10-CM EXAMPLE OF REVISED CLASSIFICATION

- Hypertension is no longer classified by type- benign, malignant or unspecified
- ICD-10 classifies hypertension as Essential (primary).
- The following are the available categories for hypertensive conditions in ICD-10-CM. In some cases you may need to note if heart failure is present (e.g., I11) and the type of heart failure.
  - I10, Essential (primary) hypertension
  - I11, Hypertensive heart disease
  - I12, Hypertensive chronic kidney disease
  - I13, Hypertensive heart and chronic kidney disease
  - I15, Secondary hypertension
- I10 is used when hypertension is not further specified/associated with/caused by another disease process such as chronic kidney disease.
- Gestational hypertension is assigned OB chapter codes O13.- or O14.-

CLINICAL IMPACTS

CLINICAL DOCUMENTATION IMPACTS

- Quality clinical documentation is essential for communicating the intent of an encounter, confirming medical necessity, and providing detail to support ICD-10 code selection.
- Identifying the affected side is important, as some payers will not reimburse claims with “unspecified” codes.
- ICD-10-CM contains multiple combination codes so the documentation must reflect the association between conditions.
- Children’s conditions differ from those of adults therefore, accurate documentation of pediatric conditions is important for proper coding.
    - The accuracy of pediatric clinical documentation can have a great impact on many factors of children’s healthcare.

WITH ICD-10, APPROPRIATE CLINICAL DOCUMENTATION CAN

- Enhance communication and collaboration among providers and between physician and patient by filling in the gaps in treatment and care.
- Provide an accurate representation of the severity and complexity of a patients illness.
- Improve the quality of patient care, the patient care experience and strengthen the doctor-patient relationship.
- Connect the pieces of the medical record together for problems, assessments, procedures and treatments.
- Support and supplement provider documentation.
- Help substantiate the level of specificity required within ICD-10.
- Provides basis for specific services we provide.

ICD-10-CM EXAMPLES OF DOCUMENTATION SPECIFICITY

- New codes identifying abnormal findings separating routine preventative exams from exams that were clinically necessary for further investigation and assessment:

  Z00.121-Ecounter for routine child health examination with abnormal findings

  Z01.01-Encounter for examination of eyes and vision with abnormal findings

  Z01.31-Encounter for examination of blood pressure with abnormal findings

  Z01.411-Encounter for gynecological examination (general) (routine) with abnormal findings

- Chronic conditions (i.e. asthma, bronchitis, etc.) requires that any related tobacco use, abuse, dependence, past history or smoke exposure (e.g., second hand) be reported.

- More specific documentation regarding laterality and anatomical location is required to identify site for medicated dressings, splints, etc.

- Hearing loss is identified by laterality, rather than the location of the affected ear, delineate if hearing is different in both ears.

- Alzheimer's disease is distinguished as early onset or late onset

ICD-10 CLINICAL DOCUMENTATION IMPACTS

- Onset of care
- Etiology and Manifestation
- Anatomical site specificity
- Complications
- Laterality
- Combination Codes
- Disease severity
- Non-specific/unspecified

DOCUMENTATION REQUIREMENTS

DOCUMENTATION CRITERIA – PHYSICIAN AND STAFF

- The physician, must take time to learn how to code; you should not solely rely on delegating the task to others.
- Work that is done must be justified by the patient's diagnoses.
- Do not refer to diagnoses from a prior progress note, etc…
- When diagnosing a patients condition make sure you evaluate each condition and not just list it
- The medical record should be complete and legible and encounter should include the following:
  - Reason for the encounter and relevant history, physical examination findings and prior diagnostic test results
  - Assessment, clinical impression or diagnosis
  - Plan for care
  - Date and legible identity of the observer.

DOCUMENTATION CRITERIA – PHYSICIAN AND STAFF

- All progress notes **must** be signed by the provider rendering the services and included with signature should be the providers credentials (stamped signatures are no longer acceptable since 1/2009).

- EMR notes must have the following wording as part of the signature and note must be closed to all changes:
  - Electronically signed
  - Authenticated by
  - Signed by
  - Validated by
  - Approved by
  - Sealed by

- Any changes that are to be made to a closed encounter can be added as a separate addendum to the DOS, but must be done in a timely manner.

DOCUMENTING DIABETES (E08-E13)

- Documentation should be consistent with current practices
- State if hypoglycemia results in coma
- Identify when diabetes is accompanied by hyperglycemia or hypoglycemia
- ICD-10 no longer includes the concept of “Uncontrolled”
- ICD-10-CM codes for diabetes are combination codes that include the etiology and the manifestations
- In ICD-10 diabetes include notes appear at the beginning of a category
- The “Excludes1” note meaning “Not coded here” appears under all the diabetes categories

DOCUMENTING DIABETES (E08-E13) (cont.)

