Ambulatory Medicine

The ICD-10 Success Series
Webconference
December 17, 2014
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Brief Overview: The ICD-10 Success Series Webconferences

Across the coming months, the Advisory Board’s Clinical Advisor Team will be hosting numerous Webconferences on a variety of documentation topics critical to a seamless and successful transition to ICD-10. As providers, please take a look at the list of upcoming sessions and save time to attend those most pertinent to your practice. We have created them to be succinct and to the point, and will be presenting lessons you can begin to incorporate into your documentation immediately (in an ICD-9 world). Below is a list of all upcoming sessions:

1. September 24th – Sepsis/Septicemia
2. October 1st – UTI
3. October 8th – Pressure Ulcers
4. October 15th – Stroke
5. October 22nd – Encephalopathy
6. October 29th – AMI & Coronary Artery Disease
7. November 5th – Respiratory Failure, Pneumonia, COPD
8. November 12th – Orthopedic Surgery, Joints, Spine
9. November 19th – Diabetes
10. December 3rd – Anemia
11. December 10th – Cellulitis
12. December 17th – Ambulatory

**All sessions will be hosted from 12:00 – 1:00 pm EST. Recordings will be made available for follow up viewing on the intranet and physician websites.**
About Today’s Speaker

Emeric Palmer, MD, FACP, FHM

- Senior Medical Director at the Advisory Board Company
- Board certified physician in Internal Medicine and Wound Care and Hyperbaric Medicine.
- Experience in Primary Care and Hospital Medicine with large, nation-wide systems as well as private group practices.
- Served as an Assistant Professor of Medicine at the University of Illinois, Chicago with Advocate Christ Medical Center.
- Earned the Healthcare IT Leadership Certificate from the American College of Physician Executives
- Former chair of the Health Information Management and Physician EHR committees at Meritus Medical Center in Hagerstown, Maryland
- Worked as an Internal Medicine Hospitalist with Kaiser’s Mid Atlantic Permanente group.
- Special areas of interest include process improvement, quality and safety, high reliability, team dynamics, and communication.

For more information, contact:

Emeric Palmer, MD, FACP, FHM
Senior Medical Director

202.266.5600
PalmerE@advisory.com
Brief Overview: Code Expansion in ICD-10 Requires Greater Documentation Specificity

Expanded Code Set in ICD-10: ~16K to ~150K

Why So Many New Codes?

The main difference between ICD-9 and ICD-10 codes, outside of structural changes, is the SPECIFICITY of the code.

ICD-10 codes specify several components not found in ICD-9, such as stage, laterality, severity, root cause operation, etc.

Key ICD-10 Concepts Required in Documentation

<table>
<thead>
<tr>
<th>Concept</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage or grade of disease</td>
<td>Severity: mild, moderate, severe</td>
</tr>
<tr>
<td>Specific anatomical location</td>
<td>Episode of care: initial vs. subsequent</td>
</tr>
<tr>
<td>Acute or chronic</td>
<td>Unilateral or bilateral condition</td>
</tr>
</tbody>
</table>
Road Map for Discussion

1. Documentation Requirements for Ambulatory Medicine in ICD-10

2. Examples of Ambulatory Procedures and Diagnoses in ICD-10-CM
Concepts Drive Changes in Documentation Requirements

Key Considerations for Ambulatory Care: ICD-10-CM

Laterality

- Type of Procedure
- Infection Site
- Causal Agent
- Type of Infection
- Complication
- Acuity
- Stage
- Type of Procedure
Concepts Drive Changes in Documentation Requirements

K Key Considerations for Ambulatory Care in ICD-10-PCS

- Approach
- Root Operation
- Type of Device
- Extirpation Site
- Drainage Site
- Insertion Site
- Excision Site
- Laterality
- Quantity
- Extirpation Site
- Insertion Site
- Excision Site
- Laterality
- Quantity
ICD-10-CM Ambulatory Documentation Basics

In the Ambulatory Care Department, be sure to include the following specificity of diagnoses in your documentation:

