Why Words Matter

Through an Internal Medicine Lens
Key Objectives for Today’s Session

1. Develop understanding of the role documentation plays in determining patient severity of illness (SOI), risk of mortality (ROM) and impacts physician quality scores

2. Understand definition changes in ICD-10-CM and ICD-10-PCS

3. Understand key terminology changes in ICD-10-CM and ICD-10-PCS

4. Understand the concepts of linking conditions and manifestations and specificity requirements for more accurate depiction of patient status
Road Map for Discussion

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

2. Concepts Drive Documentation Requirements

3. Examples of Internal Medicine Topics in ICD-10-CM/PCS
The Evolution of Clinical Documentation

What was once a tool for physician communication and note-taking is now a primary data source for a massive industry.

Who is the audience for your notes?

- Self
- Care Team
- Other Doctors
- Patients
- State Government
- Federal Government
- Insurance Companies
- Other Doctors
- Patients
- State Government
- Federal Government
- Insurance Companies
Mounting Pressures for Physician Documentation

Comprehensive documentation is vital in order to adapt to health care’s changing landscape and new payment models.
Increased Transparency For Patients

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Severity of Illness (SOI) and Risk of Mortality (ROM)

Documentation drives SOI and ROM level assignment. These levels are used to measure patient acuity, and therefore drive expected patient LOS and mortality rate.

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>
</tr>
</thead>
<tbody>
<tr>
<td>Minor</td>
<td>1</td>
</tr>
<tr>
<td>Moderate</td>
<td>2</td>
</tr>
<tr>
<td>Major</td>
<td>3</td>
</tr>
<tr>
<td>Extreme</td>
<td>4</td>
</tr>
</tbody>
</table>
What You Write Matters

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

“76 yo female elective admission for planned L THA – hip pain. Medical history includes CHF, **renal insufficiency**, DM, **cachetic**.”

**Non-specific Dx**

**Descriptor**

VS.

“76 yo female elective admission for planned L THA secondary to severe osteoarthritis L hip. Medical history includes **chronic diastolic heart failure**, ESRD on hemodialysis, controlled DM type 2 with BMI of 16.5 & cachexia - suspected severe protein calorie malnutrition. …Post op day #1 - Hgb dropped from 11.1 pre-op to 8.2 – pt c/o lightheadedness, will transfuse 2u PRBS 2/2 acute blood loss anemia.”

**470 – Major joint replacement of lower extremity w/o MCC**

RW: 2.1463
GMLOS: 3.1 Days

**469 – Major joint replacement of lower extremity w/MCC**

RW: 3.4377
GMLOS: 6.2 Days
Documentation Turns the Quality Dial

The Observed versus Expected Mortality Rate is a major quality performance indicator. As we focus on documentation improvement efforts to better capture severity of illness, a patient’s expected mortality increases to reflect this acuity.

AMI Mortality Rate

Evergreen Hospital¹

- 650 beds
- Located in the south

¹Pseudonym
Transition from ICD-9-CM to ICD-10-CM/PCS

Per Bill H.R. 4302, “The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets”.

Benefits and Goals of ICD-10-CM/PCS

- Provides better detail and a more accurate depiction of patient severity
- Improves care management of patients
- Obtains reliable and robust clinical data that can be used to make intelligent, data-driven decisions related to all aspects of health care
- Allows for more accurate payment for new procedures
- Improves disease management through capture of morbidity and mortality data
- Offers a better understanding of the value of new medical procedures
- Provides more specific data to address global disease emergencies
- Reduces the number of miscoded, rejected and improper claims for reimbursement
- Provides comprehensive data for improved fraud and abuse monitoring
ICD-9-CM vs. ICD-10–CM/PCS: A Comparison

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 ICD-9-CM, such as causal agent, type, laterality, approach, episode of care, root operation, etc.

1) Code Volume Expansion in ICD-10

Introduction to ICD-10-CM Diagnosis Coding Structure

ICD-10-CM Codes will Contain 3-7 Alphanumeric Characters with the Following Structure

- **Category**
  - α
  - #
  - α/#

- **Sub-cATEGORIES**
  - α/#
  - α/#
  - α/#

- **Extension**
  - (3-16 options depending on category)

### Key ICD-10-CM Documentation Concepts

<table>
<thead>
<tr>
<th>Specific anatomical location</th>
<th>Degree (mild, moderate, severe, or unspecified; total/complete vs partial/incomplete)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type (primary, secondary, unspecified)</td>
<td>Episode of Care (Initial, Subsequent, Sequelae)</td>
</tr>
<tr>
<td>Acuity (acute, subacute, chronic, acute on chronic, or unspecified)</td>
<td>Laterality (Right, Left, bilateral, or unspecified)</td>
</tr>
<tr>
<td>Trimester (1,2,3, unspecified)</td>
<td>Number of fetus (1-5, other)</td>
</tr>
</tbody>
</table>
Road Map for Discussion

