Documenting for ICD-10

2015 PCC Workshop

Blanchard & Lavin



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Improvement Goals

- Learn (and share) what comprises a bulletproof note
- Keep money carriers pay



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Approach

- Identify your most-treated conditions
- Research ICD-10 codes, guidance
- Identify specific holes in visit documentation
- Suggest specific changes to records for those visits



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Identify

- Ira will help you identify the codes you bill most
- That list will tell you
 - Where to focus first
 - Which conditions your clinicians and coworkers should consider adjusting



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Ira Selections

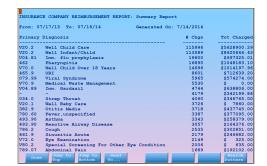


Dates & Subtotal



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Ira Results





PCC EHR (SNOMED) Results

1	Term	Total Usage
2	Allergic rhinitis	3185
3	Well child visit	2442
4	Acute upper respiratory infection	1900
5	Disorder characterized by fever	1639
6	Cough	1304
7	Otitis media	997
8	Acute otitis media	944
9	Acute sinusitis	819
10	Pharyngitis	743
11	Bronchitis	738
12	Immunization due	675
13	Attention deficit hyperactivity disorder	664
14	Well baby	633
15	Acute suppurative otitis media	577
16	Gastroesophageal reflux disease	539



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Research

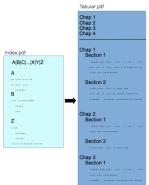
Same old ICD concepts

- · Always code to greatest specificity possible
- Chapter and section guidance
- Index then Tabular
 - http://www.cms.gov/Medicare/Coding/ICD1 0/Downloads/2015-tables-index.zip



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Index vs. Tabular





Research

- Some new ICD-10 Concepts
 - Excludes 1 & 2
 - Placeholder X
 - Episode of Care



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ICD-10 **Greater Specificity**

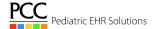
- Laterality/Dominance
- Type
- Severity
- Source/Cause
- Contributing Factors



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Review

- Take random sample of clinician's notes for visits for each condition
- Audit each note for required elements and optional elements
- Make note of changes needed by each clinician



Suggest

- Be very specific with suggestions for improvements to clinical records
- Suggest to each clinician only those changes that she/he needs to make
- Add options into protocols and templates for their use



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New ICD-10 Conventions



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Excludes in ICD-10

Excludes 1 – Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).

Excludes 2 - Indicates that the condition excluded is *not* part of the condition represented by the selected code, but a patient may have both conditions at the same time. In that case, both codes may be assigned together (both codes can be reported to capture both conditions).



ICD-10 - Excludes Simplified

Exclude 1 vs Exclude 2

- 1=These should **never** be coded together
- 2= These **may** be reported together but are distinct (instead, in addition)



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Excludes1 Example

T78.05 Anaphylactic reaction due to tree nuts and seeds Excludes1: anaphylactic reaction due to peanuts (T78.01)



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Excludes2 Example

Dermatitis and eczema (L20-L30)

Note: In this block the terms dermatitis and eczema are used synonymously and interchangeably.

Excludes2: chronic (childhood) granulomatous disease (D71)

dermatitis gangrenosa (L08.0) dermatitis herpetiformis (L13.0) dry skin dermatitis (L85.3) factitial dermatitis (L98.1) perioral dermatitis (L71.0)

radiation-related disorders of the skin and subcutaneous tissue (L55-L59) stasis dermatitis (183.1-183.2)



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ICD-10 - 7th Characters

 Codes for which the 7th position is meaningful but that have fewer than six characters require placeholder "X" be used so the 7th character lands in the 7th position. Use "X" for codes where there are more 'positions' needed than 'meaningful' digits required.



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7th Character Example

"Patient presents with pain and limited movement of right arm. Onset late yesterday. Reduced Nursemaid's elbow. RTO PRN."