- Documentation and coding will need to include the following:
  - Type or cause of diabetes
    - Type 1 or 2
    - Due to drugs or chemicals
    - Due to underlying condition
    - Other specified diabetes
  - Any complications or manifestations
  - Current treatment

- If there are complications/manifestations of the diabetes, additional details may be necessary for specific complications such as:
  - Arthropathy
  - Site of ulcer
  - Severity of retinopathy
  - With/without macular edema
  - Stage of CKD
  - Gangrene
  - Hypoglycemia

DOCUMENTING DEPRESSION (F32)

- Depression is classified as “major” and categorized as:
  - Within a single episode
  - Recurrent
- Delineates mild, moderate and severe with or without psychotic features
- If relevant, list any late effects or current injuries related to past events (e.g., fall from dizziness secondary to lithium level)
- If patient is not formally diagnosed, consider using a signs or symptom code, such as:
  - R45.2 Unhappiness
  - R45.3 Demoralization and apathy
  - R45.4 Irritability and anger
  - R45.7 State of emotional shock and stress, unspecified
  - O90.6 Postpartum mood disturbance (for postpartum blues, pospartum dysphoria, postpartum sadness)
- List any alcohol or drug use, abuse or dependence

DOCUMENTING PAIN

- State the acuity (i.e., acute or chronic).
- Identify the cause (e.g., trauma).
- Detail the following when patients are admitted for pain management or control
  - Psychological pain
  - The site of the pain
- For back pain
  - Specify the site (e.g., low back, thoracic, cervical, etc.)
  - State the laterality when applicable (i.e., right, left or bilateral)
- Identify the underlying cause of the pain.
- Differentiate between panniculitis and radiculopathy.
- Detail when lumbago is accompanied by sciatica.

DOCUMENTING VACCINATIONS (Z23)

- ICD-10 no longer includes codes specific to the type of vaccine, only an encounter for immunization
- When coding a vaccination you must first code the routine examination
- Documentation is still required for the specific vaccine in order to assign the appropriate procedure code
- If a vaccination is not carried out, note the reason such as:
  - Compromised condition of patient
  - Patient refusal
  - Parent/caregiver refusal
- When a vaccination is not carried code from category Z28

DOCUMENTING ASTHMA (J45)

- Describe the severity as mild intermittent, mild persistent or moderate persistent etc…
- List the frequency as intermittent or persistent
- Note if there is an exacerbation, and whether or not it is uncomplicated, acute or status asthmaticus
- Detail external forces that will assist in establishing a cause and effect relationship (e.g., asthma due to dusts, exercise-induced bronchospasm, allergic rhinitis with asthma, etc.)
- Include any exposure to tobacco smoke
- ICD-10-CM terminology used to describe asthma has been updated to reflect the current clinical classification system. The terms intrinsic and extrinsic are no longer used.

DOCUMENTING OSTEOPOROSIS (M80-M81)

- Indicate the presence or absence of current pathological fractures.
- Identify the current fracture site.
- Specify the healing status of the current fracture (e.g., routine, delayed, nonunion, malunion).
- Detail any past history of healed osteoporosis fractures.
- Provide information regarding the encounter type (e.g., subsequent, sequela).
- Clarify the cause (e.g., age-related, drug-induced, post-traumatic). If drug-induced list the specific drug.
- Report any major osseous defect.

DOCUMENTING ARTHROPATHIES AND POLYARTHROPATHIES (M00-M99)

- Identify the anatomical site(s) affected and the laterality for each site with as much detail as possible.

- Choices for the anatomical site(s) include
  - Shoulder
  - Elbow
  - Wrist
  - Hand
  - Hip
  - Knee
  - Ankle and foot
  - Vertebrae
  - Multiple joints

- Describe any underlying disease or condition present.

DOCUMENTING THYROID DISEASES (E00-E89)

- Indicate any iodine deficiencies
- Detail the type of congenital iodine-deficiency syndrome
  - Neurological
  - Myxedematous
  - Mixed
- State the type of goiter associated with iodine-deficiency thyroid disorders
- Detail the type of hypothyroidism list the presence or absence of a diffuse goiter
- Report any post-surgical hypothyroidism
- Specify the presence or absence of a thyrotoxic crisis, storm, or goiter with hyperthyroidism
- List the acuity of thyroiditis as acute, subacute or chronic.

DOCUMENTATION CHANGES & NEW CONCEPTS

DOCUMENTATION CHANGES

- It is vital for physicians, nurses, and coders to work together to create an environment of increased accuracy.
- With the increased number and specificity of codes under ICD-10, physicians are going to have to be more specific in their patient encounter documentation to provide the coders the best opportunity to choose the most correct codes for the most appropriate reimbursement.
- Physicians and other clinicians likely already note laterality when evaluating the clinically pertinent anatomical site(s).
- Physicians will be judged on documentation more critically in ICD-10.

