1 Introductions

- Hi! Welcome to our ICD-10 documentation training.
- I’m Dr. D. W. “Chip” Pettigrew MD, FACEP, Founder of Pettigrew Medical Business Services, and a longstanding member of the Reimbursement Committee of the American College of Emergency Physicians; and
- I will be joined by my esteemed colleague, Dr. Jeffrey Linzer MD FAAP FACEP. Jeff is a Professor of Pediatrics and Emergency Medicine at Emory. He is a member of the American College of Emergency Physicians and American Academy of Pediatrics committees dealing with coding and nomenclature. He is also a Member of the Editorial Advisory Board for the American Hospital Association’s Coding Clinic for ICD-10-CM; the American Academy of Pediatrics Representative to the ICD-9/10-CM Coordination & Maintenance Committee; a Member of the National Quality Forum’s Expert Panel on Coding; the author and editor for of several publications dealing with ICD-10-CM; and the Chair of the Pediatric Advisory Group and member of the Revision Steering Group for the World Health Organization’s pending ICD-11.
- Welcome, Dr. Linzer.

2 Our purposes for today’s instructional video are four-fold:

- To introduce ICD-10-CM (USA's Clinical Modification);
- To emphasize the importance of thorough documentation of clinical charts;
- To review diagnosis coding examples for EM and HM in ICD-10-CM; and
- To list references for those with questions or for those desiring to delve further into the specifics of ICD-10.

3 Dr. Linzer, let’s get started. What is ICD-10?

Thank you, Dr. Pettigrew, for this opportunity to participate in this educational activity.

- The International Classification of Diseases (ICD) is an official copyrighted publication of the World Health Organization and is part of a broader family of International Classifications. It provides common terminology for morbidity and mortality surveillance. The 1893 International List of Causes of Death is considered the first ICD.
- The WHO initially published this 10th revision in 1994. The US began working on its clinical modification soon after that. The development of the US version of ICD-10 included input from many medical societies.
- The US has been using ICD-10 for mortality statistics since 1999.
ICD-9-CM is 35 years old and is now very much out of date with the current state of medical practice in the USA. It is also out of room for expansion or for more codes. ICD-10-CM reflects advances in medicine and is more logically arranged to reflect anatomy, etiology and severity.

The approximately 13,000 ICD-9-CM diagnosis codes will be replaced by approximately 68,000 ICD-10-CM diagnosis codes. About 50% of the new codes are related to the musculoskeletal system, 36% to laterality and 25% to fractures. Enhancements to the new code set include better reporting of lifestyle and socioeconomic issues, common manifestations and complications.

ICD-10 codes have 3-to-7 characters compared to 3-5 with ICD-9. This allows for greater granularity making it easier to:

i  Support public health surveillance and research data;

ii Support resource utilization and quality metrics, improving appropriate and timely insurance reimbursements through reducing the need for manual review of records or supplemental information for reimbursement claims; and

iii  Allow for fewer denials and audits (if charts are documented and coded appropriately).

ICD-10-CM will be the only system of diagnosis reporting available for claims sent to any HIPAA covered entity (governmental and most insurance payers) effective October 1, 2015 and thereafter. Non-HIPAA entities such as workman's compensation programs have all agreed to abide by the new coding rules.

Just as with ICD-9-CM, the ICD-10-CM Official Guidelines for Coding and Reporting is the HIPAA standard and adherence to those guidelines when assigning ICD-10-CM diagnosis codes is required.

4 Jeff, you mentioned some benefits of the ICD-10 conversion. Would you repeat what they are?

- ICD-10 will certainly have many public health benefits due to its disease reporting specificity.
- Additionally, many feel that once ICD-10 is implemented it will lead to fewer delays in appropriate reimbursement and fewer audits of charts due to the increased specificity showing why the patients required the workup and treatment that they received. This will eventually be of great benefit to the practicing physician in speed of cash flow and in fewer administrative headaches involved in seemingly unnecessary chart audits. Initially, however, it may result in a temporary bounce-back of charts to the clinician from the coders for more specific information for an appropriate diagnosis.

5 Okay, so, Dr. Linzer, what’s new in ICD-10? (And, parenthetically, I want to let the listeners know that we are providing access for each one of you to a transcript of this video and a printable pocket guide, ICD-10-CM
Tips for Documentation. We’ll discuss how to get these at the end of our talk.)