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Nursemaid's Elbow - Index

- Nursemaid's Elbow S53.03_



Build-a-code

- Step 1: The Root Code
 - S53 = Dislocation and sprain of joints and ligaments of elbow



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S53.____

S53 Dislocation and sprain of joints and ligaments of elbow

Includes: avulsion of joint or ligament of elbow laceration of cartilage, joint or ligament of elbow sprain of cartilage, joint or ligament of elbow traumatic hemarthrosis of joint or ligament of elbow traumatic rupture of joint or ligament of elbow traumatic subluxation of joint or ligament of elbow traumatic tear of joint or ligament of elbow

Code also any associated open wound

Excludes2: strain of muscle, fascia and tendon at forearm level (S56.-)

The appropriate 7th character is to be added to each code from category S53

- A initial encounter
 D subsequent encounter
- S sequela



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Build-a-code

- Step 2: Additional Detail
 - Anatomic Site
 - "0" Denotes radial head



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S53.0___

S53.0 Subluxation and dislocation of radial head

Dislocation of radiohumeral joint Subluxation of radiohumeral joint

Excludes1: Monteggia's fracture-dislocation (S52.27-)



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S53.03

Step 2b - Laterality

- Right arm indicates

S53.031

S53.03 Nursemaid's elbow

S53.031 Nursemaid's elbow, right elbow S53.032 Nursemaid's elbow, left elbow

S53.033 Nursemaid's elbow, unspecified elbow



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Not Done Yet

• Step 3: Episode of care **must** be 7th Character

The appropriate 7th character is to be added to each code from category S53

- A initial encounter
- D subsequent encounter
- S sequela

S53.031A



ICD-10 - Episode of Care

- Initial
- Subsequent
- Sequela(e)



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Initial Encounter

- 7th Character A
- Used while patient receives active treatment
 - Surgical treatment
 - Emergency Department encounter
 - Evaluation and treatment by a new physician



Pediatric EHR Solutions

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Subsequent Encounter

- 7th Character D
- Used for encounters after pt has received active treatment and is receiving routine care during the healing or recovery phase.
 - Cast change or removal
 - Removal of external or internal fixation device
 - Medication adjustment

- Other aftercare and follow up visits



Pediatric EHR Solutions

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Sequela

- 7th Character S
- Used for use for complications or conditions that arise as a direct result of a condition such as a scar after a burn
- Use both the injury code and the code for the sequela itself
 - S is added only to the injury code
 - Sequela (e.g. scar) is sequenced first, followed by the injury code

PCC Pediatric EHR Solutions

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Episode of Care in Peds

T17 Foreign body in respiratory tract

The appropriate 7th character is to be added to each code from category T17

- A initial encounter
- D subsequent encounter S sequela

T17.0 Foreign body in nasal sinus

T17.1 Foreign body in nostril Foreign body in nose NOS



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Foreign Body in Nostril

Initial encounter...

T17.0XXA



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Break



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Otitis Media

- ICD-9 Acute
 - 381.00 Acute nonsuppurative otitis media, unspecified
 - 381.01 Acute serous otitis media
 - 381.02 Acute mucoid otitis media
 - 381.03 Acute sanguinous otitis media
 - 381.04 Acute allergic serous otitis media
 - 381.05 Acute allergic mucoid otitis media

- 381.06 Acute allergic sanguinous otitis media Pediatric EHR Solutions

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Otitis Media

- ICD-9 Acute (cont'd)
 - 382.00 Acute suppurative otitis media without spontaneous rupture of eardrum
 - 382.01 Acute suppurative otitis media with spontaneous rupture of eardrum
 - 382.02 Acute suppurative otitis media in diseases classified elsewhere



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Otitis Media

- ICD-9 Chronic
 - 381.10 Chronic serous otitis media, simple or unspecified
 - 381.19 Other chronic serous otitis media
 - 381.20 Chronic mucoid otitis media, simple or unspecified
 - 381.29 Other chronic mucoid otitis media