WOUND CARE SPECIFIC DEBRIDEMENT

- Debridement descriptors have increased and require descriptive documentation
  - Condition requiring debridement (e.g., ulcer, fracture)
  - Type of debridement (e.g., excisional, non-excisional, hydro, dressing)
  - Location, size and characteristics of the wound
  - Depth of the wound debrided
  - Specific type of tissue removed (e.g., skin, muscle)
  - Instruments used to remove tissue (e.g., scalpel, scissors)
  - Patient tolerance
  - Dressing applied and treatment plan

PRESSURE ULCER

- Includes:
  - Bed sores
  - Decubitus ulcer
  - Plaster ulcer
  - Pressure sores
- Underlying condition must be captured by the physician
- Details of ‘healing’ pressure ulcers can be captured from other clinician documentation
- Capture laterality and location site
- Pressure ulcer severity is reported using the National Pressure Ulcer Advisory Panel (NPUAP) stages 1-4 and unstageable
- Multiple ulcers need to be documented distinctly to location and stage

UNSTAGEABLE PRESSURE ULCERS

- Note there are three types of unstageable pressure ulcers:
  1. Deep-tissue-injury- The skin is intact but there is discoloration of the skin and the injury affects soft tissue from pressure (so the depth of the injury cannot be determined)
  2. Slough and/or eschar- Slough and/or eschar cover the wound bed, or the base of the ulcer is otherwise covered and the depth of the injury cannot be determined.
  3. The dressing is non-removable

NON-PRESSURE ULCER DOCUMENTATION

- In ICD-10-CM, clinicians will also need to document arterial ulcers, venous ulcers and ulcers caused by diabetic neuropathic disease.

- Documentation for non-pressure ulcers must include anatomic location and laterality, when applicable.

- Documentation for non-pressure ulcers must also capture depth specifically:
  - Limited to breakdown of skin
  - With fat layer exposed
  - With necrosis of muscle
  - With necrosis of bone

BODY MASS INDEX DOCUMENTATION CHANGES

- The classification for overweight and obesity has been expanded in terms of specificity in ICD-10-CM to include:
  - Obesity due to excess calories
  - Morbid (severe) obesity due to excess calories
  - Other obesity due to excess calories
  - Drug induced obesity
  - Morbid (sever) obesity due to alveolar hypoventilation
  - Overweight
  - Other obesity
  - Obesity unspecified

- An additional code (“Z68-”) is used to identify the body mass index (BMI), if known.

- Ensure drug listing is denoted if potential exists for drug induced obesity.

- A BMI of 40+ is morbid obesity, or BMI of 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes.

BODY MASS INDEX DOCUMENTATION CHANGES (cont.)

Body Mass Index:

- Obesity poses a serious risk to satisfactory outcome in clinical settings.
- Obesity related conditions-diabetes mellitus, hypertension with left ventricle strain resulting in left ventricular hypertrophy, diastolic dysfunction, sleep apnea, GERD, cellulitis, osteoarthritis, chronic cor pulmonae.
- BMI can be documented by any qualified healthcare practitioner but cannot be calculated by the coder.
- BMI is based on medical record documentation found in physician documentation, dieticians notes, or other non-physician provider notes.

TOBACCO USE DOCUMENTATION CHANGES

- ICD-10 documentation requires a terminology change for the capture of tobacco use
  - Current tobacco use documentation is classified to nicotine use
  - Documentation must also include tobacco use and types of second hand tobacco smoke (e.g., from parent, at work, perinatal) including, but not limited to:
    - History of nicotine dependence
    - Problems related to lifestyle, tobacco use NOS
    - Problems related to physical environment, exposure to environmental tobacco smoke (acute, chronic)
  - Type of nicotine needs to be documented (cigarette, chewing tobacco, other tobacco product)

Note: The physician must determine and document a patients:

- Tobacco abuse/dependence
- Whether tobacco use status is in remission/withdrawal/uncomplicated

DOCUMENTING UNDERDOSING

- Underdosing is an important new concept and term in ICD-10. It allows you to identify when a patient is taking less of a medication than is prescribed
- When documenting underdosing, include the following:
  1. Intentional, Unintentional, Non-compliance

  Is the underdosing deliberate? (e.g., patient refusal)

  2. Reason

  Why is the patient not taking medications? (e.g., financial hardship, age-related disability?)

T38.3X6A-Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, initial encounter
T38.3X6D-Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, subsequent encounter
T38.3X6S-Underdosing of insulin and oral hypoglycemic [antidiabetic] drugs, sequelae

Z91.120-Patient's intentional underdosing of medication regimen due to financial hardship
Z91.128-Patient's intentional underdosing of medication regimen for other reason
Z91.130-Patient's unintentional underdosing of medication regimen due to age-related debility
Z91.138-Patient's unintentional underdosing of medication regimen for other reason

CODING SUPPORTS THE PATIENT STORY

- The primary code is the main reason for the visit
  - Ensure that the primary code is an appropriate primary code as defined in the guidelines
- Additional codes should be reported where required by coding conventions (“code also”, “use additional code”)
- Document conditions that may add complexity to treatment such as cerebral palsy, seizure disorders, autism, multiple sclerosis
- Avoid “over-coding” – if it isn't relative to the visit, don’t code it

CONTACTS

If you have any questions or concerns about the information presented here, please contact Shannon Chase or Mary Ellen Reardon and we will be glad to assist you.

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Thank You