Documenting for ICD-10

2015 PCC Workshop

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Switchover to ICD-10

Foreword

Beginning October 1, 2015, the U.S. government is mandating the shift from the ICD-9 to the ICD-10 coding system, which is already in use in many other developed countries around the world. This change will expand the number of code choices from 20,000 to around 160,000, giving clinicians nearly eight times as many billing options. These codes are generally much more specific than their predecessors, and will require very thorough notes to support their use.

Many clinicians currently familiar with ICD-9 terminology are apprehensive about this change, thinking "If it ain't broke, don't fix it!" But there are several benefits that may result from this change, so learning to use the new code set is very important.

Regardless of how well clinicians or their coders understand the new coding system, practices will not fare well on reimbursement unless encounters are documented with sufficient detail to support the new codes.

Clinical documentation improvement helps prevent high ICD-10 related denial rates. Clinicians must record all details necessary for coders to code accurately or risk facing an increase in denied and reduced payment claims.

Remember, even after October 1, 2015, you will still be seeing the same old kids for the same old conditions. It's just a matter of using new codes to describe those problems in greater specificity.

Goals

This workbook is a guide for examining a clinician's current documentation practices, identifying weaknesses or areas for improvement with ICD-10 codes. It will suggest ways of improving current documentation tools/processes, with an eye toward ensuring bullet proof notes for insurance audits, to help to keep payments from being taken back by payers.

Instructors

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Certified Coder/Coding Analyst
PCC

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Software Support Technician
PCC

Benefits of Using ICD-10

The new coding system incorporates much greater clinical detail and specificity than ICD-9-CM. Terminology and disease classification are updated to be consistent with current clinical practice. This modern classification system will provide much better data needed for:

* 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;

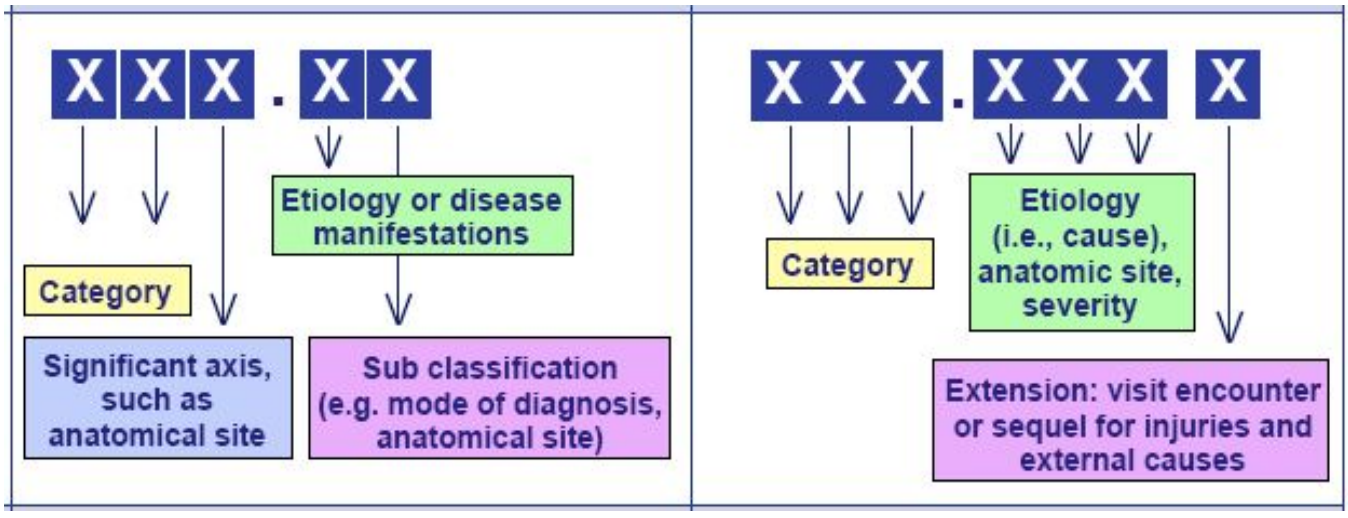
* Preventing and detecting health care fraud and abuse;

* Tracking public health and risks

Source: https://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10QuickRefer.pdf

