

ICD-10 physician script

1. It is the physicians who determine the diagnosis, perform the procedures, order the tests, and prescribe the treatments that drive the core of patient care. It is the physician documentation that undergoes translation from word into ICD-9-CM codes. These codes provide the basis for billing, medical necessity, and physician profiling. This is not a new process; however, the words that are now translated to ICD-9 codes will soon be translated to ICD-10 codes.
2. ICD-10 includes both ICD-10-CM for diagnoses and ICD-10 PCS for procedures. ICD-10-PCS will be used for reporting procedures in the inpatient setting. Procedures performed as an outpatient service will be reported with the Current Procedural Terminology (CPT) codes.
3. Although transitioning to ICD-10 is a major disruption, the upgrade will offer the coding specificity to capture the true severity of illness. Because ICD-9 was developed over 30 years ago, the codes are obsolete and can no longer adequately reflect current medical practices.
4. ICD-10-CM looks different than ICD-9-CM in its organization and structure, code composition and level of detail. There are approximately 14,000 ICD-9-CM diagnoses codes which are being expanded to approximately 68,000 ICD-10-CM diagnoses codes. ICD-9 diagnoses consist of 3 – 5 characters; ICD-10-CM consists of 3 – 7 characters.
5. The example code demonstrates how the code is classified – the first 3 characters are the category, the fourth through sixth clarify the etiology, anatomic site and severity, and the seventh is a code extension for obstetrics, injuries and external causes of injury.
6. As can be seen in this example, the ICD-10 code provides greater specificity than the current ICD-9 codes. It is important that you understand the format of the code in order to provide the most specific documentation.
7. ICD-10-PCS classification for procedures will only apply to inpatient procedural coding. ICD-10-PCS will allow the ability to assign specific and correct procedures since the approximate 3,000 ICD-9 codes are being expanded to approximately 87,000 ICD-10-PCS codes.
8. Each ICD-10-PCS code is seven characters with each character representing a specific aspect of the procedure performed such as body system, root operation, body part, approach, and devices.
9. ICD-10 will have an impact on healthcare workers, not just coders and billers. Case management and utilization review departments will need to understand the specificity requirements of clinical documentation for medical necessity. Nursing, clinical, infection preventionists, social services, and ancillary staff will play an important role in capturing the necessary level of detail in their documentation which CDI and coders may reference when preparing physician queries. End users of ICD-9 / ICD-10 data (finance, quality, IT analysts, data analysts, registrars, and department heads) will need to understand the effects of the change for hospital metrics, reporting, quality, decision support, data transfers, and reimbursement.

10. In today's healthcare industry, by documenting appropriately, providers can paint a more accurate picture of a patient's severity, improve the quality of patient care, and enhance communication among all healthcare providers.
11. Documentation is essential when painting the story of a patient's encounter. Remember the Golden Rule of Documentation, if it isn't documented, it didn't happen. To expand on that rule for ICD-10, the key word is specificity – the next slide will review the key documentation concepts for ICD-10.
12. The key documentation elements are shared across many diagnoses and conditions. Incorporating these concepts and specificity in your documentation will enhance quality reporting, research, and medical necessity. The 7 key elements are acuity, site, laterality, etiology, manifestations, external cause of injury, and signs & symptoms.
13. Now that we reviewed the key documentation requirements, let's review some common documentation needs for common conditions and diseases. First, never use symbols to document a disease. Up arrows indicate an elevated or high diagnostic study. Up arrow BP means a high blood pressure reading, not that the patient has hypertension.
14. New concepts with ICD-10 include the documentation of the specific site and laterality (this is required for bilateral body parts and paired organs), stage or severity of the disease process (examples include acute, chronic, acute on chronic, stage 1, stage 2, stage 3, stage 4), and the episode of care (initial, subsequent and sequelae).
15. For asthma patients, the documentation should be related to the severity (examples - intermittent versus persistent and mild, moderate, or severe). It is also very important to document the level of exacerbation as either uncomplicated, acute or status asthmaticus. The type or form of asthma such as allergic, allergic bronchitis, Allergic rhinitis, childhood, exercise induced, and late onset. An example of an ICD-10 code for asthma would be J45.31 – mild persistent asthma with acute exacerbation.

Asthma caused by environmental factors or exposure to tobacco should be documented to show the cause-and-effect relationship.
16. Crohn's disease will now require that the specific site be clearly documented with any manifestations such as rectal bleeding, intestinal obstruction, fistula, abscess, or other complication.
17. Diabetes will no longer require the documentation of controlled or uncontrolled. The type of diabetes or the underlying condition that caused the diabetes is required. Examples include type I or type II, or due to a specific drug. It is also necessary to link any manifestations to the diabetes, circulatory, renal, neurological, ophthalmic, skin, etc. In the example presented code E11.311 is type 2 diabetes with diabetic retinopathy with macular edema.

