



ICD-10 PEDIATRICS

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 "undercoded" versus "overcoded."

CHANGES FROM ICD-9 TO ICD-10

- ICD-10-CM codes specify laterality.
- In ICD-9-CM, coders use 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.

A photograph of a person's hands typing on a laptop keyboard. The image is overlaid with a semi-transparent red filter. The background is blurred, showing what appears to be a bookshelf.

ICD-10-CM

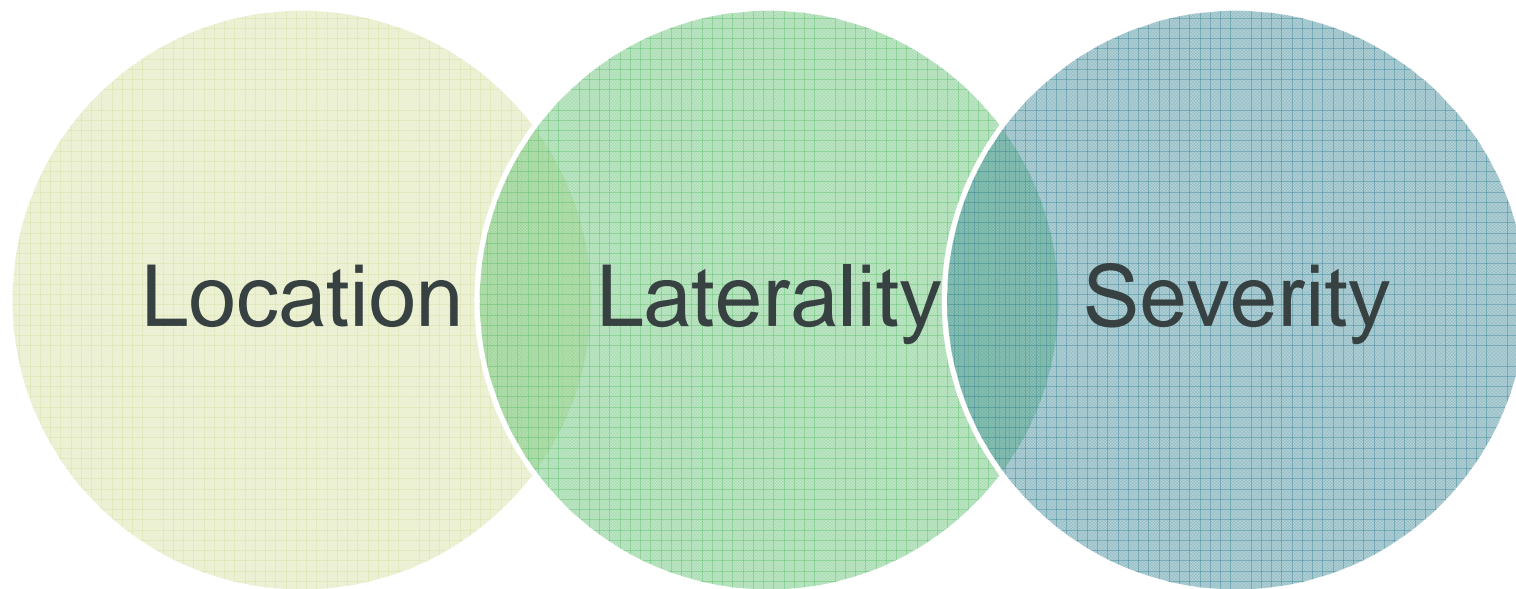
ICD-10 STRUCTURE & CONTENT

- 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.

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

OVERALL CHANGES WITH ICD-10



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.

A photograph of a person's hand typing on a laptop keyboard, overlaid with a semi-transparent red rectangle. The background is a blurred office setting with bookshelves.

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-Encounter for routine child health examination with abnormal findings

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

- Chronic conditions (i.e. asthma, bronchitis, etc.) requires that any related tobacco 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.

ICD-10 CLINICAL DOCUMENTATION IMPACTS

Onset of care

Etiology and Manifestation

Anatomical site specificity

Complications

Laterality

Combination Codes

Disease severity

Non-specific/unspecified

A background image showing a person's hands typing on a laptop keyboard. The image is partially obscured by a large, semi-transparent red rectangular overlay that covers the middle portion of the frame. The text "DOCUMENTATION REQUIREMENTS" is centered within this red overlay in white, bold, sans-serif capital letters.