Comparing ICD-9/ICD-10 Code Structures

ICD-9	ICD-10
Approximately 20,000 codes in all	Approximately 60,000 codes in all
3-5 characters	3-7 characters
Digit 1 is alpha (E or V) or numeric Digits 2-5 are numeric	Digit 1 is alpha (any letter except 'U') Digits 2 and 3 are numeric Digits 4-7 are alpha or numeric
Use of decimal after 3 characters	Use of decimal after 3 characters
	Use of dummy placeholder "x"
Limited space for adding new codes	Flexible for adding new codes
Lacks details	Very specific
Lacks laterality	Contains laterality
Structure of injuries designated by wound type	Structure of injuries designated by body part/location
813.15 *Open fracture of head of radius*	**S52.123C** *Displaced fracture of head of unspecified radius, initial encounter for open fracture type IIIA, IIIB or IIIC.*



New ICD-10 Concepts

Old ICD-9 concepts still at play:

* Review reference files for Chapter and Section Guidance

* Always code to the greatest specificity possible. The following example shows the more detailed information gained through the additional ICD-10 characters:

S52	*Fracture of forearm*
S52.5	*Fracture of lower end of radius*
S52.52	*Torus fracture of lower end of radius*
S52.521	*Torus fracture of lower end of right radius*
S52.521A	*Torus fracture of lower end of right radius, initial encounter for closed fracture*

New concepts to consider:

- '**Excludes 1**' and '**Excludes 2**' identify conditions that can never be coded together, or conditions that may be coded together but as distinct issues.
- '**Laterality**' (right/left) is required for certain ICD-10 codes. If not properly documented, the code may be considered invalid.
- '**7th Character**' describes initial/subsequent/sequela encounters.
- '**Episode of Care**' (in ICD-10) describes whether the condition is initial (ie the treatment of a burn), subsequent (ie the process of healing the burn), or sequela(e) (ie the treatment of scar tissue that resulted from a burn)
- **'Placeholder X'** describes a method of ensuring that enough meaningful digits exist in a given ICD-10 code.

ICD-10 Reference Files

ICD-9 contains approximately 15,000 pediatric specific codes, whereas ICD-10 contains over 70,000. Learning each of these new codes may take several months, but learning a new *method* for looking up these codes can be done rather quickly. Over time, recall of these new codes will become as easy and effortless as it is with ICD-9 codes now.

To assist with researching ICD-10 codes, use the following two PDF resource files,

Index.pdf – An alphabetical listing of medical issues, with each one being mapped to an ICD-10 code.

Tabular.pdf - A list of ICD-10 codes, organized 'head to toe' into chapters and sections with guidance, exclusions, descriptions and more.

These files are available on line at:
http://www.cms.gov/Medicare/Coding/ICD10/Downloads/2015-tables-index.zip

Start by looking up a condition in the alphabetical ***Index.pdf*** file (and be sure to consider synonyms), as this will give you a corresponding ICD-10 code to use for that condition.

Then look up that ICD-10 code in the ***Tabular.pdf*** file to learn more about that code family, including chapter and section guidance details. All aspects related to a diagnosis must be identified and clearly documented in the visit note in order to support the selection of that ICD-10 code for billing.

If ICD-10 codes are not selected by the clinician, then a coder must rely on the chart notes to select the code. If the notes are not clear and precise, then coding needs to be put on hold while the details are researched. These two resource files will be very important when deciding how much detail to document.

Using the ICD-10 Reference Files

When using the ICD-10 Reference Files, start with the ***Index.pdf*** file first, then go to the ***Tabular.pdf*** file for guidance and details.

Index.pdf – Identifies the correct ICD-10 code associated with a condition:

* This file contains an alphabetical listing of medical conditions broken down into 26 (alphabet) sections.

* Each medical condition is mapped to an ICD-10 code.

(Here is a *short* example: **Aarskog's syndrome Q87.1**)

* Find a condition on this list, and you will immediately know which ICD-10 code to use for reporting that condition.

