Why Words Matter

Through a Newborn/Pediatric 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 physician quality scores

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

3. Understand the concepts of linking conditions and manifestations for more accurate depiction of patient’s clinical status
Road Map for Discussion

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

2. Concepts Drive Documentation Requirements

3. Examples of Diagnoses in ICD-10
The Evolution of Clinical Documentation

What was once a tool for communication between providers and clinicians is now the primary data source to determine quality of patient care. Market forces are leading to increase in documentation scrutiny.

Who is the audience for your notes?
Increased Transparency For Patients

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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-CM/PCS code sets”.

Benefits and Goals of ICD-10-CM/PCS

• Provides better detail, a more accurate depiction, and improved communication of patients clinical status
• Allows for more accurate payment for new procedures
• Improves capture of morbidity and mortality data
• Reduces the number of miscoded, rejected and improper claims for reimbursement
ICD-9-CM vs. ICD-10-CM/PCS: A Comparison

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.

Why so many new codes?


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# Introduction to ICD-10-CM Diagnosis Coding Structure

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

\[
\alpha \# \alpha/\# \bullet \alpha/\# \alpha/\# \alpha/\# \alpha/\#
\]

- **Category**
- **Sub-categories** (Etiology, Anatomic Site, Severity, Laterality, Complication)
- **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>
# Introduction to ICD-10-PCS Coding Structure

In this exercise, we will dissect the structure of an ICD-10-PCS code

**α/#**  
<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
</table>

1. **Section** – 16 options identifying the general type of procedure. Example: Medical/Surgical Section represents the vast majority of procedures reported in an inpatient setting

2. **Body System** - e.g. circulatory system, respiratory system

3. **Root Operation** - 31 options, based on the objective of the procedure

4. **Body Part** - e.g. pericardium, coronary artery, heart, atrium, mitral valve

5. **Approach** - 7 options, e.g. open, percutaneous, percutaneous endoscopic

6. **Device** - 4 basic groups: Grafts/prostheses, implants, simple or mechanical appliances, and electronic appliance

7. **Qualifier** - e.g. identify destination site in a Bypass, Diagnostic, Full thickness burn

**Physician documentation required:**

- *Type and intent* of procedure (root operation)
- Specific anatomic sites treated
- Approach
- Specific type of device used
- Validate surgical complications
- Diagnoses that support inpatient medical necessity
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 Diagnoses in ICD-10
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, pathology 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/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 for physicians. Coders cannot assume clinical relationships.

Examples: Linking Diseases

- Hypertension with heart disease
- Endocarditis due to staph aureus
- Right heart failure due to primary pulmonary hypertension

Use terms like “due to” or “with”

Note: Lists, commas, and the word “and” do not link conditions
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>
“Suspected” Scenario

Newborn (suspected to be) affected by maternal use of cocaine

- Newborn (suspected to be) affected by noxious substances transmitted via placenta or breast milk
- Maternal use of cocaine

- Anesthesia or analgesia in pregnancy, labor and delivery
- Other maternal medications
- Use of tobacco
- Drugs of addiction: Cocaine or Other
- Use of alcohol
- Use of nutritional chemical substances
- Exposure to environmental chemical substances
- Other maternal noxious substances
- Unspecified noxious substance
Age Categories Updated in ICD-10-CM

'Ages' in ICD-10-CM overlap one another

New Age Categories Define Patients Across Lifespan

- Adult age: 15 - 124 Years
- Maternity age: 12 - 55 Years
- Pediatric age: 0 - 17 Years
- Newborn: 0 Years
  - Neonate: 0-28 Days
### Documentation of Newborns in ICD-10-CM

#### 4 Essential Documentation Concepts for Normal Newborns

1. Document newborn weight
2. Document weeks of gestation
3. Place of birth
4. Type of delivery

**Note:** Infant transfers are important to document for accurate reflection of the status of the newborn

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#### Additional Considerations for Preterm Newborns