- It’s important to remember that the basic rules haven’t changed. The physician uses the term that best explains the reason or significant finding of the encounter (visit) to the highest level of clinical certainty. The increased granularity, or **SPECIFICITY**, for descriptions of illnesses and injuries include (among other things) laterality, acuity, manifestation, and etiology. This specificity allows the clinician to not only communicate the patient’s healthcare status more appropriately, but also helps support E&M services, procedures and resources that were provided to the patient. Key, of course, is the documentation that supports the visit diagnoses. Poor of sloppy documentation and/or selection of too generic a diagnosis may cause many payers to reconsider why the evaluation, management and interventions were necessary. Let me put this in perspective. In ICD-9, fractures are identified as open or closed, and anatomic location. In ICD-10, additional details including laterality, type of fracture, displaced versus non-displaced are needed. The payers will expect to see this degree of detail.

- This increased specificity helps to identify a more specific “severity of illness” (or “severity of risk”), which allows for a more complete clinical picture of the patient. There are **SEVEN KEY POINTS** that can help in demonstrating the patient’s severity of risk:
  - Disease/disorder specificity,
  - Acuity,
  - Laterality/location/site,
  - Common or disease process manifestations,
  - Underlying conditions and/or causal agents,
  - Supporting labs and/or socioeconomic issues,
  - Complications or adverse effects of therapy.

- Consistently documenting these key principles will result in better reporting of the patient’s condition and the work required. ICD-10 does not require more documentation. However, payers will take advantage of poor documentation by delaying or reducing payments.

- **Laterality and location** should be important considerations in all of your documentation efforts. An unspecified term should not be used when there is one specifically identifying the laterality or location of the condition.

- A 7th character is used with codes for fractures, injuries, poisonings and certain other consequences of external causes to show which type of an encounter the patient is having with healthcare resources. This 7th character is not used with any other condition. These patient encounters are described as: Initial, subsequent and sequelae.
  - Initial – is used while the patient is receiving active care. Examples of active treatment are: trauma-related surgery, ED care, and ongoing active treatment by the same or different
physician. For example, the initial phase of care would apply to both the EP and the orthopedist who provides definitive care a few days later;

ii **Subsequent** – after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase (e.g., cast change or removal, check healing status of a wound, medication adjustment, other aftercare and follow up visits following treatment of the injury). This is similar to the current aftercare codes. A good example would be a patient being seen for suture removal; or

iii **Sequelae** – for complications or conditions that arise as a direct result of a condition. There is no defined time frame as to when sequelae appear. When using the sequelae descriptor, it’s also necessary to have the condition documented for the sequela. This is the same as our current aftercare codes. An example would be a scar that was the result of a previous injury.

- **Symptom and complaint based diagnoses will continue to be acceptable.** Signs and symptoms can be used when a specific diagnosis has not been established (confirmed) by the clinician. However, signs and symptoms that are routinely associated or are an inherent part with a condition should not be assigned as additional codes. For example, a patient with fever, vomiting and diarrhea should have a diagnosis of infectious acute gastroenteritis instead of the individual signs and symptoms. Signs and symptoms can be used as additional diagnoses to help explain the encounter.

- **Pre-coordinated or combination codes** are diagnosis codes that can show more than one diagnosis or concept in a single code. This could be a chronic condition with an acute manifestation (e.g., Hb-SS disease with Acute Chest Syndrome), two concurrent acute conditions (e.g., severe sepsis with septic shock), or an acute condition with an external cause (intentional aspirin overdose). In cases where there isn’t a combination code to show the etiology and manifestation of a condition, the clinician should clearly document both. For example, the type of chronic kidney disease (the etiology) would be listed before the CKD-related anemia (the manifestation). Clinicians won’t have to know these codes, but they will need to describe the patient’s condition so that the coders may correctly apply the appropriate code.

- **There is no time limit for defining when pain becomes chronic.** The clinician’s documentation is used to determine if a pain is chronic or acute.