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

2. Key Concepts To Capture in Your Documentation

3. Examples of Internal Medicine Topics in ICD-10-CM/PCS
Concepts Drive Changes in Documentation Requirements

Key Considerations for Internal Medicine

- Laterality
- Infection Site
- Complication
- Inflammation Site
- Type of Vessel
- Type of Infection
- Causal Agent
- Onset
- Acuity
Conflicting, Incomplete, or Ambiguous Documentation

Physicians are queried for additional documentation when the record fails to meet one or more of the following criteria:

- **Legibility** (*e.g.*, illegible handwritten entry in the provider’s progress notes, and the reader cannot determine the provider’s assessment)

- **Completeness** (*e.g.*, a report indicating abnormal test results without notation of the clinical significance of these results)

- **Clarity** (*e.g.*, diagnosis noted without statement of a cause or suspected cause)

- **Consistency** (*e.g.*, conflicting documentation between two or more treating providers with respect to a condition or diagnosis)

- **Precision** (*e.g.*, where clinical reports and clinical condition suggests a more specific diagnosis than is documented)

  or

- **Documentation is not in ICD-10-CM/PCS compliant terminology (missing information or elements to accurately assign a code)**
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. *ICD-10-CM Official Coding Guidelines III.B*

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-CM code set. These codes can help capture the highest level of complexity and acuity in publicly reported data.

Linking clinically relevant conditions, where appropriate, is the key takeaway physicians need to incorporate into their documentation today. Remember, coders cannot assume such clinical relationships.

Examples: Linking Diseases

- HTN with heart disease
- Acute blood loss anemia d/t esophageal ulcer with bleeding
- Type 1 DM with CKD stage 4
- Septic shock due to gram positive pneumonia

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. Key Concepts To Capture in Your Documentation

3. Examples of Internal Medicine Diagnoses in ICD-10-CM/PCS
ICD-10-CM Internal Medicine Diagnoses Covered Today

Let’s move on to these diagnoses to help explain what documentation will be required in ICD-10-CM

<table>
<thead>
<tr>
<th></th>
<th>Diagnosis</th>
<th></th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Acute Myocardial Infarction</td>
<td>9</td>
<td>Respiratory Failure</td>
</tr>
<tr>
<td>2</td>
<td>Coronary Artery Disease</td>
<td>10</td>
<td>Sepsis</td>
</tr>
<tr>
<td>3</td>
<td>Heart Failure</td>
<td>11</td>
<td>CVA</td>
</tr>
<tr>
<td>4</td>
<td>AFIB</td>
<td>12</td>
<td>Chronic Kidney Disease</td>
</tr>
<tr>
<td>5</td>
<td>Asthma</td>
<td>13</td>
<td>Malnutrition</td>
</tr>
<tr>
<td>6</td>
<td>Bronchitis</td>
<td>14</td>
<td>Pain</td>
</tr>
<tr>
<td>7</td>
<td>COPD &amp; Emphysema</td>
<td>15</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>8</td>
<td>Pneumonia</td>
<td>16</td>
<td>Diabetes</td>
</tr>
</tbody>
</table>
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 history STEMI two weeks ago

Patient enters ER, shortness of breath and continued pain

MD identifies AMI of anterior wall on EKG

Specify in days for accurate code selection

> 28 Days?

“a month ago”

≤ 28 Days

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
Specify STEMI or NSTEMI?

- Documentation Requirements:
  - Specific Wall – Anterior, Inferior, Other
  - Specific Artery – L main, L anterior descending, Right Coronary Artery, L circumflex, Other
  - Was tPA administered? At transferring facility or current facility?
  - Was the patient discharged alive?
  - Tobacco exposure?
  - Document any “Current Complication of STEMI”:
    - Hemopericardium will need further clarification if related to or a complication of the MI or if it is not a complication

**Documentation Teaching Point:**
- AMI defaults to STEMI in ICD-10-CM, unless otherwise specified in your documentation
- Carry all clinically significant information from the cath report / echo or other testing results into the progress notes to ensure it will be captured in the coded record
Atherosclerosis, Angina, and Acute Coronary Syndrome (ACS)

Documentation Teaching Points:

- ICD-10-CM assumes Angina pectoris is due to atherosclerosis unless otherwise documented.

- Acute coronary syndrome (ACS) sequences to a nonspecific diagnosis of unspecified acute ischemic heart disease.