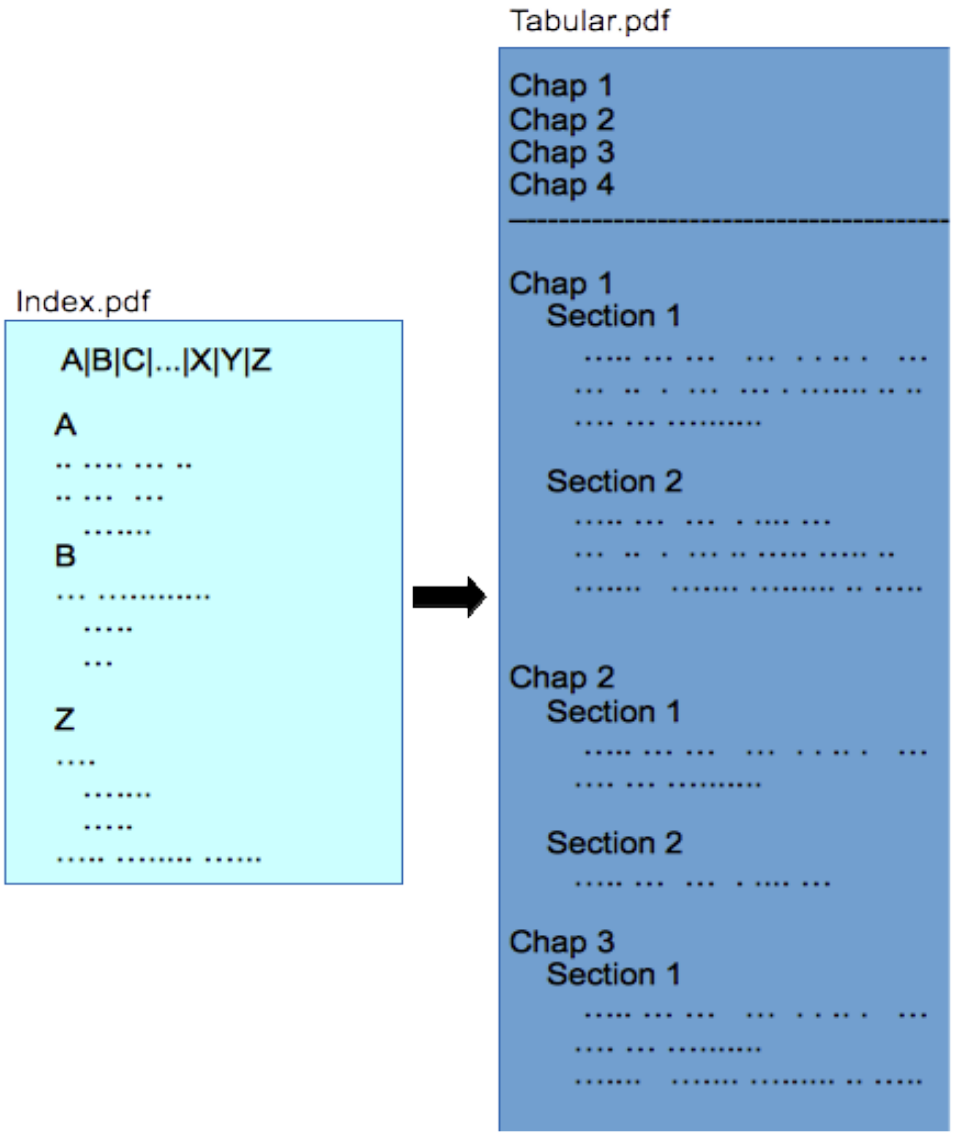
Tabular.pdf – Describes supporting evidence for a given ICD-10 code:

* This file contains a listing of ICD-10 codes, their descriptions, exclusions, and chapter and section guidance for documentation.

* Codes are organized from 'head' to 'toe'.

* Starting at the top of the file, first locate the desired chapter (**Q00**) and read any chapter guidance found there. Then scroll down to the desired section (**Q80**) and read any section guidance. Finally, scroll down to the desired code (**Q87.1**) for details regarding proper documentation.

ICD-10 Reference Files (overview)



Start with ***Index.pdf***, then move to ***Tabular.pdf***

Beware “Unspecified” Codes

ICD-10 does contain several unspecified code options. Preferably, more specific codes will be used in as many cases as possible, however these unspecified codes may be used when the clinician has not given enough supporting details in the documentation.

ICD-10 also contains “Other specified” codes, which means that while the detail is understood/documented, there is no specific code choice available for that particular description.

In many instances, payers will not pay a claim with an unspecified code!