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 NEWBORN EXAMS AND WELL CHILD VISITS

- Health exams for newborns are classified as 0-28 days old
- Health exams for children are classified as children 29 days and older
- Well child exams for children can be coded as with or without abnormal findings
- Documentation of specific abnormal findings should be included

Z00.110 - Health examination for newborn under 8 days old

Z00.111 - Health examination for newborn 8-28 days old

Z00.121 – Encounter for routine child health examination with abnormal findings

Z00.129 – Encounter for routine child health examination without abnormal findings

DOCUMENTING NEWBORN FEEDING PROBLEMS

- “Newborn” is identified as the first 28 days of life
- If condition was diagnosed within the first 28 days, and remains present after 28 days, these codes can be used throughout the life of the patient
- If the condition **first** presents **after** 28 days, it is not considered a newborn condition

ICD-9-CM	ICD-10-CM
Bilious vomiting Failure to thrive Feeding problems Other vomiting	Difficulty feeding at breast Failure to thrive Overfeeding Regurgitation and rumination Slow feeding Underfeeding Vomiting <ul style="list-style-type: none"> • Bilious • Other Other Unspecified

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 OTITIS MEDIA (H65-H67)

- Include the following:
 - Laterality (e.g., left right or bilateral)
 - Tympanic membrane rupture, if present
 - Secondary causes such as tobacco smoke

- Inquire and collect information to assist in identifying:
 - Type as serous, sanguineous, suppurative, nonsuppurative, allergic or mucoid
 - Infectious agent such as strep, staph, Scarlett fever, influenza measles, mumps
 - Temporal factors as acute, subacute, chronic or recurrent

- Use additional code(s) to identify the following:
 - Exposure to environmental tobacco smoke
 - Exposure to tobacco smoke in the perinatal period
 - History of tobacco use
 - Occupational exposure to environmental tobacco smoke
 - Tobacco dependence
 - Tobacco use

OTITIS MEDIA EXAMPLES

ICD-10 Codes	ICD-10 Descriptions
B05.3	Measles complicated by otitis media
H65.01	Acute serous otitis media, right ear
H65.113	Acute and subacute allergic otitis media (mucoid) sanguinous) (serous), bilateral
H65.194	Other acute non suppurative otitis media, recurrent, right ear
H65.32	Chronic mucoid otitis media, left ear
H66.012	Acute suppurative otitis media with spontaneous rupture of ear drum, left ear
H66.13	Chronic tubotympanic suppurative otitis media, bilateral
H66.22	Chronic atticoantral suppurative otitis media, left ear
J11.83	Influenza due to unidentified influenza virus with otitis media

DOCUMENTING ATTENTION DEFICIT DISORDER (F90)

- Terminology for attention deficit disorder has been revised to attention deficit hyperactivity disorder dropping the classification for hyperkinesis
- Indicate if condition is predominantly inattentive, hyperactive or combined

Note: While mental health disorders are reported using ICD diagnosis codes, there are clinical criteria that are standard to mental and behavioral health providers for diagnosing these types of conditions.

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 INJURIES

- When describing an injury detail is important.

- Examples of information to include:
 - Anatomical site of the injury, including laterality with appropriate landmarks
 - Type of the injury
 - Severity of the injury
 - Is infection present?
 - Episode of care (e.g., initial, subsequent, sequelae). Initial encounters may also require, where appropriate, intent (e.g., unintentional or accidental, self-harm, etc.), and status (e.g., civilian, military, etc.)
 - Description of the circumstances-timeframe, how, where, when the injury or accident occurred.
 - Causation, if relevant, what was the patient doing at the time of the injury or accident (e.g., sports, motor vehicle crash, pedestrian, slip and fall). These would be identified as external causes and are relevant to all types of injuries.

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 (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:
 - Chronic kidney disease
 - Foot ulcer
 - Hypoglycemia without come

DOCUMENTING ADVERSE EFFECTS, POISONINGS OR TOXIC EFFECTS

- Document nature of adverse effect such as:
 - Aspirin gastritis
 - Nephropathy
 - Blood disorders
 - Contact dermatitis
- Identify complications or manifestations caused by a substance such as cardiac arrest, convulsions or an anaphylactic reaction
- Document the name of the substance causing the complications or manifestations (e.g., Prednisone, shellfish, digoxin, latex, tide detergent, etc...)
- Indicate abuse or dependence associated with the substance
- Specify any external causes
- Provide information regarding the circumstances surrounding the event or the mindset of to help identify if the event was accidental, intentional or the result of an assault

A close-up photograph of a blue plastic medical tray containing various items: a white cloth, a pair of blue-handled forceps, a blue-handled T-shaped instrument, a yellow cap, and a clear plastic container. The image is overlaid with a semi-transparent red and white banner.

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.

TOBACCO USE DOCUMENTATION CHANGES

- ICD-10 documentation requires the capture of tobacco environmental exposure to tobacco smoke as:
 - Contact with second hand smoke
 - Affected in utero by maternal use of tobacco
 - Exposure to parental tobacco smoke in the perinatal period

Z77.22 - Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)

P04.2 - Newborn (suspected to be) affected by maternal use of tobacco

P96.81 - Exposure to (parental) (environmental) tobacco smoke in the perinatal period

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 Bujak-Chase or Mary Ellen Reardon and we will be glad to assist you.

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Thank You