- Clarifying ACS and Angina can impact SOI/ROM and DRG assignment:
  - Angina and the TYPE (unstable, with spasm, other, and unspecified)
  - Atherosclerosis without angina
  - Atherosclerosis with angina with type (unstable, with spasm, other, and unspecified)
  - Acute ischemic heart disease (thrombosis without infarction, Dressler’s syndrome, or other)

  OR

  - STEMI or NSTEMI
Coronary Artery Disease with Angina

Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris

Chronic Ischemic Heart Disease

Vessel Type

Native coronary artery
Autologous vein graft
Autologous vein graft
Non autologous biological graft
Other Graft
Unspecific graft

Type of Angina

Unstable Angina pectoris
Angina pectoris with documented spasm
Other forms of angina pectoris
unspecific
Some doctors might have noticed unspecified options for both the vessel type and angina. Why should I document them both if a coder can code without it?
Specificity Drives Severity: Vessel Type and Angina Type Matter

In some cases, presence of angina can serve as a severity driver

<table>
<thead>
<tr>
<th>Vessel Type</th>
<th>Angina Type</th>
<th>Comorbid Condition (CC) Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unspecified Coronary Bypass Graft</td>
<td>Angina (Unspecified)</td>
<td>No comorbid condition (CC) present</td>
</tr>
<tr>
<td>Native Coronary Artery Of Transplanted Heart</td>
<td>Unstable Angina Pectoris</td>
<td>Comorbid condition (CC) present</td>
</tr>
<tr>
<td>Autologous Vein Coronary Artery Bypass Graft</td>
<td>Angina with Documented Spasm</td>
<td>Comorbid condition (CC) present</td>
</tr>
</tbody>
</table>

**Note:** A “CC” is a secondary condition that is classified as a complication or comorbid condition that impacts SOI/ROM and reimbursable in some cases.
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*
## Comorbid (CCs) and Major Comorbid Conditions (MCCs)

To capture SOI, please specify in *your* documentation

<table>
<thead>
<tr>
<th><strong>Comorbid Conditions (CCs)</strong></th>
<th><strong>Major Comorbid Conditions (MCCs)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Systolic heart failure</td>
<td>• Acute systolic heart failure</td>
</tr>
<tr>
<td>• Chronic systolic heart failure</td>
<td>• Acute on chronic systolic heart failure</td>
</tr>
<tr>
<td>• Diastolic heart failure</td>
<td>• Acute diastolic heart failure</td>
</tr>
<tr>
<td>• Chronic Diastolic heart failure</td>
<td>• Acute on chronic diastolic heart failure</td>
</tr>
<tr>
<td>• Combined systolic and diastolic heart failure</td>
<td>• Acute combined systolic and diastolic heart failure</td>
</tr>
<tr>
<td>• Heart failure due to hypertension with CKD Stage 5 or ESRD</td>
<td>• Acute on chronic combined systolic and diastolic heart failure</td>
</tr>
<tr>
<td>• Rheumatic heart failure</td>
<td>• Acute pulmonary edema of lung without heart disease or heart failure</td>
</tr>
<tr>
<td>• Left ventricular heart failure</td>
<td></td>
</tr>
</tbody>
</table>

### Specificity Matters

- CHF → Systolic Heart Failure (CC) → Acute Systolic Heart Failure (MCC)
- Chest Pain → Unstable Angina (CC) → Probable NSTEMI (MCC)
Heart Failure

Acute systolic heart failure

<table>
<thead>
<tr>
<th>Heart Failure</th>
<th>Type of Heart Failure</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Documentation Teaching Point:

Remember: If a patient has HTN and CHF, the physician documentation needs to identify a cause and effect relationship.

Example: “Hypertensive heart disease with acute systolic heart failure due to medication noncompliance”
# Four Types of Atrial Fibrillation

<table>
<thead>
<tr>
<th>ICD-10-CM Atrial Fibrillation Documentation Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paroxysmal</strong></td>
</tr>
<tr>
<td><strong>Persistent</strong>*</td>
</tr>
<tr>
<td><strong>Permanent (chronic)</strong></td>
</tr>
<tr>
<td><strong>Unspecified</strong></td>
</tr>
</tbody>
</table>

*Persistent atrial fibrillation is a Comorbid Condition
## Making the Case for Additional Specificity

Leaving out specificity in documentation can lead to improper SOI/ROM and reimbursement.

### Atrial Fibrillation Scenarios

**Principal DX: I21.4 NSTEMI**  
**Secondary Dx: I48.x Atrial Fibrillation**

<table>
<thead>
<tr>
<th>Physician</th>
<th>Atrial Fibrillation Scenarios</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician A</strong></td>
<td></td>
</tr>
</tbody>
</table>

- **Atrial Fibrillation**  
  *I48.9 Atrial Fibrillation, unspecified*  

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Dollars</th>
</tr>
</thead>
</table>
| 282 – AMI, discharged alive, w/o CC/MCC | Relative Weight: 0.7551  
Reimbursement: $3,933  
GMLOS: 2.1 |

$ 1,572

<table>
<thead>
<tr>
<th>Physician B</th>
<th>Persistent Atrial Fibrillation Scenarios</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician B</strong></td>
<td></td>
</tr>
</tbody>
</table>