Multiple Codes/Single Condition

In some instances, you may need to record multiple codes for a single condition. Notes in the Tabular List indicate whether you're required to report more than one code. These notes use verbiage such as "Use additional code" or "Code first." ("Code first" indicates you should code the underlying condition first.) You should also be aware that ICD-10 includes several combination codes, which are single codes used to classify two or more conditions that often occur together.

With injury codes, you often will submit external cause codes that further describe the scenario that resulted in the injury. You will find these codes in Chapter 20: External cause codes. These are secondary codes, which means they further describe the cause of an injury or health condition by capturing how it happened (cause), the intent (intentional or accidental), the place the event occurred, the activity the patient was engaged in at the time of the event, and the person's status (e.g., civilian or military). You can assign as many external cause codes as necessary to explain the patient's condition to the fullest extent possible.

For example: *let's say the patient strained his or her Achilles tendon while running on a treadmill at a gym. To code for this particular set of circumstances, you will need an activity code, a place of occurrence code, and an external cause status code. The appropriate activity code for running on a treadmill is Y93.A1; the place of occurrence code for a gym is Y92.39; and the external cause status code in this case would be Y99.8, recreating or sport not for income or while a student. So, in this example, you would submit a grand total of four ICD-10 codes to accurately describe that the patient presented with an Achilles tendon sprain in his or her right foot—an injury the patient suffered while recreationally running on a treadmill at a gym.*

ICD-10 Documentation Approach

The basic approach to improving ICD-10 documentation involves the following steps:

* **Identify most treated conditions**

Practice Management systems should provide reports that highlight the most frequently used diagnosis codes per clinician. Focus on these issues first to get the biggest bang for your buck.

* **Research ICD-10 codes/guidance**

For unfamiliar ICD-10 codes, use the two resource files provided at this seminar to learn what elements must be properly documented to support that code. Use the ***Index.pdf*** file first, and then refer to the ***Tabular.pdf*** file for chapter/section guidance and other details.

* **Identify specific holes in visit documentation**

Perform random chart audits (for each clinician), to determine if the required elements for that code are already being documented in the note. Remember that the element could appear anywhere within the note for that visit. Take notice of any element that is not clearly documented, as that points out an area where a clinician could improve their documenting skills.

* **Suggest specific changes to records for those visits**

Provide a summary, per provider, per diagnosis, of any notable gaps in documentation. Suggest modifications to current processes or charting templates to help prevent these gaps for future visits.

* **Implement and monitor changes**

Bottom line: *If an ICD-10 code is not properly documented in the visit note, the payer may demand their payment back.*