<table>
<thead>
<tr>
<th>Key Ambulatory Care Documentation Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acuity</td>
</tr>
<tr>
<td>Systems reviewed</td>
</tr>
<tr>
<td>Tobacco dependence or exposure</td>
</tr>
<tr>
<td>Medical decision making</td>
</tr>
<tr>
<td>Specify medication complications as:</td>
</tr>
<tr>
<td>• Adverse effects</td>
</tr>
<tr>
<td>• Poisoning</td>
</tr>
<tr>
<td>• Under dosing</td>
</tr>
<tr>
<td>Injury</td>
</tr>
<tr>
<td>• Site</td>
</tr>
<tr>
<td>• Causes</td>
</tr>
<tr>
<td>• Additional associated injuries</td>
</tr>
<tr>
<td>Laterality</td>
</tr>
<tr>
<td>Consultation time</td>
</tr>
</tbody>
</table>

For procedures, specify site and link to conditions and or diagnoses justifying the procedure.
Linking Conditions Critical to Capturing Patient Severity

There is a significant increase in the number of “combination codes” available in the ICD-10-CM/PCS code set. These codes can help capture the highest level of complexity and acuity in the public eye.

- Linking clinically relevant conditions, where appropriate, is the key takeaway physicians need to incorporate into their documentation today whether working in the inpatient or outpatient arena. Remember, coders cannot assume such clinical relationships.

Examples: Linking Diseases

- HTN with heart disease
- Hypertension with heart disease and CKD, Stage 3
- Type 1 DM with CKD stage 4
- Dehydration due to acute renal failure
- Chest pain due to GERD

Use terms like “due to” or “with”

Note: Lists, commas, and the word “and” do not link conditions
Road Map for Discussion

1. Importance of Documentation and Basics of ICD-10-CM/PCS

2. Examples of Ambulatory Scenarios and Diagnoses in ICD-10-CM
# ICD-10-CM Ambulatory Diagnoses & Concepts Covered Today

Let's move on to these diagnoses & concepts to help explain what documentation will be like in ICD-10-CM.

<table>
<thead>
<tr>
<th></th>
<th>AMI</th>
<th></th>
<th>Digestive System Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Heart Failure</td>
<td>8</td>
<td>CKD</td>
</tr>
<tr>
<td>3</td>
<td>Tobacco Exposure</td>
<td>9</td>
<td>Urinary Conditions</td>
</tr>
<tr>
<td>4</td>
<td>COPD and Emphysema</td>
<td>10</td>
<td>Infections</td>
</tr>
<tr>
<td>5</td>
<td>Pneumonia and Influenza</td>
<td>11</td>
<td>CVA</td>
</tr>
<tr>
<td>6</td>
<td>Coma</td>
<td></td>
<td></td>
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ICD-10-CM Ambulatory Documentation Basics

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<td>Laterality</td>
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For procedures, specify site and link to conditions and or diagnoses justifying the procedure.
Understanding Implications for AMI Changes

Limited time frame for ‘acute’ designation will require increased specificity

“PMH: Patient suffered a STEMI involving the left circumflex coronary artery two weeks ago and was discharged home. Same patient is admitted today for a STEMI of the anterior wall.”

Patient enters Ambulatory Care Center, shortness of breath and continued pain

MD identifies MI of anterior wall on EKG; Transfers to hospital setting

Specify in days for accurate code selection

> 28 Days?

≤ 28 Days

“a month ago”

Understand implications for MI’s

Note:
- Acute MI – (within the last 4 weeks)
- Subsequent MI – (another MI within 4 weeks)
- New Acute MI - (another MI after 4 weeks)
- “Old” MI – (MI more than 4 weeks old)

*4 weeks = 28 days
Acute Myocardial Infarction

Initial ST elevation (STEMI) myocardial infarction of anterior wall involving left main coronary artery