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Otitis Media

- ICD-9 Chronic (cont'd)
 - 381.3 Other and unspecified chronic nonsuppurative otitis media
 - 382.1 Chronic tubotympanic suppurative otitis
 - 382.2 Chronic atticoantral suppurative otitis media



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Chronic Otitis Media -ICD-10 Index

- - chronic H66.90
- - with effusion (nonpurulent) -see Otitis, media, nonsuppurative, chronic
- - allergic —see Otitis, media, nonsuppurative, chronic, allergic
- - benign suppurative -see Otitis, media, suppurative, chronic, tubotympanic
- - catarrhal —see Otitis, media, nonsuppurative, chronic, serous
- - exudative -- see Otitis, media, nonsuppurative, chronic
- - mucinous —see Otitis, media, nonsuppurative, chronic, mucoid - mucoid —see Otitis, media, nonsuppurative, chronic, mucoid
- - nonsuppurative NEC —see Otitis, media, nonsuppurative, chronic
- - purulent -see Otitis, media, suppurative, chronic
- - secretory —see Otitis, media, nonsuppurative, chronic, mucoid
- - seromucinous see Otitis, media, nonsuppurative, chronic
- - serous —see Otitis, media, nonsuppurative, chronic, serous
- - suppurative —see Otitis, media, suppurative, chronic - - - transudative -see Otitis, media, nonsuppurative, chronic, mucoid



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Chronic Otitis Media Section - ICD-10 Tabular

H66 Suppurative and unspecified otitis media

Includes: suppurative and unspecified otitis media with myringitis

Use additional code to identify:

exposure to environmental tobacco smoke (Z77.22) exposure to tobacco smoke in the perinatal period (P96.81) history of tobacco use (Z87.891)

occupational exposure to environmental tobacco smoke (Z57.31) tobacco dependence (F17.-)

tobacco use (Z72.0)



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Chronic Otitis Media Entry – ICD-10 Tabular

H66.1 Chronic tubotympanic suppurative otitis media

Benign chronic suppurative otitis media

Chronic tubotympanic disease

Use additional code for any associated perforated tympanic membrane (H72.-)

H66.10 Chronic tubotympanic suppurative otitis media, unspecified

H66.11 Chronic tubotympanic suppurative otitis media, right ear

H66.12 Chronic tubotympanic suppurative otitis media, left ear

H66.13 Chronic tubotympanic suppurative otitis media, bilateral



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Otitis Media - ICD-10 Notes

- · Laterality: Left, right, bilateral, unspecified
- · Occurrence: Recurrent, acute, chronic
- Types: Allergic (acute, subacute), serous, nonsuppurative, mucoid, sanguinous, seromucinous, tubotympanic, atticoantral
- Rupture: Code for perforation (Without vs. With)
- **Extra Credit: Tobacco exposure



Exercise Steps

- 1)Terms (with synonyms)
- 2)Refer to Index for lookup
- 3)Refer to Tabular to confirm
- 4)Review documents to distill clinician-specific differences
- 5)Plan of attack to communicate differences to clinician/apply protocol and template edits



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Otitis Media Exercise



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Morning Quiz: Insect Bite



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Morning Quiz: Sunburn



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Lunch



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Grade Quizzes



Continue Records Review

- Influenza (& related conditions)
- Asthma
- Well child/Immunizations
- Pharyngitis



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Exercise Steps

- 1)Terms (with synonyms)
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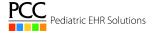
Afternoon Exercise 1

 Share specific weaknesses identified in your note(s)



Afternoon Exercise 2

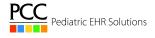
• Share specific strategies to encourage improvements in documentation



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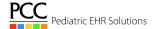
Wrap Up

- Detailed notes but the same old conditions
- Identify and highlight missing pieces only
- Make specific suggestions for each clinician to address their missing pieces



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Questions?



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Thank You!!



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