Pressure Ulcers

The ICD-10 Success Series
Webconference
October 8, 2014
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If you select the “Use Mic & Speakers” option, please be sure that your speakers/ headphones are connected.
How to Submit Questions to Our Panelists

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Type your question and hit send

The presenter may answer the question here or respond verbally
Managing Your Screen

To minimize the control panel

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- Minimizes the control panel to the right side of your screen
- Re-opens the control panel

To maximize the presentation area

The blue button with the white square will maximize the presentation to fill your screen
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

Dan Avstreih, MD FACEP

- Medical Director at the Advisory Board Company
- Board certified physician in Emergency Medicine
- Since 2006, Dr. Avstreih has practiced at an ultra high-volume, tertiary care/level 1 trauma emergency department in Northern Virginia
- Dr. Avstreih holds clinical professor appointments at both the Virginia Commonwealth School of Medicine and the George Washington University School of Medicine
- Dr. Avstreih is an Associate Medical Director of the largest fire-rescue department in Virginia, overseeing the emergency medical care of more than 1.1 million citizens
- Serves in emergency management roles for both Northern Virginia and the National Capital Region.

For more information, contact:

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Brief Overview: Code Expansion in ICD-10-CM/PCS Requires Greater Documentation Specificity

Expanded Code Set in ICD-10: ~16K to ~140K

Why So Many New Codes?

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

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

Key ICD-10 Concepts Required in Documentation

| Stage or grade of disease | Severity: mild, moderate, severe |
| Specific anatomical location | Episode of care: initial vs. subsequent |
| Acute or chronic | Unilateral or bilateral condition |
Road Map for Discussion

1. Key Requirements for Documenting Pressure Ulcers in ICD-10

2. Clinical Scenario

3. Upcoming Webconferences
**Present on Admission (POA) Review**

*POA indicators must be submitted for all diagnoses on claims involving inpatient admissions to acute care hospitals.*

**Indicators:**
- **Y** = present at the time of the inpatient admission
- **N** = not present at the time of inpatient admission
- **U** = documentation is insufficient to determine if condition is present on admission
- **W** = provider is unable to clinically determine whether the condition was present on admission or not

**Additional Considerations**
- There is no required timeframe as to when the provider identifies a condition as POA
- All documentation within the record can be utilized to assist the physician in determining POA status such as the nursing skin assessment
- In some cases, it may be days before a definitive diagnosis is reached. This does not mean it was not POA.
- POA codes assignment directly impact quality reporting

**Hospital Acquired Conditions (HACs):**
- Are high cost or high volume or both,
- Result in the assignment of a case to an MS-DRG that has a higher payment when present as a secondary diagnosis, and
- Could reasonably have been prevented through the application of evidence-based guidelines.
## Pressure Ulcers

Always specify stage, laterality, and site of an ulcer

### ICD-10-CM Diabetes Documentation Concepts

| Pressure ulcer synonyms *(acceptable 10/1/15)* | • Bed sore  
• Decubitus ulcer  
• Plaster ulcer  
• Pressure ulcer  
• Pressure area  
• Pressure sore |
| Laterality | • Right or Left |
| Sites | • Ankle  
• Elbow  
• Back (Upper, Lower or Sacral region)  
• Buttock  
• Buttock ant hip  
• Hip  
• Heel  
• Head |
| Severity | Identify Stage: I-IV  
*(Stage III and IV are MCCs if POA)* |
| Is it current/new or healing pressure ulcer? | Is it gangrenous or not? |
| Identify if other types of ulcer (specify if different then pressure ulcer) | • Diabetic  
• Non-pressure, chronic  
• Skin infection  
• Traumatic wound  
• Varicose |
Pressure Ulcer Example

Pressure ulcer of right buttock, stage 4

Other disorders of skin and subcutaneous tissue (pressure ulcer)

Example:
- Excisional debridement bed sore of left lower back, stage 4 with gangrene
- New pressure ulcer, stage 1, left buttock
Debridement and Skin Ulcers

It is important for the physician to clearly describe the type of ulcer requiring excisional debridement. Consider one of the following if clinically appropriate for the patient:

- Chronic skin pressure ulcer
- Diabetic ulcer
- Stasis ulcer
- PVD ulcer (diabetic or non-diabetic)
- Neuropathic ulcer (diabetic or non-diabetic)

The presence of a stage III or IV pressure ulcer has been identified as a “Never Event" by the National Quality Forum and a Hospital Acquired Condition (HAC) by CMS. The physician is responsible for establishing the pressure ulcer as "present on admission" (POA) in the medical record documentation if clinically appropriate for his/her patient, in order to avoid HAC classification.

CMS; Final Rule 2009.
Debridement

Critical to specify Excisional vs. Non-excisional Debridement

Type:
1. **Excisional:**
   - Root operation (Excision): “Cutting out or off, without replacement, a portion of a body part”

2. **Non-excisional, sharp:**
   - Root operation (Extraction): “Pulling or stripping out or off all or a portion of a body part by the use of force”

Additional Documentation needed:
- Identify if “excisional” or “non-excisional” debridement
- Instruments used (e.g. scalpel, scissors)
- Location
- Depth, “removal of”:
  - Epidermis/dermis
  - Subcutaneous tissue
  - Muscle
  - Bone
- Surface Area is required for CPT coding
  - 20 sq cm increments for each depth

Common Insufficient Documentation:
“Debridement to left heel”

VS.