- **Consistent across all AMIs**: 1
- **Order**: 1
- **Type and Site**: 0

**Specific artery**
- Left main artery
- Left anterior descending
- Other coronary artery

**Myocardial Infarction**
- **Initial**
  - STEMI Inferior Wall
  - STEMI Anterior Wall
- **Subsequent**
  - STEMI Unspecified site
  - STEMI Other site
  - NSTEMI
Heart Failure Specificity for Severity of Illness

Link all pieces of an illness to get the highest severity of illness to support tests, procedures or therapies

Components to Best Practice Documentation

- **Specify Acuity:** Acute, Chronic or Acute on Chronic Heart Failure
- **Specify Type:** Systolic, Diastolic, or Combined systolic and diastolic
- **Clarify the relationship of the hypertension to the heart disease or heart failure**
  When linked together, this may impact the severity of illness and risk of mortality of the patient
- **Identify (if known, the underlying etiology of the failure):**
  - Is it an exacerbation of stable heart failure, due to fluid overload, or due to missed dialysis causing signs?
- **Echocardiogram Findings:**
  - Document findings of systolic, diastolic or both from the echo in your progress notes and discharge summary, if available

Heart Failure Combination Codes Examples:

- Hypertensive heart disease with heart failure
- Neonatal cardiac failure
- Heart failure following surgery
ICD-10-CM requires documentation of tobacco exposure, specifically for:

- Pulmonary & Digestive diseases
- Diseases of the head, neck, mouth and esophagus
- During pregnancy, birth and puerperium

<table>
<thead>
<tr>
<th>Document Level of Usage</th>
<th>Type of Usage/Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Use</td>
<td></td>
</tr>
</tbody>
</table>
| Exposure                | • During pregnancy, birth and puerperium  
                          • Environmental tobacco smoke (2nd hand smoke) |
| Use                     | • Tobacco use (current)  
                          • Tobacco use (past) |
| Dependence              | • Nicotine dependence and source (e.g. cigarettes, chewing tobacco, other)  
                          • Nicotine dependence in remission  
                          • With or without other nicotine-induced disorders |
Asthma

ICD-10-CM Documentation Concepts (now aligned with National Heart, Lung, and Blood Institute (NHLBI) guidelines

Types:
- Intermittent
- Persistent

Acuity:
- Mild
- Moderate
- Severe

“With”
- Uncomplicated
- Acute exacerbation
- Status asthmaticus

Severe persistent asthma with acute exacerbation

Chronic lower respiratory diseases (Asthma)

Type and acuity

“With”

Documentation Tip:

Document (if present):
- Exercise-induced bronchospasm
- Cough variant asthma
- Detergent asthma
- Eosinophilic asthma
- Wheezing

Always document tobacco exposure
# Respiratory Conditions: Pneumonia & Influenza Documentation Requirements

## Pneumonia

| Identify the organism | Viral or Bacterial?...name the organism  
Example: “Probable pneumonia due to MRSA” |
|-----------------------|----------------------------------------------------------------------------------|
| Link any associated conditions to the pneumonia: | • Influenza with secondary gram negative pneumonia  
• Sepsis due to pneumonia  
• Acute respiratory failure due to pneumonia |
| Aspiration PNA | Identify if:  
• Due to solids or liquids  
• Due to anesthesia during L/D  
• Due to anesthesia during puerperium |

## Documentation Tips:
- Both required documentation of tobacco
- Do not need a + CXR or culture

## Influenza

| Type | • Novel influenza virus type A  
• Influenza virus |
|------|--------------------------------------------------|
| Associated conditions | • Pneumonia, specify causative organism if known  
• Respiratory illness (laryngitis, pharyngitis, upper respiratory symptoms)  
• GI Illness – excludes intestinal flu  
• Encephalopathy  
• Myocarditis |
Pneumonia

Pneumonia due to methicillin resistant Staphylococcus aureus

Influenza and Pneumonia
(Bacterial pneumonia)

Specific Organism

- MSSA
- MRSA
- Other
- Unspecified

Note:
- When the organism is not identified, the default is Pneumonia, unspecified
- Documentation of the terms Healthcare Acquired (HAC) / Hospital Acquired (HAP) / Community-Acquired (CAP) Pneumonias default to pneumonia, unspecified
Digestive System
Enteritis ICD-10-CM Documentation Concepts