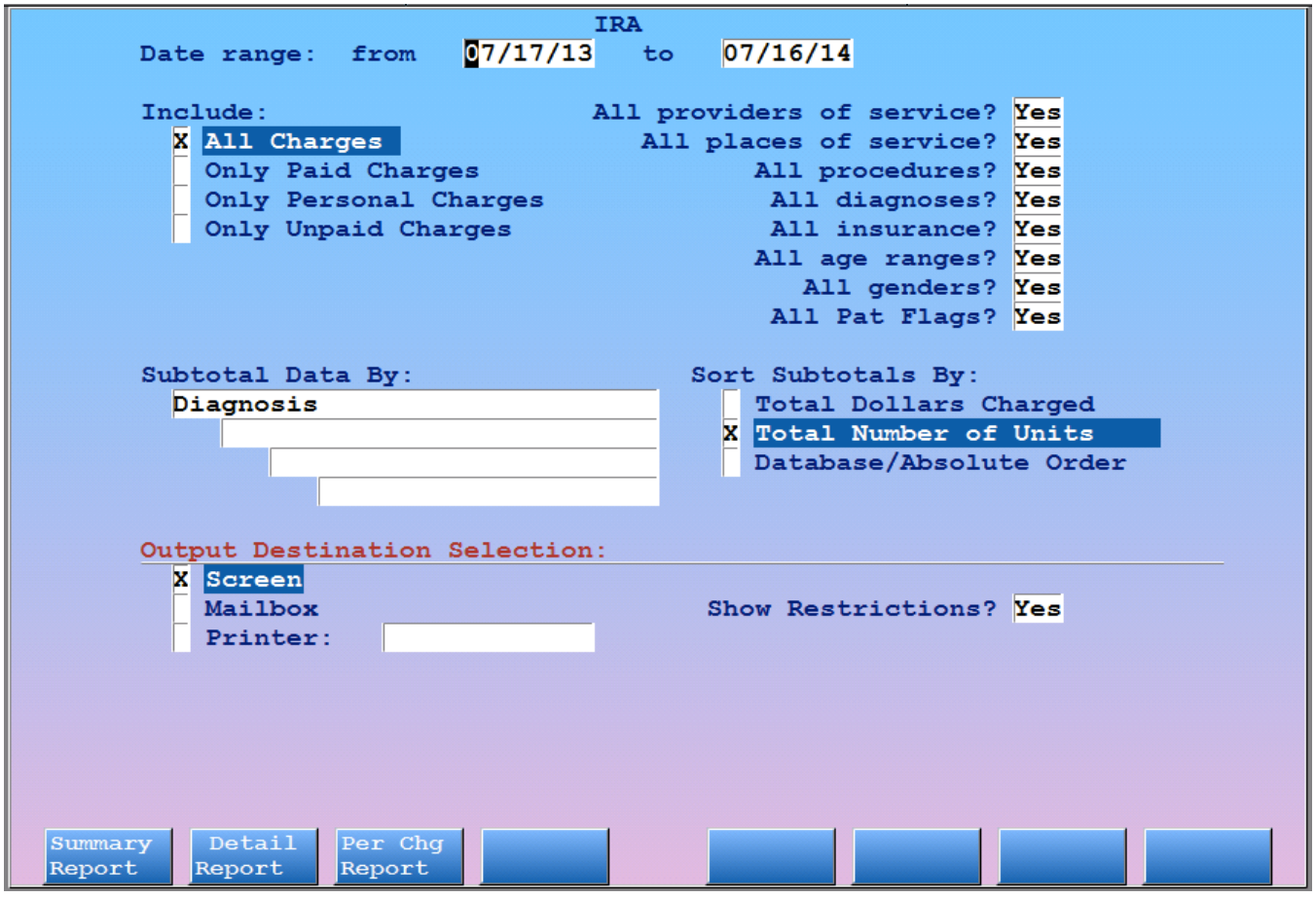
Step 1: Identify Most Treated Conditions

While many clinicians have already memorized the codes they often use in ICD-9, it may be a bit harder to do that with ICD-10 simply because the system is more elaborate. Therefore, start by focusing on the most important codes for your practice, and develop tools to help support those code selections.

PARTNER users can run the '*ira*' (Insurance Reimbursement Analysis) report to determine the most frequently used diagnoses, per clinician, over a period of time. Hints for running this report can be found on *learn.pcc.com*

Offices with other practice management systems should consult with their vendor to determine how to get such a report.

Here is a sample 'ira' screenshot showing the settings needed to generate a list of the most frequently used diagnoses during a given date range:



And here is a sample '*ira*' report showing the desired information needed to help decide where to focus first:

INSURANCE COMPANY REIMBURSEMENT REPORT: Summary Report

From: 07/17/13 To: 07/16/14 Generated On: 7/14/2014

Primary Diagnosis		# Chgs	Tot Charged
V20.2	Well Child Care	115996	$5628900.29
V20.2	Well Infant/Child	113589	$8620646.43
V04.81	Imm. flu prophylaxis	19600	$697325.01
462	Pharyngitis	16895	$1048183.10
V70.0	Well Child Over 18 Years	14696	$1014197.96
465.9	URI	8601	$712639.20
079.99	Viral Syndrome	5965	$574274.00
V70.9	Medical Waste Management	5530	$ 0.00
V04.89	Imm. Gardasil	4744	$638806.00
-	-	4179	$342199.86
034.0	Strep Throat	4060	$346765.00
V20.1	Well Baby Care	3726	$ 7860.00
382.9	Otitis Media	3718	$437745.00
780.60	Fever,unspecified	3387	$377095.00
493.90	Asthma	3343	$258379.00
493.90	Reactive Airway Disease	3057	$164376.00
786.2	Cough	2535	$302851.00
461.9	Sinusitis Acute	2179	$246682.00
V72.0	Eye Examination	2149	$ 325.00
V80.2	Special Screening For Other Eye Condition	2006	$ 635.00
789.07	Abdominal Pain	1689	$192102.00

Done | Jump to Top | Jump to Bottom | Send To... | | | | Search Pattern

Notice that certain ICD-9 codes may appear more than once on this report (ie V20.2) because historically in Partner, users were able to customize the diagnosis names. Many clients have made many copies of many ICD-9 codes, thus several entries for the same code may appear. ICD-10 descriptions will not be editable so this problem will go away.