Best Practice Documentation:
“Excisional debridement to left heel of subcutaneous tissue using scalpel to remove necrotic tissue”
Excisional debridement
Subcutaneous Tissue & Fascia, **Excision**, Left Upper Leg, Open, No device, No Qualifier

**Procedure Codes Capture Approach Usage Excision**

- **Section**: 0
- **Body System**: J
- **Root Operation**: B
- **Body Part**: M
- **Approach**: O
- **Device**: Z
- **Qualifier**: Z

**Medical & Surgical**

**Subcutaneous Tissue & Fascia**

**Excision**

**Left Upper Leg**

**Open**

**None**

**No qualifier**

**Note:**

- Physician documentation must specify if debridement is “excisional” or “non-excisional”
- Excisional debridements are “valid¹” OR procedures
- Can be performed at bedside or in the OR
A Brief Aside: Revisiting Severity of Illness and Risk of Mortality (SOI & ROM)

Let’s revisit these key quality metrics to ensure all those on the line have a thorough understanding of A) how your documentation directly impacts these metrics and B) how these metrics play a large role in the publicly reported quality scores that are increasingly available to the non-clinical audience out there.

Breakdown of SOI/ROM and their Implication on Quality Measures

Four mutually exclusive SOI/ROM categories exist (1-4), and are determined based on a number of factors including primary and secondary diagnoses, comorbidities, demographics, patient history, treatment/procedure delivered, etc.

<table>
<thead>
<tr>
<th>Level</th>
<th>Assigned SOI/ROM Category</th>
<th>Impact on Expected: LOS, Cost of Care, and Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>1</td>
<td>Increase in Value</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Major</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Extreme</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
Remember: Signs, Symptoms & Test Results Must Be Linked to Related Diagnoses

While important pieces of the medical record, signs, symptoms and test results are not sufficient for coders to assign a diagnosis.

- Linking signs and symptoms to diagnoses may increase SOI and ROM in the inpatient setting. (The terms ‘probable’, ‘likely’, or ‘suspected’ are all acceptable on the inpatient record)

- In the ambulatory setting, documentation regarding patient condition should be to the highest level known, treated or evaluated

- Abnormal findings (laboratory, x-ray, pathological and other diagnostic test results) cannot be coded and reported unless the clinical significance is identified by the treating provider

Reminder! The attending physician is responsible for:

- Documenting all conditions in the progress notes and discharge summary
- Resolving conflicts in the documentation
Linking Conditions Critical to Capturing Patient Severity

There is a significant increase in the number of “combination codes” available in the ICD-10 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 to need incorporate into their documentation today. Remember, coders cannot assume such clinical relationships.

Examples: Linking Diseases

• Stage III pressure ulcer left heel
• Stage II pressure ulcer right great toe secondary to diabetes with PVD

Use terms like “due to” or “with”

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

1. Key Requirements for Documenting Pressure Ulcers in ICD-10-CM/PCS

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3. Upcoming Webconferences
Clinical Scenario Highlighting Insufficient Documentation

76 y/o admitted with non-healing foot ulcer. BMI of 17.5. PEG tube and enteral feedings.

Debridement completed on left foot ulcer. IV antibiotics started and followed by WOCN.

The patient improves on the prescribed wound care treatment & discharged home.

Common Insufficient Documentation

“76 y/o admitted with non-healing foot ulcer. Debridement done. IV antibiotics. Wound care. See orders.”

Excision or nonexcisional?
Clinical Scenario Highlighting Best Practice Documentation

76 y/o admitted with foot ulcer that is not healing. Hx of neuropathy, documented BMI of 17.5 with PEG tube and enteral feedings.

Debridement completed on left foot ulcer. IV antibiotics started and followed by WOCN.

The patients improves on the prescribed wound care treatment & discharged home.

Best Practice Documentation

“76 y/o admitted after failing outpatient management of a chronic non-healing Stage III pressure ulcer of the left foot with purulent drainage. Excisional debridement of this ulcer into the subcutaneous tissue with a 10 blade.”
What You Write Matters

As words become data, your documentation plays an increasingly important role.

“76 y/o admitted with non healing left foot ulcer. Debridement done. IV antibiotics. Wound care. See orders.

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG 594 Skin Ulcer without CC/MCC</td>
<td>Relative Weight: 0.6814</td>
</tr>
</tbody>
</table>

VS.

76 yo admitted after failing outpatient management of a chronic non healing Stage III pressure ulcer of the left foot with purulent drainage. Excisional debridement of this ulcer into the subcutaneous tissue with a 10 blade.

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRG 570 Skin Debridement with MCC</td>
<td>Relative Weight: 2.4154</td>
</tr>
</tbody>
</table>

¹) Base rate of $5,209

Source: Advisory Board Research and Analysis
Road Map for Discussion

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Upcoming Webconferences

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**Upcoming Sessions:**

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- October 22nd – Encephalopathy
- October 29th – AMI & Coronary Artery Disease
- November 5th - Respiratory Failure, Pneumonia, COPD
- November 12th - Orthopedic Surgery, Joints, Spine
- *And more…*

*Please reach out to John McConnell, mccojo@valleyhealth.com if you need assistance registering.*

*All sessions are from 12-1pm EST*
https://www.surveymonkey.com/s/ICD10-PressureUlcers
Questions?

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