**Crohn’s Disease**
- Specify Site:
  - Small intestine
  - Both small and large intestine
  - Large intestine

**Ulcerative (chronic) Colitis**
- Type: Pancolitis, proctitis or rectosigmoiditis
- Inflammatory polyps of colon
- Left-sided colitis

**Documentation Tip:**
- Always document complications of:
  - Rectal bleeding
  - Intestinal obstruction
  - Fistula
  - Abscess
- Alcohol/tobacco abuse or dependence
Kidney Disease

ICD-10-CM: Specificity of *type* of kidney damage in order to reflect accurate severity.

<table>
<thead>
<tr>
<th>Acute Renal Failure/Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Document the Type if Damage</strong></td>
</tr>
<tr>
<td>ARF or AKI “with”:</td>
</tr>
<tr>
<td>• Tubular necrosis</td>
</tr>
<tr>
<td>• Acute cortical necrosis</td>
</tr>
<tr>
<td>• Medullary necrosis</td>
</tr>
<tr>
<td>• Associated underlying condition</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chronic Kidney Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identify the Stage</strong></td>
</tr>
<tr>
<td>Stage I-V</td>
</tr>
<tr>
<td><em>(stages IV-V are CCs)</em></td>
</tr>
<tr>
<td>*<em>Is the CKD related to Hypertension or Diabetes? If so, document the linkage (“due to”/ “with”)</em></td>
</tr>
<tr>
<td><strong>Transplant Status</strong></td>
</tr>
<tr>
<td>Document if the patient has had a transplant</td>
</tr>
<tr>
<td>or</td>
</tr>
<tr>
<td>If the patient is a candidate for a transplant</td>
</tr>
</tbody>
</table>

**CKD as a Manifestation: Link Diseases**

**Examples:**
- Hypertensive chronic kidney disease *with* Stage 4 CKD
- Type 2 DM with diabetic CKD stage 5
- Hypertensive heart and CKD with heart disease and stage 3 CKD

Use terms like “due to” or “with”

Note: Lists, commas, and the word “and” do not link conditions
Chronic Kidney Disease

Hypertensive chronic kidney disease, stage 5

Note

- Unlike HTN and heart disease, ICD-10-CM presumes a cause-and-effect relationship between HTN and CKD
- Coders will assign a secondary code to identify CKD Stage 5 (N18.5)
- If the patient has HTN, CKD and Acute Renal Failure an additional code is required
Please Specify:

1. Acuity

2. “Sepsis from a urinary source” or only “UTI”
   - “Urosepsis” does not have a default in ICD-10-CM and will require a query
   - Typically, a UTI does not support medical necessity for inpatient admission, clarify the reason for the inpatient admission.

3. Name diseases or conditions
   - Link all signs, symptoms and test results together

4. Name suspected organism or cause

5. For renal calculus:
   - Exact anatomic site of stone
   - Location of obstruction (could be different than location of the stone)
   - Link the stone to other conditions
   - Sepsis
   - Uric acid stones secondary to gout

Reminder
- “Urosepsis” will no longer default to a UTI in ICD-10-CM and will require a query
## Infection Documentation

**ICD-10-CM Infection Documentation Needed**

<table>
<thead>
<tr>
<th>Specify Site</th>
<th>Your “suspected organism” is based on antibiotic selection or risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify Laterality</td>
<td>Link infection to a source, if possible</td>
</tr>
<tr>
<td>Specify Type of infection</td>
<td>When giving antibiotics document: “Treating based on clinical evidence”, not “covering for”</td>
</tr>
<tr>
<td>- Abscess</td>
<td>- Document any drug resistance</td>
</tr>
<tr>
<td>- Cellulitis w/ or w/o lymphangitis</td>
<td>- Name infection sequelae</td>
</tr>
<tr>
<td>- Cutaneous abscess, furuncle, or carbuncle</td>
<td></td>
</tr>
<tr>
<td>- Lymphadenitis</td>
<td></td>
</tr>
<tr>
<td>- Sepsis</td>
<td></td>
</tr>
<tr>
<td>- Necrotizing fasciitis</td>
<td></td>
</tr>
<tr>
<td>- Peritonitis</td>
<td></td>
</tr>
</tbody>
</table>