- **Persistent Atrial Fibrillation**  
  *I48.1 Atrial Fibrillation, Persistent*  

<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Dollars</th>
</tr>
</thead>
</table>
| 281 – AMI, discharged alive, w/CC | Relative Weight: 1.0568  
Reimbursement: $5,505  
GMLOS: 3.1 |
Tobacco Exposure

ICD-10-CM requires documentation of tobacco exposure, specifically for:

- Pulmonary disease
- 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

J 4 5

Type and acuity

1

“With”

Chronic lower respiratory diseases (Asthma)

Documentation Tip:

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

Always document tobacco exposure
Documentation Tips:

When documenting Bronchitis or Bronchiolitis, specify:

1. **Acuity** of condition (acute, chronic, or acute on chronic)
2. **Type** of condition
   - Chronic *asthmatic* bronchitis
   - Chronic *obstructive* bronchitis, etc.
3. **Causal organism**
   - Ex: “bronchiolitis *due to* Respiratory syncytial virus (RSV)”

*Remember: Always document tobacco exposure!*
COPD & Emphysema

ICD-10-CM Documentation Concepts

COPD
• Is the COPD “with”:
  • Acute lower respiratory infection
  • Or acute exacerbation?

Emphysema
• Specify type:
  • Unilateral
  • Panlobar
  • Centrilobular

Other considerations include:
• Compensatory
• Due to inhalation of chemical gases, fumes, or vapors
• With chronic (obstructive) bronchitis
• Interstitial
• Mediastinal
• Neonatal interstitial
• Surgical (subcutaneous)
• Traumatic subcutaneous

Reminder:
Always document tobacco exposure
# Pneumonia & Influenza

ICD-10-CM Pneumonia & Influenza Documentation Concepts

## Pneumonia

<table>
<thead>
<tr>
<th>Identify the organism</th>
<th>Is it Viral or Bacterial? Name the organism, known or suspected</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Example: “Probable pneumonia due to MRSA”</td>
</tr>
</tbody>
</table>

*Remember: Probable, likely and suspected are all acceptable terms in the inpatient setting*

<table>
<thead>
<tr>
<th>Link any associated conditions to the pneumonia:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Influenza with secondary gram negative pneumonia</td>
<td></td>
</tr>
<tr>
<td>• Sepsis due to pneumonia</td>
<td></td>
</tr>
<tr>
<td>• Acute respiratory failure due to pneumonia</td>
<td></td>
</tr>
</tbody>
</table>

## Aspiration Pneumonia

<table>
<thead>
<tr>
<th>Identify if:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Due to solids or liquids</td>
</tr>
<tr>
<td>• Due to anesthesia during L/D</td>
</tr>
<tr>
<td>• Due to anesthesia during puerperium</td>
</tr>
</tbody>
</table>

## Influenza

<table>
<thead>
<tr>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Novel influenza virus type A</td>
</tr>
<tr>
<td>• Influenza virus</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Associated conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Pneumonia, specify causative organism if known</td>
</tr>
<tr>
<td>• Respiratory illness (laryngitis, pharyngitis, upper respiratory symptoms)</td>
</tr>
<tr>
<td>• GI Illness* – excludes intestinal flu</td>
</tr>
<tr>
<td>• Encephalopathy</td>
</tr>
<tr>
<td>• Myocarditis</td>
</tr>
</tbody>
</table>

### Documentation Tips:

- Both required documentation of tobacco
- Do not need a + CXR or culture
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
# Respiratory Failure

ICD-10-CM Respiratory Failure Documentation Concepts

<table>
<thead>
<tr>
<th>ICD-10-CM Documentation Concepts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acuity</strong></td>
<td></td>
</tr>
<tr>
<td>• Acute</td>
<td></td>
</tr>
<tr>
<td>• Acute on Chronic</td>
<td></td>
</tr>
<tr>
<td>• Chronic</td>
<td></td>
</tr>
<tr>
<td><strong>Specificity</strong></td>
<td></td>
</tr>
<tr>
<td>With</td>
<td></td>
</tr>
<tr>
<td>• Hypoxia</td>
<td></td>
</tr>
<tr>
<td>• Hypercapnia</td>
<td></td>
</tr>
<tr>
<td>• Unspecified</td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco Use</strong></td>
<td></td>
</tr>
<tr>
<td>Document if patient has</td>
<td></td>
</tr>
<tr>
<td>• exposure to environmental tobacco smoke</td>
<td></td>
</tr>
<tr>
<td>• history of tobacco use</td>
<td></td>
</tr>
<tr>
<td>• occupational exposure to tobacco smoke</td>
<td></td>
</tr>
</tbody>
</table>

**Physician Documentation Tips:**

- Mild, moderate or severe respiratory distress and respiratory insufficiency do not equal respiratory failure
- Blood gases and mechanical ventilation are not required
- Clarify the need for continuous home oxygen – dependence on home oxygen also does not capture severity of illness
Always Document Date & Time of Intubation and Extubation

The duration of intubation and mechanical ventilation must be documented, as it is a direct reflection of the severity of a patient’s condition. Mechanical Ventilation greater than 96 hours shifts DRG assignment and SOI/ROM.