Step 2: Research ICD-10 Codes/Guidance

Once you have identified a condition to research,, then use the ICD-10 Reference Files (***Index.pdf*** and ***Tabular.pdf***) to look up that condition and find it's corresponding ICD-10 code.

Start by looking up the condition in the ***Index.pdf*** file. Remember that the condition may not appear under the exact same phrasing that you are imagining, so try using synonyms or other phrasing to find the corresponding condition. When you find the entry, it should give you a root ICD-10 code.

Next, review the ***Tabular.pdf*** file, paying special attention to any mention of the new ICD-10 concepts like laterality, type, severity, cause and other contributing factors. These are the elements that must be clearly documented in a note in order to successfully support the use of this particular ICD-10 code.

The appendix in this workbook contains sample worksheets that can be used to organize all of these details. Feel free to photocopy them to help organize your thoughts. Simply document the condition and clinician being reviewed, and then list the specific elements that must be clearly documented in the note.

Once you have completed this research, and know what needs to be documented, then you are ready to move on to the next step.

Step 3: Identify Specific Holes in Visit Documentation

Once an ICD-10 code has been explored, decide whether or not each clinician is documenting well enough to support its use.

Why wait for a carrier to announce an audit? Perform continuous, proactive clinical audits to ensure that accuracy is achieved and errors are avoided. This is a perfect opportunity to identify documentation weaknesses, and to consider changes that will address these issues for future visits.

* Randomly select a handful of notes, per clinician, per condition (well, asthma, influenza, etc). Be sure to include a list of ICD codes billed for each visit.

* Audit each condition within each note for required/optional ICD elements. Remember, supporting documentation can appear anywhere within the note. If all required elements are being documented, then no changes are needed (for that clinician, for that condition anyway).

* Make a list of changes needed, per clinician, per condition, in order to meet documentation requirements. Identifying these gaps can lead to work flow changes that can address these concerns easily.

* Reviewing sample notes every 6-8 months is a good way to ensure things are not falling through the cracks, and should make an actual audit a breeze!

Step 4: Suggest Improvements

Once a problem area has been uncovered, brainstorm ways to address the issue.

If a clinician consistently fails to document a required element for a certain condition, consider modifying the note template (either electronic or paper) to prompt a series of questions or discussions.

* **Be specific with suggestions for improvements to clinical records**

Identify the specific elements that are currently missing from the note. Realizing that details could appear anywhere within a note, consider specific areas where those details might easily be added.

* **Suggest to each clinician only those changes that she/he needs to make**

Be careful not to create additional work! If a note is already well documented enough to survive an audit, even if the details are found in random places throughout the note, then do not worry about adding specific questions to help address those same details. Only make modifications that will help to improve a clinicians' notes, not to bog them down.

* **Add options to protocols and templates for their use**

Also, keep in mind that different clinicians may need help in different areas, depending on the condition in question. It may be helpful to chart your results of these audits, to help keep track of forthcoming improvements.

When suggesting changes, it does not matter whether you are using a paper charting system or a full fledged EHR. Simply consider ways of modifying your current templates to help guide your clinicians in areas where they need additional details. This built-in guidance will help ensure that the necessary details are entered into every note, every time.

Exercise Steps

1. Define the condition using common terms (consider using synonyms).

2. Refer to ***Index.pdf*** file to look up the corresponding ICD-10 code.

   Jump to the alphabetical section and then search <alt><f> looking for the condition in **bold** lettering. This will either give you a root ICD-10 code, or it will point you toward a synonym elsewhere in this file that will have a root ICD-10 code.

3. Refer to ***Tabular.pdf*** file for Chapter/Section Guidance, and Exclusions, and to confirm the correct diagnosis. Jump to the desired Chapter, then Section, and then Entry. Note the variety of options available under ICD-10 (as well as all of the specific details to consider/document when selecting a particular code.

4. Examine a sample note to determine the quality of current documentation efforts.

5. Identify areas where documentation improvements could be beneficial.

6. Design protocol/template modifications to help produce desired results in the final note.

Group Exercise

Attendees will apply Documentation Approach to determine which elements need to be clearly documented in the note.