### Best Practice Documentation:

- Rectal fistula secondary to rectal abscess
- Peritonitis d/t ruptured appendix
- Pneumonia due to streptococcus pneumoniae
Otolaryngology Documentation

Documentation needed:

- History of tobacco exposure
- Acuity
- Whether or not recurrent (new in ICD-10-CM)
- Laterality (also needed in vertigo)
- Type or underlying cause of the ear problem
- Name all parts of ear and mastoid involved
- Underlying cause
- Link to associated conditions

Example: Chronic suppurative otitis media of right ear
# Otitis Media

Increased Specificity

<table>
<thead>
<tr>
<th>When documenting Otitis Media, include the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
</tr>
<tr>
<td>Infectious Agent</td>
</tr>
<tr>
<td>Temporal Factors</td>
</tr>
<tr>
<td>Side</td>
</tr>
<tr>
<td>Tympanic Membrane Rupture</td>
</tr>
<tr>
<td>Secondary Causes</td>
</tr>
</tbody>
</table>

**Documentation Examples:**

- Acute suppurative otitis media without spontaneous rupture of ear drum, right ear
- Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear
- Acute serous otitis media, bilateral
- Total perforations of the tympanic membrane, right ear
Injuries

ICD-10 CM Documentation Requirements

<table>
<thead>
<tr>
<th>ICD-10-CM Injury Key Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anatomic site of Injury</strong> (e.g. head, neck, thorax)</td>
</tr>
<tr>
<td><strong>Site Subclassification</strong> (e.g. scalp, eyelid, cervical esophagus)</td>
</tr>
<tr>
<td><strong>Encounter</strong> (e.g. initial, subsequent, or sequelae)</td>
</tr>
</tbody>
</table>
## Glasgow Coma Scale

GCS Score can now be captured in ICD-10-CM

<table>
<thead>
<tr>
<th>Criteria Type &amp; Points</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes Open</td>
<td>Never¹</td>
<td>To pain¹</td>
<td>To sound</td>
<td>Spontaneous</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Best Verbal Response</td>
<td>None¹</td>
<td>Incomprehensible words¹</td>
<td>Inappropriate words</td>
<td>Confused conversation</td>
<td>Oriented; converses normally</td>
<td>N/A</td>
</tr>
<tr>
<td>Best Motor Response</td>
<td>None¹</td>
<td>Extension to painful stimuli¹</td>
<td>Abnormal flexion to painful stimuli</td>
<td>Flexion withdrawal from painful stimuli¹</td>
<td>Localizes painful stimuli</td>
<td>Obeys commands</td>
</tr>
</tbody>
</table>

**Note**

Used in conjunction with:
- Traumatic brain injury
- Acute Cerebrovascular disease
- Or other sequelae of cerebrovascular disease

**Scale**

- Severe, with GCS <9
- Moderate, GCS 9-12
- Minor, GCS > 13

**Documentation Tip:**

- Report each of the subcategory scores rather than just the total score
- Some coma diagnoses codes are categorized as MCCs

¹ Indicates MCC designation
Specify the following:

- Laterality

- Intraoperative (non-trauma injury)
  - During eye surgery or other surgery

- Tissue injured
  - Conjunctiva
  - Cornea
  - Eyeball
  - Orbit

- Was there a functional deficit as a result?