### Key Documentation Concepts Required for Intubation and Mechanical Ventilation

<table>
<thead>
<tr>
<th>Intubation</th>
<th>Mechanical Ventilation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD-10-PCS Documentation Concepts</strong></td>
<td><strong>ICD-10-PCS Documentation Concepts</strong></td>
</tr>
<tr>
<td><strong>Root Operation</strong></td>
<td><strong>Root Operation</strong></td>
</tr>
<tr>
<td>Insertion</td>
<td>Performance</td>
</tr>
<tr>
<td><strong>Body Part</strong></td>
<td><strong>Body Part</strong></td>
</tr>
<tr>
<td>Mouth/throat</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Trachea</td>
<td></td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td><strong>Duration</strong></td>
</tr>
<tr>
<td>Via Natural or Artificial Opening</td>
<td>&lt;24 consecutive hours</td>
</tr>
<tr>
<td><strong>Device</strong></td>
<td>24-96 consecutive hours</td>
</tr>
<tr>
<td>Intraluminal Device</td>
<td>&gt;96 hours</td>
</tr>
<tr>
<td>Endotracheal Airway</td>
<td></td>
</tr>
<tr>
<td><strong>Qualifier</strong></td>
<td><strong>Function</strong></td>
</tr>
<tr>
<td>None</td>
<td>Ventilation</td>
</tr>
<tr>
<td><strong>Example:</strong> OBH17EZ - Insertion, Trachea, Natural Opening, Intraluminal Device, No Qualifier</td>
<td><strong>Example:</strong> 5A1935Z - Performance, Respiratory, &lt;24 consecutive hours, Ventilation, No Qualifier</td>
</tr>
</tbody>
</table>

### Don’t Forget Time of Extubation

While date/time of intubation is generally well documented, always be sure to document the time of extubation as well.
Sepsis, Severe Sepsis, Septic Shock, and Severity of Illness (SOI)

Properly documenting sepsis has a significant impact on severity captured

Sepsis vs. Bacteremia in the coding world
• “Bacteremia” is an abnormal lab finding and considered a sign and symptom.
• Bacteremia does not represent a systemic process
• Physicians need to clarify if the patient has a systemic infection (sepsis) or if the patient only has the finding of bacteria in the bloodstream.

Sepsis Documentation Should:
• Link the underlying local infection (e.g. pneumonia) to the systemic infection
• Identify the (suspected) organism
  – And any drug resistant organism
• Link or clarify if there is associated:
  – Organ failure
  – Shock

ICD-10 Update:
• “Urosepsis” will require a query in ICD-10-CM and no longer defaults to UTI
Sepsis Continued

Properly documenting sepsis has a significant impact on severity captured.

**Severe Sepsis** is defined as sepsis with documented organ failure.
Documentation requirements include:
- The systemic Infection (causative organism) suspected or known
- Identify any other associated organ failure
  
  *Example: Acute renal failure d/t E Coli sepsis*

**Septic Shock** generally refers to circulatory failure associated with severe sepsis.
Documentation required:
- The systemic Infection (causative organism) suspected or known
- Identify any other associated organ failure

---

<table>
<thead>
<tr>
<th>SIRS Criteria</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature</td>
<td>&lt; 96.8°F (36°C) or &gt; 100.4°F (38°C)</td>
</tr>
<tr>
<td>Heart Rate</td>
<td>&gt; 90 bpm</td>
</tr>
</tbody>
</table>
| Respiratory Rate              | > 20 breaths/min  
or PaCO₂ < 32 mmHg |
| White Blood Cell Count        | > 12,000 or < 4,000 cells/mm³  
or > 10% bands |
Chronic Kidney Disease
Per National Kidney Foundation

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

<table>
<thead>
<tr>
<th>Stage</th>
<th>GFR (mL/min/1.73m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>&gt; 90</td>
</tr>
<tr>
<td>II</td>
<td>60-89</td>
</tr>
<tr>
<td>III</td>
<td>30-59</td>
</tr>
<tr>
<td>IV</td>
<td>15-29</td>
</tr>
<tr>
<td>V</td>
<td>&lt;15</td>
</tr>
</tbody>
</table>

**CKD as a Manifestation: Link Diseases**

**Examples:**
- Type 2 DM with diabetic CKD Stage 5
- Hypertensive heart disease with CKD Stage 3 and with chronic diastolic heart failure
- Hypertension with CKD Stage 4

Use terms like “due to” or “with”