Instructor will hand out a standard *Otitis Media* note that attendees will use. After applying this process, class will discuss results to see what each attendee found. After practicing this approach together, the next step will be for attendees to apply the approach individually to their own redacted notes.

Individual Exercise

Now we will apply this Documentation Approach (summarized below) to actual *Otitis Media* notes brought with them. Check off each step as it is completed

[ ] Take out your *Otitis Media* note.

[ ] Look up Otitis Media in the ***Index.pdf*** file to identify it's ICD-10 code.

[ ] Look up that ICD-10 code in the ***Tabular.pdf*** file and identify any documentation requirements for this condition.

[ ] Audit chart(s) to see if required notations exist.

[ ] Identify weaknesses (absence of details) for this clinician, for this type of visit.

[ ] Consider changes to existing processes/tools to assist clinician in addressing these documentation gaps (protocols/templates/etc).

Quiz

Question #1:

Patient presents with evidence of an insect bite. What details must the clinician include in the documentation/note that would allow a coder to properly select a bullet proof ICD-10 code (without having to interrupt the clinician for clarification later on)?

Question #2:

Does the following visit note (for a patient suffering from rash), contain appropriate details allowing the biller to select a bullet proof ICD-10 code?

(Instructor will hand out a sample note for this visit)

Question #3:

Does the following visit note (for a patient suffering from sunburn), contain appropriate details allowing the biller to select a bullet proof ICD-10 code?

(Instructor will hand out a sample note for this visit)

More Individual Exercises

Now we will apply the same Documentation Approach to other notes.

In the afternoon, attendees will decide as a group which visit type to research next, and everyone will apply the process to their own individually redacted notes. The group will get back together after each session to review what each user found, and to answer any questions encountered along the way. Remember to use the worksheets found in the Appendix to document findings along the way.

Summary and Take Aways

Summarize any clinician weaknesses already identified throughout this course, and prioritize them in order of importance (the most important issue that needs to be fixed, then the next most important, etc).

This Appendix in this workbook contains a worksheet that will help you organize your thoughts on these matters and will allow you to easily communicate your findings to the clinician.

Once weaknesses have been identified, it is time to consider how your current processes/templates could changed to automatically address these gaps for each clinician.

For EHRs, consider adding additional questions/prompts/fields to specifically guide the clinician into clearly documenting a previously missing element.

For paper systems, consider adding similar prompts to the paper templates.

Remember: try not to duplicate efforts. If a clinician is already addressing an element, then do not bother adding separate questions just for that element as it's already being addressed elsewhere. Just provide guidance tools for those clinicians who need help filling in the gaps.

Conclusion

ICD-10 is going to be a significant transition for everyone involved. It will require adaptation and modification of processes and tools, giving pause to every one who is already familiar with them. But the benefits are worth the change. A genuine effort to make this change will help reduce the frustration, and allow for an easy transition, but it will take time. Break it down into small manageable tasks and you will see forward momentum. While focusing on ICD-10 documentation, remember the following:

* Identify your most recent conditions
* Research appropriate ICD-10 codes for those conditions
* Perform chart audits to determine the current level of coding
* Identify weaknesses in current coding techniques
* Suggest specific improvements in the current process to help ensure the proper notes are documented every time for those codes

Despite the differences between ICD-9 and ID-10,the basic rules of coding will remain unchanged. The key to getting comfortable with the new code set is to understand how the ICD-10 expansion allows for more specific codes to report laterality, episode of care, and other clinical details more precisely.

And don't panic, because before you know it, ICD-10 will seem as effortless as ICD-9 seems now!

Good Luck!!!

Appendix

While all carriers are supposed to be ready for ICD-10 on 10/01/2015, it is prudent to assume that some will not. If you do encounter any ICD-10- related disagreements with a payor after this transition date, you may want to involve your State Banking Insurance Commissioner.

Additionally, consider contacting Lou Terranova, who manages the AAP Private Payor Advocacy initiative, and serves as primary staff to the AAP Private Payer Advocacy Committee (PPAAC).