- Foreign body or not
  - Magnetic?
  - Exact tissue location

- Type of Injury (e.g. abrasion, laceration, prolapse of intraocular tissue)

- Type of Encounter
  - Initial
  - Subsequent
  - Sequelae
## Diabetes

Specificity in diabetes documentation may increase severity of patient captured in the record

<table>
<thead>
<tr>
<th>Document</th>
<th>Potential Specifications</th>
</tr>
</thead>
</table>
| Type of Diabetes                 | • DM Type 1  
• DM Type 2  
• DM due to underlying condition (e.g. Cushing’s syndrome)  
• Drug/chemical induced DM (Document the drug/chemical)  
• Gestational DM                   |
| Use of Insulin                   | • Long term  
• Current                                          |
| Any manifestations or complications related to DM | **Example**: Hyperglycemia, Hyperosmolarity                                           |

### ICD-10-CM Key Terminology Change

- If left unspecified, diabetes will default to the DM Type 2
- It is no longer required to specify ‘controlled’ or ‘uncontrolled’ diabetes

---

**Physician Documentation Example:**

“*Type 1 diabetes with mild nonproliferative diabetic retinopathy with macular edema*”

“*Type 1 diabetes with ketoacidosis without coma*”

ICD-10-CM allows the capture of related conditions with one code instead of multiple codes
Diabetic Manifestations & Complications

Providing sufficient documentation to link diabetes to manifestations and/or complications, when appropriate, can significantly increase the severity of illness (SOI) of the patient.

**Two Ways to Capture Documentation:**

**The term “with”:**
- Diabetes “with”:
  - Hypoglycemia
  - Hyperglycemia
  - Hyperosmolarity
  - Ketoacidosis
  - Coma/nonketotic hyperglycemic-hyperosmolar coma

**The term “Diabetic”:**
- Diabetic nephropathy
- Diabetic chronic kidney disease stage 4
- Diabetic gastroparesis
- Diabetic neuropathy (mono/poly/autonomic)

*Example: “Type 2DM with hypoglycemia without coma with diabetic gastroparesis”*

**Key Terminology Changes:**
- The term “uncontrolled” or “controlled” does not exist in ICD-10-CM.
- When diabetes is documented as “inadequately controlled, poorly controlled, or out of control” it will be coded to diabetes by type with the complication of hyperglycemia.
## Documentation Concepts

<table>
<thead>
<tr>
<th>Question</th>
<th>Example</th>
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</thead>
<tbody>
<tr>
<td>Is the pain “Acute” or “Chronic”?</td>
<td></td>
</tr>
<tr>
<td>Admission for inpatient treatment of pain or underlying condition causing the pain?</td>
<td>Example: Admitted for treatment of pain due to bone metastases of breast cancer</td>
</tr>
<tr>
<td>Link pain type to the condition: Example:</td>
<td></td>
</tr>
<tr>
<td>• Chronic pain due to …</td>
<td></td>
</tr>
<tr>
<td>• Phantom limb pain from R BKA</td>
<td></td>
</tr>
<tr>
<td>If pain is from a polyneuropathy, what is the cause?</td>
<td></td>
</tr>
<tr>
<td>• Inflammatory or due to diabetes?</td>
<td></td>
</tr>
<tr>
<td>Is a spinal neurostimulator or intrathecal infusion pump being used to treat the patient?</td>
<td>If so, clarify in your documentation.</td>
</tr>
</tbody>
</table>
Pain

**Acute pain due to trauma**

- **G**
- **8**
- **9**

Other disorders of the nervous system

- **1**
- **1**

<table>
<thead>
<tr>
<th>Type of Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
</tr>
<tr>
<td>Post-thoracotomy</td>
</tr>
<tr>
<td>Trauma</td>
</tr>
<tr>
<td>Post-procedural</td>
</tr>
<tr>
<td>Chronic</td>
</tr>
</tbody>
</table>
ICD-10-CM Documentation needed:

1. Name of the drug
2. State if drug was “Correctly prescribed” and “properly administered”
3. Nature of the adverse effects
4. Link the adverse effect to the suspected or proven drug
   - Known drug allergy or not?