Note: Lists, commas, and the word “and” do not link conditions
Key Points

- Acuity
- Laterality

- Identify if hemorrhage or infarction
  - Site of non-traumatic intracerebral hemorrhage
    - Hemisphere
    - Brain stem
    - Cerebellum
    - Intraventricular
    - Multiple localized
  - Cerebral infarctions documentation must include:
    - Embolism
    - Thrombosis
    - Stenosis/occlusion
    - Artery if known

- Associated symptoms
- Presence of hemiparesis and/or hemiplegia
- Hand dominance of patient (right, left, or ambidextrous)
- tPA administration in a different facility in the last 24 hours
### Malnutrition Criteria

American Academy of Nutrition and Dietetics & American Society for Parental and Enteral Nutrition (ASPEN)

Malnutrition Criteria: Need at least two or more of the following six characteristics help to identify a malnutrition diagnosis:

<table>
<thead>
<tr>
<th>Malnutrition Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ Insufficient energy intake</td>
</tr>
<tr>
<td>✔ Weight loss</td>
</tr>
<tr>
<td>✔ Loss of muscle mass</td>
</tr>
<tr>
<td>✔ Loss of subcutaneous fat</td>
</tr>
<tr>
<td>✔ Localized or generalized fluid accumulation that may sometime mask weight loss</td>
</tr>
<tr>
<td>✔ Diminished functional status as measure by hand grip strength</td>
</tr>
</tbody>
</table>
## Malnutrition

Additional clinical indicators/documentation that support diagnosis of malnutrition

<table>
<thead>
<tr>
<th>Multiple Key Components to Weight-Related Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BMI&lt;19</strong></td>
</tr>
<tr>
<td>• Will impact SOI/ROM</td>
</tr>
<tr>
<td>• For protein-calorie malnutrition, indicate mild, moderate or severe</td>
</tr>
<tr>
<td>• Use “starvation” in abuse cases</td>
</tr>
<tr>
<td>• Abnormal weight loss + acuity of weight loss</td>
</tr>
<tr>
<td>• Link to other illnesses</td>
</tr>
<tr>
<td><strong>BMI&gt;40</strong></td>
</tr>
<tr>
<td>• Will impact SOI/ROM</td>
</tr>
<tr>
<td>• Severe or morbid obesity</td>
</tr>
<tr>
<td>• Link to cause</td>
</tr>
<tr>
<td>• May find in medical history</td>
</tr>
<tr>
<td>• If drug induced, give the name of the drug</td>
</tr>
<tr>
<td>• Bariatric procedures performed</td>
</tr>
<tr>
<td>• Identify any associated conditions such as obesity hypoventilation syndrome</td>
</tr>
<tr>
<td><strong>Additional documentation needs:</strong></td>
</tr>
<tr>
<td>• History of</td>
</tr>
<tr>
<td>• Exam</td>
</tr>
<tr>
<td>• Skin care/assessment</td>
</tr>
<tr>
<td>• Diagnostic tests</td>
</tr>
<tr>
<td>• Diagnoses and linkage</td>
</tr>
<tr>
<td>• Treatments in place to treat malnutrition</td>
</tr>
<tr>
<td>• Possible infusion (e.g. TPN)</td>
</tr>
<tr>
<td>• Administration of vitamins/supplements (e.g. Ensure/Boost)</td>
</tr>
<tr>
<td>• Dietician physical therapy notes</td>
</tr>
</tbody>
</table>

**Documentation Tip:**

- Weight loss, failure to thrive, cachectic appearing, and malnourished documentation does not impact SOI/ROM
### Documentation Concepts

<table>
<thead>
<tr>
<th>Clarify if the pain is “Acute” or “Chronic”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarify: Is this an admission for inpatient treatment of pain or is an underlying condition causing the pain?</td>
</tr>
</tbody>
</table>

*Example: Admitted for treatment of pain due to bone metastases of breast cancer*

<table>
<thead>
<tr>
<th>Link pain type to the condition.</th>
</tr>
</thead>
</table>

*Example:*
- Chronic pain due to…
- Phantom limb pain from R BKA

<table>
<thead>
<tr>
<th>If pain is from a polyneuropathy, what is the cause?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inflammatory or due to diabetes</td>
</tr>
</tbody>
</table>

| Is a spinal neurostimulator or intrathecal infusion pump being used to treat the patient? If so, specify this in documentation. |
Pain

Acute pain due to trauma

Other disorders of the nervous system

Acute

1

Type of Pain

1

Post-thoracotomy

Trauma

Post-procedural

Chronic
Substance Abuse Disorders

ICD-10-CM Documentation Requirements

- **Alcohol & Other Substances**
  - Specify the name of the substance (e.g. alcohol, cocaine, opioids, hallucinogens)
  - 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)
  - 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)
Substance Abuse

Cocaine abuse with intoxication with delirium

- F14
  - Mental & behavioral disorders d/t psychoactive substance use

Type of Use

- 1
  - Intoxication
    - 1
      - Intoxication with delirium
    - 2
      - Intoxication unspecified
    - 4
      - Intoxication with perceptual disturbance