- **Indeterminate terms** such as impending, threatened, rule out, possible, probable, consistent with, or most likely due to may NOT be used as part of the diagnosis. A condition is either confirmed (clinically or via testing) as a diagnosis, or the signs/symptoms are to
be used. Each healthcare encounter should be documented (and
subsequently coded) to the level of clinical certainty known for that
encounter. Testing is not required in order to make a diagnosis. The
clinician needs to provide sufficient documentation in order to
support the selected diagnoses. Not documenting accurately and
thoroughly will result in the use of lower severity of illness codes, “not
otherwise specified” or “unspecified” codes. While these types of
codes will continue to be acceptable in limited situations,
documentation should support greater specificity when appropriate.
These should be kept to a minimum for the best continuity of care for
your patients and for appropriately justifying your time and the
resources spent in the care of your patient.

- Just as with the current system, the clinician needs to document an
interpretation of any laboratory findings considered clinically
significant. A coder cannot interpret the significance of a lab value. For
example, if a patient has an oxygen saturation level of 76, the clinician
will need to document “hypoxia” in order to show the clinical
relevance of the lab value.

- The principle or primary diagnosis should be the one that carries the
greatest risk of morbidity or mortality and is the principle reason for
the encounter. Contributing or secondary diagnoses are those that
help show additional medical necessity for the patient’s encounter
and help support resource utilization.

6 Wow, that’s a lot to remember Jeff! Tell us, what would you consider to be THE KEY to successful ICD-10 implementation for the practicing EM or HM physician?

That’s a great question!
It is unfortunate we do such a poor job of teaching students and
residents how to document. “S.O.A.P.” should be limited to washing our
hands and not be used as a documentation tool. We need to think of
our documentation as a short story that provides the narrative for the
patient’s encounter.
First, the key to good documentation is a good descriptive history of
the present illness (HPI). Using checkboxes for an HPI may be helpful
for billing but really doesn’t carry over a good picture as to why the
patient was seeking medical care.
Checkboxes for the physical exam can be useful, as long as the
appropriate information to designate location and laterality are
present.
Finally, a good summary assessment is necessary, putting together all
the findings. Interpretation is really valuable in helping in providing
the necessary details for appropriate diagnosis coding.
Let me give an example. Let's say you have a 65 year-old with a history
of atrial fibrillation who is currently taking an anticoagulant and falls
and injures the right forearm.
The HPI should start with the reason for the encounter, describing important aspects of the incident that lead to the arm injury. Did the patient fall down some stairs at home, slip in the kitchen or get hit by a car?

Contributing information would be the history of A fib. and the anticoagulant therapy would be noted as contributing details. This helps identify additional risks for the patient.

The physical exam, of course, would note any deformity of the right forearm as well as any signs of bruising or tenderness. In this example with no other injuries, laboratory tests show a therapeutic INR and x-rays show a displaced mid-shaft radius-ulna fracture. The summary assessment should describe only the pertinent findings of the radiology report (because radiologists’ reports often contain indeterminate language). The clinician needs to document the specifics.

With this type of documentation, the physician can establish a more complete description of the disease, injury or other cause of evaluation, the severity of illness/injury, and the clinician’s rationale for the services and resources provided to the patient.

The record needs to communicate the information clearly for the benefit of patient’s healthcare team for better care coordination, as well as to other interested parties such as payers, state health agencies and researchers (when appropriate). Good documentation is the best way to demonstrate to others your good patient care. Poor, sloppy or lazy documentation will result in delays, bounce backs for more documentation, down coding, payment denials, and a higher chance of being audited.

7  Great advice! Now, let’s look at some specific items that will require the clinician to document differently in ICD-10.

Dr. Linzer, would you take the lead on this again?

Sure.

- Let’s start with how sepsis, severe sepsis, and septic shock are used in ICD-10-CM. To make the diagnosis of sepsis, documentation of the underlying systemic infection is important. The underlying infectious agent or cause, e.g. infection following a procedure, or puerperal sepsis, should be listed as the principle diagnosis. If the type of infection or causal organism is not known or stated (as is often the case in the ED or early in the hospital course), then “sepsis unspecified organism” will be documented (same as septicemia NOS). Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis. The cause of sepsis should be identified when possible (streptococcal sepsis, Group A Strep, Group B Strep, other Strep, Staph, methicillin-sensitive, MRSA, other Staph, H. flu, anaerobes, other Gram negatives, E. coli, Pseudomonas, Serratia, Enterococcus, etc). When there is organ dysfunction related to the infection, then the term severe sepsis is
applied as a contributing (secondary) diagnosis. Severe sepsis can be with or without septic shock. Septic shock no longer exists as a standalone code. Manifestations such as acute kidney failure or DIC should be noted.