Contact info: lterranova@aap.org

PCC 2015 ICD-10 Workshop Dates and Locations:

Mon	04/20	Winooski, VT
Fri	04/24	Boston, MA
Mon	05/04	Columbus, OH
Wed	05/06	Dallas, TX
Fri	05/08	Philadelphia, PA
Mon	06/15	Tulsa, OK
Wed	06/17	Jacksonville, FL
Fri	06/19	Atlanta, GA
Fri	07/17	Denver, CO
Mon	07/20	San Francisco, CA

Worksheet A

Audit Check List

Clinician: _____

Use this worksheet to record your progress as you perform ICD-10 coding audits, per clinician, per condition.

Condition	Score	Comments
ADHD		
Asthma*		
Conjunctivitis		
Cough		
Eczema		
Fever		
Gastroesophageal Reflux (GERD)		
Influenza (and related conditions)*		
Otitis Media*		
Pharyngitis*		
Sinusitis		
UTI		
Viral Syndrome		
Well Child/Immunizations*		

* Redacted notes (brought by attendees) to be reviewed in class.

Worksheet B

Condition Check List

Given a particular condition/visit type, first research the INDEX.pdf and TABULAR.pdf resource files to determine what details are necessary to select an appropriate ICD-10 code, and then determine whether existing charts already contain those details (or not).

Clinician: _____

Condition: _____

Required? *Is the necessary detail already in the sample note?*

[ ] Laterality: _____Bilateral _____ Right _____Left (___ Dom. ___ Non-Dom.)

[ ] Episode of Care:_____
(Initial, Subsequent, Sequela)

[ ] Location:_____
(Body site)

[ ] Type: _____
(Type of condition may vary based on condition)

[ ] Severity:_____
(Mild, Moderate, Severe)

[ ] Stage:_____
(Healing)

[ ] Place:_____
(Location of occurrence)

[ ] Intent:_____
(Accident, assault)

[ ] Source: _____
(Perpetrator, cause, origin)

Notes:

_____

_____

_____

Worksheet C

Action Plan

One take away from this workbook should be a concrete plan on how to address any documentation weaknesses identified during this session. Use this template to organize thoughts and to plan changes at the office.

Clinician: _____

Condition: _____

Plan: _____

_____

_____

Condition: _____

Plan: _____

_____

_____

Condition: _____

Plan: _____

_____

_____

Condition: _____

Plan: _____

_____

_____

Most Used Diagnoses (PCC HER)

SNOMED Description	Total Usage
Child health medical examination	360313
Well child visit	294539
Upper respiratory infection	126168
Cough	104500
Fever	98057
Acute upper respiratory infection	91098
Pharyngitis	82697
Dietary management education, guidance, and counseling	82123
Otitis media	75490
No known allergies	71578
Exercises education, guidance, and counseling	66403
Allergic rhinitis	63481
Acute otitis media	57102
Acute pharyngitis	51310
Streptococcal sore throat	50827
Body mass index normal K/M2	49785
Asthma	47503
Viral syndrome	44112
Sinusitis	41967
Eczema	40268
Attention deficit hyperactivity disorder	39467
Needs influenza immunization	36155
Viral disease	35475
Active immunization	33702

Abdominal pain	29458
Well baby	28190
Wheezing	27461
Gastroesophageal reflux disease	25653
Constipation	25325
Headache	22501
Acute suppurative otitis media	22380
Acute sinusitis	22023
Otalgia	21792
Vomiting	20860
Nasal congestion	20474
Croup	20419
Serous otitis media	20346
Gastroenteritis	19529
Diarrhea	19462
Body mass index high K/M2	18003
History and physical examination, annual for health maintenance	17586
Attention deficit hyperactivity disorder, predominantly inattentive type	16713
Pneumonia	16100
Bronchiolitis	15477
Management of drug regimen	15458
Acne	15191
Bronchitis	15152
Well child visit, newborn	14500
Attention deficit hyperactivity disorder, combined type	14059
Immunization due	13870

Influenza	13860
Dysuria	13131
Reactive airway disease	13005
Influenza vaccination	12361
Disorder characterized by fever	12249
Breastfeeding problem in the newborn	12175
Well child visit, 2 week	12106
Neonatal jaundice	12077
Vaccination required	11583
Atopic dermatitis	11187
Follow-up visit	11040
Exacerbation of asthma	10999
Feeding problems in newborn	10400
Teething syndrome	10394
Obesity	10293
Rhinitis	10086
Impetigo	10049

Source: PCC EHR 2015