Behavioral disorder

- Cocaine
  - abuse
  - dependence
  - use
## Diabetes

**ICD-10-CM Documentation**

### Key Documentation Concepts

| Identify DM Type: | • Gestational DM  
|                  | • Preexisting type 1  
|                  |   • Juvenile onset  
|                  |   • Ketosis-prone diabetes  
|                  | • Preexisting type 2  
|                  | • Diabetes due to an underlying condition (e.g. Cushing’s syndrome, malnutrition)  
|                  | • Drug/chemically induced diabetes (adverse effect)  
|                  |   • Name of the drug/chemical  
|                  |   • Whether the drug was correctly prescribed and properly administered  
|                  |   • Encounter (initial, subsequent)  
|                  | • Document whether it is “postprocedural” diabetes  
| Indicate if: | • “Preexisting”: Onset was prior to this current pregnancy  
|             | • Abnormal glucose tolerance test and not diabetes  
| Clarify if the pregnancy was incidental to the encounter for diabetic conditions? | • *Preexisting type 1 diabetes with pregnancy related to insulin dosing*  
| |   • *CKD Stage 4 due to type 2 DM, unrelated to the pregnancy*  
| Is the diabetes controlled by: | • Diet  
| | • Insulin  
| Link diabetes to any associated complications and manifestations |
Diabetic Manifestations & Complications

DM manifestations and complications increase SOI when linked to DM

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 2 DM 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.
Summary of Best Practice Documentation Teaching Points

Key Documentation Concepts

• When documenting a recent MI, define the estimated time since it occurred in days/weeks, not months
• AMI defaults to STEMI in ICD-10-CM, unless otherwise specified in your documentation
• AMI documentation must state both the wall and specific artery affected
• ICD-10-CM assumes Angina pectoris is due to atherosclerosis unless otherwise documented
• To capture CAD patient’s true severity, specify to the greatest degree possible the vessel type affected and the type of angina observed
• When documenting heart disorders, name the type of valve and disorder observed
• Specify acuity and type of CHF observed
• Carry all significant findings from the echo and other tests into the progress notes to ensure it will be captured in the coded record
Key Documentation Concepts

- Pneumonia requires:
  - Suspected organism based on treatment ordered and risk factors
  - Aspiration needs to be supported by aspiration risk factors
  - Resistance to medication and what medication
  - With or without sepsis, influenza or acute respiratory failure

- Influenza requires:
  - Whether or not there are novel influenza viruses
  - Link to other illness such as URI, myocarditis, laryngitis, pneumonia

- Conflicting, incomplete, or ambiguous documentation will lead to a query

- Carry all documentation over from diagnostic test into the progress notes to ensure it will be captured in the coded record

- Documentation of tobacco exposure is crucial

- Mechanical ventilator time frames have changed to allow capture of < 24 hours, < 24 - 96 hours, and > 96 hours; Capture extubation time

- Mild, moderate or severe respiratory distress/insufficiency do not equal respiratory failure

- Blood gases and mechanical ventilation are not required for the capture of respiratory failure
Circling Back: Concepts Drive Changes in Documentation Requirements

Key Considerations for Internal Medicine ICD-10-CM

- Laterality
- Infection Site
- Type of Infection
- Inflammation Site
- Causal Agent
- Type of Vessel
- Complication
- Acuity
- Onset
Appendix
Case Study Examples
Let’s Take a Look at Five Cases Studies Showcasing the Importance of Capturing the Following Concepts

<table>
<thead>
<tr>
<th></th>
<th>Documenting Diagnosis Instead of Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Avoiding Symbols as Short-hand</td>
</tr>
<tr>
<td>3</td>
<td>Capturing Specificity</td>
</tr>
<tr>
<td>4</td>
<td>Linking Associated Conditions/Manifestations</td>
</tr>
<tr>
<td>5</td>
<td>Preventing Conflicting Documentation</td>
</tr>
</tbody>
</table>
Case Study #1

Documenting Diagnosis Instead of Symptoms

Clinical Scenario: Mrs. Smith is a 60 year-old female admitted for the evaluation of chest pain. The morning of admission she awoke with midsternal chest discomfort associated only with nausea. The patient’s pain was relieved after receiving nitroglycerin sublingual and a GI cocktail in the ED.

Patient admitted for evaluation of chest pain. Placed on a cardiac monitor and started on topical nitrates. Stress test and Echocardiogram were administered; Both registered as normal. Cardiac enzymes normal. Chest pain and symptoms resolved with GI cocktail. Patient discharged home.