- **Urosepsis**, like in ICD-9-CM, is coded as “UTI.” If the patient is septic from a UTI, then the documentation should state “sepsis secondary to UTI.”
- **Bacteremia** is not sepsis. It is a positive blood culture without any specific condition.
- The term **SIRS (Systemic Inflammatory Response Syndrome)** is used for non-infectious sepsis-like conditions. The underlying conditions such as trauma or heatstroke should be documented as the principle diagnosis. Documentation should include mention of the presence or absence of organ dysfunction. Manifestations such as acute kidney failure or DIC should be noted.
- **Locations of infections** should be specifically anatomically documented (nasopharyngitis, sinusitis, pharyngitis, tonsillitis, laryngitis, tracheitis, obstructive laryngitis and epiglottitis, etc).
- There are separate categories for **Type 1, Type 2 and other specified (primary) diabetes** as well as diabetes secondary to a condition or drug. Documentation should identify complications and affected body systems. The term “uncontrolled diabetes” has been removed. You should document if the patient has hypo- or hyperglycemia, as well as any other complication present.
- **Mental health disorders** should be documented according to their underlying condition along with documentation of clinical descriptors including in remission, recurrent episodes, mild, moderate, severe, specific substance abuse and/or dependence (opioids, cannabis, alcohol, etc).
- Neurological diseases- Nerves and conditions are documented by limb and laterality, including documenting dominant or nondominant side involvement.
- **Epilepsy** should be specifically documented as to the type of epilepsy. Documentation should include whether it’s status epilepticus, pharmaco-resistant, treatment resistant, refractory, poorly controlled, fever related, post traumatic, etc.
- **Eye** presentations should not only include laterality, but if eyelid involvement the documentation should distinguish upper and lower.
- **Hypertension** documentation should specify the underlying etiologies and end organ effects: essential (primary), secondary, associated with heart disease, kidney disease or both. When associated with heart disease note if heart failure is present or not. When associated with chronic kidney disease, indicate what stage of CKD is present. If the HTN is secondary, note if it is associated with renovascular or other renal disorders, endocrine disorders, other secondary condition.
- There have not been any significant changes with **heart failure.** You
should still note if the failure is left sided, systolic, diastolic or combined (congestive) or “congestive” (same as right side unspecified), as well as if acute, acute on chronic, or chronic.

- **Sequela of cerebrovascular disease**, including cognitive, speech, paralysis, etc. should be documented when appropriate.
- **Chest pain** documentation should, when appropriate, be specified as “angina”, “ischemic chest pain”, pleuritic, precordial or anterior wall chest pain.
- For myocardial infarctions, documentation should indicate whether it’s a **STEMI or NSTEMI**. If it’s a STEMI, then note additional details such as anterior or inferior and the affected vessel if known. A “subsequent MI” is one that occurs within 28 days of a previous MI.
- In patients transferred from one facility to another, administration of **TPA** given at the transferring facility within 24 hours of admission to the new facility should be documented.
- **Smoking** history should be documented, when appropriate, with many cardiovascular, respiratory or malignant conditions.
- **Emphysema** and **COPD** are considered unique conditions that would not be coded together. In a patient with emphysema, document if they have unilateral, panlobular or centrilobular type, if known. Emphysema with chronic (obstructive) bronchitis is considered a form of COPD. In patients with COPD, note if associated with an acute exacerbation or lower airway infection.
- Documentation for **Asthma** should reflect current NHLBI terminology: mild intermittent, mild persistent, moderate persistent, severe persistent. “Unspecified asthma” will continue to be acceptable in the ED setting if this information is not available. Each of these classifications can be associated with an acute exacerbation or status. Document additional information such as exercise induced or cough variant, if applicable. You can find this information on your Tips printout.
- It is important to remember that the term “acute gastroenteritis” actually says “non-infectious AGE”. Since most of the time the clinician actually indicates that there is a likely infectious origin then the terms “infectious”, or “viral” AGE should be used. When occurring with the same illness, vomiting and diarrhea are considered to be inherent to gastroenteritis and are not separate diagnoses.
- **Cellulitis (acute lymphangitis)**, abscess, furuncle, and carbuncle should be documented for specific location and laterality (finger, toe, right or left, etc). Document the infectious agent if possible (or probable as in MRSA), and document any significant underlying medical condition that affects the management of the condition (DM, long-term steroid use, etc).
- **Pressure ulcers** should be documented by location, laterality and Stage. (You’ll need to know Stages 1-4 are 1. focal edema; 2. abrasion, blister, partial thickness skin loss; 3. full thickness skin loss; 4.
necrosis of soft tissues to underlying muscle, tendon or bone). These are also available on with your printouts.