18. Epilepsy documentation requires the type (localization-related, generalized, absence) and the specific type (intractable versus not intractable) and with or without status epilepticus. The example codes demonstrate the specificity required – localization-related idiopathic epilepsy with seizures of localized onset, and then further defining the intractable and status epilepticus.
19. The fracture codes have been expanded to require the cause (what was the reason – traumatic, stress or pathological), location (which bone, which part of the bone, laterality (right, left, both)), type (what type of fracture – open, closed, displaced, non-displaced), encounter (when is the patient being seen – is this the initial visit or a subsequent visit), and external cause (for traumatic fractures, how did the fracture occur during a specific activity – example patient fell while skiing) .
20. For open fractures, the type and specificity should be documented using the Gustilo-Anderson classification for forearm, femur and lower leg fractures. There are 3 types of fractures – type 1 wound is smaller than 1 cm and is clean; type 2 – wound is longer than 1 cm and is not contaminated and has no major soft tissue damage; type 3 is longer than 1 cm with significant soft tissue disruption.

Type 3 is further subdivided into classes: A – soft tissue coverage, B – disruption of the soft tissue is extensive, C – associated with an arterial injury.
21. Pathologic fractures will require the exact location of the fracture, the etiology or cause of the fracture, and the encounter type (initial or subsequent).
22. The ICD-10 codes for the Glasgow coma score have been expanded. A score from each of the assessment areas (eye opening, verbal and motor response) will be required in addition to the total score.

On the example provided for eye opening, the 6th digit of the ICD-10 code represents the assessment (eyes never open, eyes open to pain, eyes open to sound, eyes open spontaneously). The ICD-10 classification for the total score is based on ranges of the GCS (example 13 – 15)
23. The largest change for the myocardial infarction codes is the timing of the infarction. In ICD-9, a current MI was considered to be within 8 weeks. The codes for ICD-10 classify recent as within 28 days. It is very important to document the date of any MI in order to classify it as a current or historical event. In addition, the type of MI and specific location and site affected should be clearly documented (anterior wall, interior wall, left anterior descending coronary artery, etc.). Example provided, code I21.01 – STEMI involving the left main coronary artery.
24. Pregnancy codes are being updated to indicate the trimester of the pregnancy. The ICD-10 definition for trimesters are first (less than 14 weeks, 0 days), second (14 weeks, 0 days to less than 28 weeks, 0 days), and third (28 weeks until delivery). Documentation of diabetes needs to clearly define if the condition is gestational or if the patient was diabetic. If gestational

diabetes, the documentation should indicate if the diabetes is diet controlled or insulin controlled.

25. Strokes / Cerebrovascular disease clearly specific the location or source of the hemorrhage. Also include the cause (thrombosis, embolism, occlusion, stenosis, etc.). For non-traumatic cerebrovascular hemorrhage, document the site (subarachnoid or intracerebral). A subarachnoid hemorrhage requires identification of the affected vessel (example – right vertebral artery). For any paralytic syndromes or residual side effects, it is very important to document if the dominant or non-dominant side is affected.
26. Drug and Alcohol abuse codes are being expanded to classify the cause and effect indicators. Documentation requirements include the specific aspect of the effect (example – abuse and / or dependence), the aspects of use (example - withdrawal state), and any identified manifestations (example – hallucinations).
27. Drug Under-dosing is a new code for ICD-10. It was created to identify times when a patient has taken less of a medication than what was prescribed. The documentation to support this code should include the medical condition that was a result of not taking the correct dosage, the medical condition or reason the patient was prescribed the medication, and the reason that the patient did not take the correct dosage. An intentional example is the patient could not afford the medication; an unintentional example is an elderly patient who may forget to take the medication due to an age-related debilitation.
28. ICD-10-PCS will allow the ability to assign specific and correct procedures since the approximate 3,000 ICD-9 codes are being expanded to approximately 87,000 ICD-10-PCS codes. The 3 main components that need to be documented include the anatomic site, the root operation, and the surgical approach. Since ICD-10-PCS does not allow for unspecified procedure codes, it is very important to document appropriately all aspects of the procedure. NOTE – bedside procedures, OR procedures, and ancillary procedures for inpatient cases will be assigned ICD-10-PCS codes. Examples of the root operations are displayed on the slide (examples – bypass, excision, reattachment, resection)
29. There are 7 main operational approaches, please clearly document the approach in your operative report. Example – via natural opening endoscopic or open
30. Postoperative complication codes have been expanded to identify an intraoperative complication and post-procedural complication. The provider must clearly document the relationship between the condition and the procedure. In the example provided, the hemorrhage of the spleen is coded D78.01 for the intraoperative hemorrhage complicating a procedure and code D78.21 is for a post-procedural hemorrhage following a procedure on the spleen.

31. Numerous resources are available for the transition to ICD-10. This screen provides several links. If you have any specific questions or need additional information, you should reach out to the HIM Director at your local facility.

32. In summary, physicians are not expected to understand every ICD-10 code.

Remember the Golden Rule of Documentation, if it isn't documented, it didn't happen. To expand on that rule for ICD-10, the key word is **specificity**. Incorporating these 7 concepts and specificity in your documentation will minimize questions asking for clarification in your documentation. Acuity, site, laterality, etiology, manifestations, external cause of injury, and signs & symptoms.

Thank you.