Common Insufficient Documentation
- Chest pain
- Nausea

Best Practice Documentation
- Chest Pain probably due to GERD
- Cardiac Ischemia was ruled out

Documentation Teaching Point:
Final Diagnoses should not be symptoms (such as chest pain, nausea, shortness of breath) when a likely or probable diagnosis is known. In addition, when a diagnosis is “ruled out” it should be documented as such.
**Clinical Scenario:** Patient is a 65 year-old white female who was admitted with atrial fibrillation with a rapid ventricular response. She was treated with IV antiarrhythmics and converted to normal sinus rhythm. Her past medical history includes chronic kidney disease. Her admission laboratory studies were as follows:

- WBC: 15.4
- RBC: 3.89
- Hemoglobin: 8.6
- Hematocrit: 25.0
- Platelets: 160K
- BUN: 24
- Creatinine: 1.7

**Best Practice Documentation**

- PDx: Atrial fibrillation with RVR
- CKD, Stage III
- Anemia of chronic renal disease

**Common Insufficient Documentation**

- PDx: Atrial fibrillation
- CKD – stable/at baseline
- ↓ H/H

**Documentation Teaching Point:**

The use of symbols to describe a diagnosis cannot be coded; it is necessary to document the actual diagnosis. Furthermore, specifying the stage of disease also impacts SOI/ROM.
Case Study #3

Capturing Specificity

**Clinical Scenario:** 75 y.o. with chronic lung disease dependent on home oxygen (24/7) is admitted with fever, leukocytosis, SOB with hypoxia and altered mental status. Vitals: temperature 100.9, pulse 101, BP 90/50 and RR 22. Treated w/ IV Vancomycin. Blood cultures results pending. PMHx indicated COPD.

Admitted with diagnosis of fever, leukocytosis, hypoxia and AMS.
CXR identified pneumonia. IV vancomycin started. Blood cultures + Staph aureus.
The patient’s symptoms improved on the prescribed treatment. The patient discharge home with continued home O2.

**Common Insufficient Documentation**
- Fever
- Hypoxia
- Leukocytosis

**Best Practice Documentation**
- Staph aureus sepsis secondary to pneumonia
- Septic encephalopathy
- COPD with acute exacerbation
- Chronic Respiratory Failure

**Documentation Tip:**
- Non-specific documentation does not accurately reflect the SOI or ROM. If specifics are known regarding a diagnosis, they should be documented to capture the acuity of the patient.
- A positive blood culture is *not required* for the clinical diagnosis of sepsis.
Case Study #4

Linking Associated Conditions/Manifestations

**Clinical Scenario:** 75 y.o. male admitted with cough and fever. He has a history of urinary retention and chronic indwelling Foley catheter. Vitals: Temp 100.9 Pulse 88, Blood Pressure 110/60, Respiratory Rate 20. Sputum culture positive for MSRA and urine culture positive for E Coli.

**Documentation Tip:**
- Clearly link all conditions that are associated and provide the underlying etiology whenever known. The important language in this example is “due to.”
- UTI is considered a Healthcare Acquired Condition unless documented as Present On Admission (POA).

---

**Common Insufficient Documentation**
- Pneumonia
- UTI

**Best Practice Documentation**
- Pneumonia due to MRSA
- E. Coli UTI secondary to indwelling foley, present on admission.

---

**Documentation Tip:**
- Patient admitted with a diagnosis of pneumonia and UTI.
- Patient started on broad spectrum IV antibiotics. Indwelling foley was changed in the ED.
- The patient status improved. Discharged home on antibiotics and monthly Foley catheter changes.
Preventing Conflicting Documentation

**Clinical Scenario:** Patient presented to the ED with chest pain and diagnosed with an Acute Myocardial Infarction. The patient’s medical history includes: hypertension, diabetes, GERD, CVA with L sided weakness. During the stay, the patient developed SOB w/ fever. The attending documented bronchitis without any further specification and IV antibiotics were started.

During hospitalization, the patient developed acute shortness of breath and a fever. Attending documents bronchitis. Orders pulmonary and speech and language consult.

- CXR showed RLL infiltrates
- SLP consult identified dysphagia w/ aspiration risk
- Pulmonologist documented probable aspiration pneumonia.
- IV clindamycin started

Patient was discharged home with home health & speech therapy. Dysphagia diet & 7 additional days of antibiotics.

### Common Insufficient Documentation

| • AMI | • Hx CVA |
| • Bronchitis | • GERD |
| • Weakness, left side | • Hypertension |

### Best Practice Documentation

| • AMI, anterolateral, initial episode | • GERD |
| • Aspiration Pneumonia | • Hypertension |
| • Hx CVA with left hemiparesis |

### Documentation Tip:

A conflict occurs when 2 physicians call the same condition 2 different things. In this case, the consultant has described his diagnosis as “aspiration pneumonia”, but the attending physician’s discharge summary states “Bronchitis”. If there is conflicting physician documentation, and the coder fails to query the attending physician to resolve the conflict, hospitals are encouraged to code the attending physician’s version.

1) Indicates attending agrees and acknowledges the consultant’s diagnosis.

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