Documentation Examples:

- Excessive bleeding from acute gastric ulcer, adverse effect of anticoagulant correctly prescribed and properly administered for AFIB
- Allergic rash due to correctly prescribed and properly administered PCN
Poisoning Documentation

Adverse Effects have a large impact of SOI

Poisoning definition:
• Exposure to toxins, reactions to improper use of medication, interaction between drugs, alcohol or illegal or herbal substances

Poisonings include:
• Overdose
• Wrong dose or given/taken in error
• Wrong route of administration

Document:
• Name of drug/chemical
• Describe all manifestations
• Describe intent
  – Accidental
  – Intentional self-harm
  – Assault
  – Investigated but undetermined

Encounter: Initial, Subsequent or Sequelae

Documentation Example:
• Acute toxic encephalopathy with coma due to accidental overdose of stolen oxycodone, initial visit

ICD-10-CM Table of Drugs and Chemicals
(55 pages)

Based on:
• Substance
• Poisoning, Accidental
• Poisoning, Intentional Self-harm
• Poisoning, Assault
• Poising, Undetermined
• Adverse Effect
• Under dosing

Source: The Advisory Board Company research; Health Data Consulting
4 Components to Capture When Documenting Under Dosing:

1. Name of medication

2. Result of dosage failure during medical/surgical care
   a. Wrong drug given in error
   b. Under dosing & non-administration of necessary medication

3. Did the patient inadvertently under dose?
   a. Given/taking less substance than prescribed/instructed
   b. Wrong substance taken by error

4. Was the patient noncompliant with treatment?
   a. Intentional under dosing (medical reasons, financial reasons, other)
   b. Unintentional under dosing of medication (due to age-related debility, other)
   c. Other noncompliance with medication

Documentation Example

“Patient discontinued Lasix due to financial reasons”
Substance Abuse Disorders

ICD-10-CM Documentation Requirements

• Alcohol & Other Substances
  • Specify the name of the substance (e.g. alcohol, cocaine, opioids, hallucinogens)
  • Specify Type of Use:
    • Use (e.g. smoked a cigarette today)
    • Dependence – “new terminology” was called Addiction
      • Is the patient “dependent” on the substance?
      • If yes, patient’s SOI is higher. = Comorbid condition (CC)
    • Abuse – (e.g. occasional drug user or binge drinker)
  • Specify Current status:
    • In remission with intoxication, or with withdrawal
  • Document any behavior disorders associated with the substance problem:
    • (e.g. anxiety disorder, delirium. hallucinations, sleep disorders etc.)

Difference in Terminology:

• Blood Alcohol Level (BAL) or Blood Alcohol -
  Physician will want to document Blood Alcohol Level (BAL)
Impact on Ambulatory Care Physicians

ICD-10-CM will be used by all physicians

ICD-10 Ambulatory Care Services

• ICD-10-PCS (procedures) should not significantly impact ambulatory care physicians as it is for inpatient encounters only
  • However, Ambulatory care physicians must consider **3 Day Rule**:
    – Hospital outpatient procedures occurring with 72 hours of a related inpatient admission will be rolled into the hospital admission
    – Reimbursed as part of the inpatient claim
    – Billed using ICD-10-PCS code assignment
    – Some facilities may ask emergency physicians to document procedures to capture both CPT and ICD-10-PCS documentation for accurate code assignment
Summary of Best Practice Documentation Teaching Points

Key Documentation Concepts

- Conflicting, incomplete, or ambiguous documentation may lead to a query
- External Causes should be captured for all poisoning and injuries
- AMI defaults to STEMI in ICD-10-CM, unless otherwise specified in your documentation
- Glasgow coma scale can now be captured
- Asthma classification follows the NHLBI guidelines
- If a patient has HTN and CHF clarifying the relationship between these conditions can impact SOI and ROM reporting.
- Document all conditions treated and resolved in the Urgent Care Center
- Documenting medical decision making regarding the reason to admit the patient supports medical necessity and assists in capturing the severity of illness of the patient. It is often this assessment that is the “first look” of the patient.
- Link sign, symptoms and test results to a disease or condition
https://www.surveymonkey.com/s/ICD10-Ambulatory
Questions?

Please do not forget to fill out your CME Survey Link!