1. Document status as “preterm” or “premature”
2. Document weeks of gestation
3. Document other standard newborn concepts: weight, place of birth, type of delivery

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**Defining ‘prematurity’**
Between 28 and 37 weeks completed gestation. Note: Coder cannot calculate from the last menstrual period, weeks must be documented
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 Newborn Diagnoses in ICD-10-CM
ICD-10-CM Newborn Diagnoses Covered Today

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

<table>
<thead>
<tr>
<th></th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Congenital Malformations</td>
</tr>
<tr>
<td>2</td>
<td>Birth Injuries</td>
</tr>
<tr>
<td>3</td>
<td>Perinatal Respiratory Disorders and Infections</td>
</tr>
<tr>
<td>4</td>
<td>Fetal and Neonatal Hemorrhage and Jaundice</td>
</tr>
<tr>
<td>5</td>
<td>Tobacco Exposure</td>
</tr>
</tbody>
</table>
### Documenting Congenital Malformations in ICD-10-CM

<table>
<thead>
<tr>
<th>Congenital Malformation</th>
<th>Documentation Concept to Capture</th>
<th>Specify As…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleft Lip and Palate Disorders</td>
<td>Type/Description of Abnormality</td>
<td>• Hard or soft palate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• With unilateral, bilateral cleft lip</td>
</tr>
<tr>
<td></td>
<td>Laterality</td>
<td>• Cleft lip disorders are classified as:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bilateral, median, or unilateral</td>
</tr>
<tr>
<td>Cystic Kidney Disease</td>
<td>Type/Description of Abnormality</td>
<td>• Congenital renal cyst</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Single or multiple</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Polycystic kidney, infantile type</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• With congenital dilation of collecting ducts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Polycystic kidney, adult type</td>
</tr>
</tbody>
</table>

**Note:** The terms “complete” v. “incomplete” are no longer sufficient to capture type of cleft lip disorder.

**Note:** Describe abnormality, specifying site and laterality where possible for all malformations.

**Example:** “polydactyly of right thumb”
## Birth Injury Documentation in ICD-10-CM

<table>
<thead>
<tr>
<th>Birth Injury To:</th>
<th>Document Specific Site and Laterality</th>
<th>Document Resulting Condition</th>
</tr>
</thead>
</table>
| **Skeleton**    | • Skull  
                    • Femur or other long bone  
                    • Clavicle                  | Injury to skull resulting in:  
                                                                 • Chignon (from vacuum extraction)  
                                                                 • Bruising of scalp |
| **Peripheral Nervous System** | • Erb’s nerve  
                                 • Klumpke’s nerve  
                                 • Pherenic nerve             | • Erb’s nerve paralysis  
                                                                 • Klumpke’s nerve paralysis  
                                                                 • Pherenic nerve paralysis |
| **Central Nervous System** | • Facial nerve  
                               • Other cranial nerves  
                               • Spinal cord              | • Cerebral edema  
                                                                 • Facial nerve injury or palsy  
                                                                 • Fracture of the spine  
                                                                 • Other specified brain damage |
| **Other Locations** | • Liver  
                           • Spleen  
                           • Eyes  
                           • Genitalia             | • Hemorrhage (Intracranial, Intraventricular, etc.)  
                                                                 • Injury or rupture of the liver or spleen  
                                                                 • Subconjunctival hemorrhage  
                                                                 • Facial contusion  
                                                                 • Subcutaneous fat necrosis |

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Documentation Tips for Birth Injuries

Birth injury code specificity has increased substantially in ICD-10-CM better reflect severity of illness

Document Each Injury for Accurate Reflection of SOI

1. Unlike ICD-9-CM, each birth injury is assigned a separate code, the specificity of each injury should be identified
2. Document congenital malformation throughout patient’s life, clarify as a personal history of (“PHO”) if the condition is corrected
3. Specify all injuries to greatest degree possible: type of hemorrhage, location of rupture, laterality and type of fracture, etc.
## Perinatal Respiratory Disorders