- **Stages of Chronic Kidney Disease** should be documented (Stages 1-5). Transplant status, if appropriate, should also be documented.

- **Gout** should be documented as to its type (e.g., chronic gout, lead-induced gout, drug-induced gout, gout due to renal impairment, other secondary gouts). The presence or absence of tophi should also be documented for chronic gout.

- The appropriate **pregnancy trimester** for pregnancy-related conditions should be documented. It’s important to document the stage of the patient’s pregnancy in weeks, months or trimester.

- There are specific diagnosis terms for **neonates**. These codes are used for conditions that begin during the newborn period. This is the first 28 days of life. Since the day of birth is considered day 0, these codes would be applicable to 29 days.

- **TBI** documentation should include loss of consciousness and duration, any GCS recorded, any associated injuries, circumstances associated with the injury. The **Glasgow Coma Scale** score (eyes, verbal, motor) should be used to fully describe coma secondary to TBI. The score may come from a number of sources (EMT, ED, RN, etc). Documentation should also include the time when the reported GCS was reported: unspecified time, in the field, arrival at the ED, at admission, and 24 hr or more after admission.

- **Fractures** have a lot more documentation requirements. Among them are specificity in naming the
  - **Fracture type** (open, closed, pathologic, neoplastic, torus, bent, greenstick, stress, osteoporosis)
  - **Displacement** (non-displaced, displaced)
  - **Fracture pattern** (transverse, oblique, spiral, comminuted, segmental)
  - **Laterality** (right, left or bilateral)
  - **Specific anatomic site of the injury**
  - **Joint involvement** (intra-articular, extra-articular)
  - **Classification** (Salter-Harris or Gustilo)
  - **Named fractures** (Colle’s, Smith’s, Barton’s, LeFort, etc)
  - **Healing stage** (routine, delayed, nonunion, malunion)
  - **Type of encounter** (initial, subsequent, or for sequelae)

  A good suggestion would be to document on the chart the radiologist’s report describing specific clinically relevant findings of the fracture.

- **Open wounds** have many of the same requirement for complete documentation as do fractures, including whether a superficial injury, abrasion, blister, laceration, bite, puncture wound, constriction, crushing injury or amputation, presence of infection, foreign body, and any associated complications.
• **Burns and corrosions** should be classified according to the extent of the body surface involved (utilizing the Rule of 9s in adults).
• **Repeated falls** is a separately reportable condition, if it’s documented.
• **Drug toxicities** include adverse effects and poisoning (errors made in prescription, intentional OD, drug combination causes, drugs and alcohol). Documentation should be specific about the drug(s) or other causes, and whether there was any intent or if the exposure was accidental. Causes of under-dosing should be documented (financial, misunderstanding of instructions, lack of tolerance, etc).
• The **External Causes of Morbidity** are things such as vehicle accidents, assaults, lightning strikes, etc. There is no national requirement for mandatory ICD-10-CM external cause code reporting. However, we recommend that you do document **external causes** in case your particular state, or the patient’s particular insurance company, mandates their use (e.g., work related injuries and motor vehicle accidents).
• Documenting the **reason(s) for contact** by the patient with healthcare services can be important for reimbursement and other purposes. This documentation should include reasons such as for: contact or an exposure, alleged assault/rape, status as disease carrier, personal or family history of disease (e.g., alcoholism, drug addiction in family), suspected abuse, screening exams, observation for specific event/effect, aftercare and follow-up (for other than injuries), donor status, counseling, routine exams, OB/reproductive services, and also for noncompliance with medical treatment recommendations (dietary, under-dosing due to financial reasons, other noncompliance…).

