Clinical Documentation Challenges with ICD-10-CM

Golden Rule: If it’s not documented by the physician/provider, it did not happen; therefore, it cannot be coded or billed.

Objective: To ensure medical record documentation is documented to the fullest extent possible in order to support the greater specificity afforded in the ICD-10-CM (Clinical Modification) code sets.

With the transition to ICD-10-CM, some documentation issues will require physicians/providers to capture new information; others involve updated, modified and otherwise expanded documentation needs.

ICD-10-CM contains multiple combination codes so the documentation must reflect the association between conditions. For example, ICD-10-CM code K50.814 designates “Crohn’s disease of both small and large intestine with abscess.” The ICD-9-CM equivalent codes would be “555.2-Regional enteritis, small intestine with large intestine” and “569.5-Abscess of intestine.”

In addition, laterality needs to be documented. For example, ICD-10-CM code M05.271 designates “Rheumatoid vasculitis with rheumatoid arthritis of right ankle and foot.” The ICD-9-CM equivalent code would be “714.27-Rheumatoid arthritis with visceral or systemic involvement, ankle and foot.”

The following are some of the potential problem areas related to insufficient documentation that physicians/providers need to be aware of so the level of specificity required in the clinical documentation can be better understood:

Diabetes Mellitus
ICD-9-CM features 59 codes for diabetes, while ICD-10-CM offers more than 200 codes. The expanded diabetes code set has added a provision of “poorly controlled” to the categories of controlled or not controlled and there are multiple combination codes (e.g., ICD-10-CM code E09.11 designates “Type 1 diabetes mellitus with ketoacidosis with coma”).

Injuries
ICD-10-CM features an expanded category for injuries. A seventh character extension identifies the encounter type:
• “A” for the initial encounter,
• “D” for the subsequent encounter for fracture with routine healing,
• “G” for subsequent encounter for fracture with delayed healing, and
• “S” for sequel of fracture.
Coding professionals will also need to code the size and depth of the injury under ICD-10-CM which may not be captured in physician documentation. In addition to coding the type of injury, the cause of the injury should be documented and coded as well.

Continued on next page
Drug Under-dosing
Under-dosing is a new code in ICD-10-CM. It identifies situations in which a patient has taken less of a medication than prescribed by the physician.
- The medical condition is sequenced first.
- The under-dosing code is listed as a secondary diagnosis.
- The additional code explains why the patient is not taking the medication (e.g., financial reasons). Since this is new, many physicians will not be in the habit of documenting a patient’s reasons for under-dosing in the record.

Cerebral Infarctions
- Late effects of stroke are differentiated by type of stroke.
- Combination codes for common etiologies/manifestations are included (e.g., ICD-10-CM code I63.012 designates “cerebral infarction due to thrombosis of left vertebral artery”).

Acute Myocardial Infarction (AMI)
- Age definition for AMI has changed to four weeks rather than eight weeks.
- New categories for subsequent AMI and for complications within 28 days of AMI.
- Different terminology is used and laterality is included (e.g., I21.02 designates “ST segment elevation myocardial infarction [STEMI] involving left anterior descending coronary artery”).

Musculoskeletal Conditions
ICD-10-CM includes more diagnosis codes related to musculoskeletal conditions. For example, there are eight codes for pathologic fractures in ICD-9-CM, but in ICD-10-CM there are more than 150 codes.

Pregnancy
- Documentation of trimester is now required.
  - Counted from first day of last menstrual period.
  - Must document number of weeks.
  - Episodes of care have been deleted.
  - For example, ICD-10-CM code of O15.03 designates “eclampsia in pregnancy, third trimester.”
- Obstructed labor codes incorporate reason for the obstruction and code extensions are used to identify specific fetus (1-5) affected by obstetric condition (e.g., ICD-10-CM code O64.1xx2 designates “obstructed labor due to breech presentation, fetus 2”).

Respiratory/Vents
Some codes require time frames attached to them, such as the respiratory/ventilator codes, which note if a patient has been on a ventilator for less than 24 consecutive hours, 24-96 consecutive hours, or greater than 96 hours.

NOTE: Unspecified codes are still available since there are times when even the clinician does not have the information necessary about the disease process in order to assign a more specific code. But the goal is to ensure the medical record documentation is as comprehensive as it can be to support the greater specificity in the ICD-10-CM code sets to the absolute extent possible. When the specificity is greater, there should be a reduction in payment denials and requests for additional information from payers.

What can be done NOW to prepare physicians/providers for the changes that will occur when ICD-10-CM is implemented?
- Perform Clinical Documentation Assessments. This can involve evaluating samples of various types of medical records to determine whether the documentation supports the level of detail found in ICD-10-CM.
- Implement documentation improvement strategies to address areas where documentation is found to be lacking.
- Designate a physician/provider champion to assist in clinical documentation education and promote the positive aspects of moving to ICD-10-CM.

This is a reprint (and update) of a bulletin originally published in November 2011. Content was provided by the NCHICA ICD-10 Taskforce. For more information on ICD-10 and to read past Bulletins, click here.