New ICD-10-CM Documentation Concepts – Time Frame, Specificity, Linking

<table>
<thead>
<tr>
<th>Condition</th>
<th>Documentation Concept</th>
<th>Example Specifications</th>
</tr>
</thead>
</table>
| Metabolic Acidemia            | Time of occurrence                          | • Before onset of labor  
|                               |                                             | • During labor  
|                               |                                             | • After birth                                               |
| Congenital Pneumonia          | Time of occurrence                          | • Acquired in utero or during birth                         |
|                               | Causative organism                          |                                                             |
| Neonatal Aspiration           | Causative organism (known or suspected)     | • Meconium, amniotic fluid, blood, milk                      |
|                               | Link to associated conditions               | • With or without respiratory symptoms                      |
|                               |                                             | • Secondary pulmonary hypertension                          |
| Interstitial Emphysema        | Link to associated conditions               | • Pneumothorax  
|                               |                                             | • Pneumomediastinum                                         |
|                               |                                             | • Pneumopericardium                                         |
Perinatal Infections

Infections acquired in utero, during birth, or during the first 28 days after the birth

- Congenital viral diseases include
  - Rubella syndrome
  - Cytomegalovirus
  - Herpes simplex virus
  - Other congenital viruses

- Bacterial sepsis of newborn
  - Clarify organism
  - Clarify presence of severe sepsis
  - Clarify if there is an associated organ dysfunction

- Omphalitis of newborn
  - With mild hemorrhage
  - Without hemorrhage
### New Classifications of Hemorrhages

<table>
<thead>
<tr>
<th>Category</th>
<th>Specificity and Cause</th>
</tr>
</thead>
</table>
| **Umbilical hemorrhage of newborn** | - Massive umbilical hemorrhage of newborn  
- Slipped umbilical ligature          |
| **Intracranial non-traumatic hemorrhage** | - Clarify if related to birth or traumatic injury  
- Intracranial hemorrhages secondary to anoxia or hypoxia are further specified as *Grades 1-4* |
| **Other neonatal hemorrhages**   | - Hematemesis or melena which is not due to swallowed maternal blood  
- Rectal hemorrhage                   |

Documentation of a newborn identifies those hemorrhages that are not due to the birth process or injury.
Neonatal Jaundice
Greater specificity required in ICD-10-CM

Document the underlying cause for neonatal jaundice

**Cause of excessive hemolysis**
- Bruising
- Bleeding
- Infection *(identify organism)*
- Polycythemia
- Drugs or toxins
  - Name of drug/toxin
  - Poisoning or adverse effect
  - Transmitted from mother or given to newborn
- Swallowed maternal blood

**Other causes of neonatal jaundice**
- Associated with preterm delivery
- Inspissated bile syndrome
- Other hepatocellular damage
- Physiologic jaundice
Documenting Tobacco Exposure

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 (2\textsuperscript{nd} hand smoke) |
| Use                     | • Tobacco use (current)  
|                         | • Tobacco use (past)     |
| Dependence              | • Nicotine dependence and source (e.g. cigarettes, tobacco, other)  
|                         | • Nicotine dependence in remission  
|                         | • Uncomplicated  
|                         | • In remission  
|                         | • With withdrawal  
|                         | • With or without other nicotine-induced disorders |
Summary of Best Practice Teaching Points

Key Documentation Concepts

- Conflicting, incomplete, or ambiguous documentation will lead to a query
- Carry all documentation from diagnostic test into progress notes to ensure it will be captured
- Documentation of tobacco exposure is crucial
- Sign, symptoms and test results do not contribute to SOI unless their significance is documented or they are linked to a named disease
- Clear documentation regarding non-traumatic intracranial hemorrhage regarding the cause to separate from a birth or traumatic injury
- Document cause of neonatal jaundice
- Always document the patient’s “story” through to the discharge summary, including those conditions that may have future health implications
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