8 **That’s a LOT of SPECIFICITY! Dr. Linzer, how are the coders going to know how to do their job with so many new requirements?**
• It’s the responsibility of the practicing healthcare provider to **properly document the patient’s encounter**. If it’s not on the chart, then the coder will not be able to code properly. Improperly coded charts will lead to bounce-backs or rejection for further documentation, or to denials of payment and (possibly) audits.
• It cannot be overemphasized that **the responsibility of the practicing physician is to paint a complete picture of the patient’s episode of care**.

9 **Well then, let’s look at a few specific examples of EM and HM diagnoses and see how ICD-10 will affect the physician’s documentation requirements.**

[Spreadsheets will show on screen as we discuss the specific examples.]

As you can see, the transition to ICD-10 is not simple. **Successful transition to ICD-10 will require thorough documentation and close coordination between the clinician and the professional coder.** You should
expect feedback from your coders as you progress along the curve to better and more specific documentation. You should also remember that coders don’t have medical degrees and won’t understand pathology and physiology as well as the clinicians. However, most clinicians don’t have professional coding training, either. It’s a team effort! The startup may be somewhat awkward with increased communications back and forth between coder and clinician, but the end result should be much more smooth all around than with the vagueness and lack of specificity allowed under the old ICD-9 system.

Let’s give some good references for our viewers in case they want to know more about ICD-10 and how they should document.

- The best resource is the National Center for Healthcare Statistics’ website [http://www.cdc.gov/nchs/icd/icd10cm.htm](http://www.cdc.gov/nchs/icd/icd10cm.htm). NCHS is primarily responsible for the diagnosis codes. You can also download the latest .pdf version of ICD-10-CM from the site as well.
- The AHIMA (American Health Information Management Association) has just recently developed some documentation tips for clinicians. This is an excellent source of information. The Documentation Tips may be downloaded at [http://bok.ahima.org/PdfView?oid=300621](http://bok.ahima.org/PdfView?oid=300621)
- The CMS website [https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosisCodes/index.html](https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosisCodes/index.html) has a lot of technical materials for review. It also has some pretty good videos on YouTube ([www.youtube.com](http://www.youtube.com)). Some of the better videos are:
  1. Countdown to ICD-10: 10 Facts About ICD-10;
  2. Introduction to ICD-10 Coding;
  3. ICD-10 and Clinical Documentation
- The ACEP website ([www.acep.org](http://www.acep.org)), under the tabs of Clinical & Practice Management/Resources/Reimbursement/ICD-10 includes the following resources:
  1. ICD-10 FAQ;
  2. IDC-10-CM and the Emergency Physician;
  3. ICD-10 For the Busy EP;
  4. ICD-10-CM Clinical Examples;
  5. ICD-10 Coding Tips to Help EPs Navigate Documentation Change.
- The Society of Hospital Medicine website ([www.hospitalmedicine.org](http://www.hospitalmedicine.org)) has no specific guidance online. There is a subscription-only bulletin for $250/yr for members available to provide information on ICD-10 documentation and coding: Code Optimally by Documenting Effectively for Hospitalists (CODE-H).
- The AAPC (American Academy of Professional Coders) offers a training course for clinicians in ICD-10 documentation. The cost for this course is $395 for non-members. Information on this course can be obtained at [www.aapc.com](http://www.aapc.com).
- Pettigrew Medical [ICD-10 Tips for Documentation](https://www.pettigrewmedical.com). This printable and
foldable pocket guide has been developed to help you document well under ICD-10. You’ll want to keep this guide handy. It’s available for free on the Pettigrew Medical website, www.pettigrewmedical.com, as are the links to the other resources mentioned above.

10 Thank you, Dr. Linzer, for your expert explanation and advice on the transition to ICD-10.
And, thank you, viewers for your interest in being prepared for the transition to ICD-10.
This concludes our instructional video. If you have further questions about ICD-10 transition or any information in this video, please contact:

Pettigrew Medical Business Services
(800) 532-6151