# ICD-10-CM Documentation in the Real World: What We Have Learned

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# Key Objectives

- Identify query opportunities related to ICD-10 CM specificity
- Examine the impact of code specificity on SOI/ROM
- Discuss the impact code specificity has on MS-DRG assignment



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# About Today's Speakers



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# Disclosure

**We have no actual or potential conflict of interest in relation to this program/presentation.**



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# Biography

## SHAWN M. MACPHEE, MSN, RN, CCDS

Shawn MacPhee is the CDI Manger at Anthelio Healthcare Solutions. In this capacity Ms. MacPhee focuses on improvement in the quality, completeness, and accuracy of the medical record documentation through extensive audit, education and data analysis while applying best practice clinical documentation improvement strategies.

Ms. MacPhee has over four years of experience in clinical documentation improvement. In addition to her current role, she has served as CDI Auditor/Educator and Clinical Documentation Specialist at Anthelio Healthcare Solutions. Her achievements include: standardization of physician query templates across the organization and leading the physician engagement initiative. In addition, she initiated/led corporate wide CDI projects in the area of CDI policy and procedure, CDS orientation, process flow, and quality monitoring.

Ms. McPhees professional experience includes over 15 years of acute care nursing with a focus on critical care and perioperative nursing. Prior to joining Anthelio Healthcare Solutions, Ms. MacPhee held the role of Assistant Director of the Heart and Vascular Center at McLaren Central Michigan. She established policies and procedures utilizing evidenced based practice and created staff orientation and training programs.

A graduate of Walden University with a Masters in Nursing Leadership and Management and a Bachelor of Science in Nursing from Michigan State University, Ms. MacPhee is credentialed as a Certified Clinical Documentation Specialist (CCDS) and is a member of the Association of Clinical Documentation Improvement Specialists (ACDIS).

# Biography

## Jenny DelRocco, BSN, RN, CCDS

Jenny DelRocco is a Clinical Documentation Improvement Auditor/Educator at Anthelio Healthcare Solutions. In this capacity, Ms. DelRocco focuses on improving healthcare quality reporting and mid-cycle optimization through reviewing the medical record to identify documentation opportunities and utilizing best practice methodologies to attain physician engagement.

Ms. DelRocco has over 10 years of acute care nursing which include specialties of Medical/Surgical Intensive Care, Cardiac Surgery, PCU/Telemetry, and has served as a Rounding Nurse for a Nephrology and Infectious Disease Group.

Prior to joining Anthelio Healthcare Solutions, Ms. DelRocco served as a Clinical Documentation Coordinator at McLaren Flint Hospital for 3 years where she managed a CDI Team, collaborated with a multidisciplinary team to create a pre-bill PSI/HAC/Complication review process, led CDI/Physician Education on the effects of documentation on quality care and reporting, performed appeals, led ICD-10 Initiative of Dual Coding/Education, and maintained compliance with CMS, AHIMA, and HIPPA.

A graduate of the University of South Florida with a Bachelor of Science in Nursing, Ms. DelRocco is credentialed as a Certified Clinical Documentation Specialist (CCDS) and AHIMA ICD-10 Trainer. She has memberships with the Association of Clinical Documentation Improvement Specialists (ACDIS) and the American Health Information Management Association (AHIMA).

# Biography

**Jane C. Ruhstorfer, BSN, RN, CCS, CCDS**

Jane Ruhstorfer is a CDI Auditor and Educator at Anthelio Healthcare Solutions. In this capacity Ms. Ruhstorfer focuses on improvement in the quality, completeness, and accuracy of the medical record documentation through extensive audit, education, and data analysis while applying best practice clinical documentation improvement strategies.

Ms. Ruhstorfer has over five years of experience in clinical documentation improvement. Ms. Ruhstorfer's professional experience includes 15 years of acute care nursing, including orthopedics, medical surgical, and IV therapy. Prior to joining Anthelio Healthcare Solutions, Ms. Ruhstorfer was Clinical Documentation Management Program Coordinator at McLaren-Flint.

Ms. Ruhstorfer is a graduate of Michigan State University with a Bachelor of Science in Nursing. Ms. Ruhstorfer is credentialed as a Certified Clinical Documentation Specialist (CCDS), Certified Coding Specialist (CCS), AHIMA-approved ICD-10-CM/PCS trainer, and is a member of the Association of Clinical Documentation Improvement Specialists (ACDIS).

# Specificity

- The goal of transitioning to ICD-10 was to provide better detail in the codes reported. If appropriate, specification should decrease denials, support medical necessity, create audit defensibility, and could effect DRG/SOI/ROM assignment.

- A query should be placed if there is clinical evidence of higher specification.

| Common Diagnosis Specification Needed | |
|---|---|
| **Acuity** (acute, subacute, chronic, or acute on chronic) | **Severity** (mild, moderate, or severe; total/complete vs partial/incomplete) |
| **Anatomical Location** | **Associated Organism** |
| **Laterality** (right, left, bilateral, or unilateral) | |



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# Specify Sepsis Organism

| | ICD-10 | Potential |
|---|---|---|
| **Principal Dx** | A419 Sepsis, unspecified organism | A4152 Sepsis due to Pseudomonas |
| **MS-DRG** | 872 Septicemia or Severe Sepsis w/o MV > 96 hours w/o MCC | 872 Septicemia or Severe Sepsis w/o MV > 96 hours w/o MCC |
| **Relative Weight** | 1.0427 | 1.0427 |
| **GMLOS** | 3.9 | 3.9 |
| **SOI / ROM** | 1 – Minor / 1 - Minor | **2 – Moderate** / 1 - Minor |

Documentation for higher specificity: **Associated Organism**

"Sepsis secondary to pseudomonas bacteremia"



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# Specify COPD and Asthma

| | ICD-10 | Potential |
|---|---|---|
| **Principal Dx** | J449 COPD, unspecified | J441 COPD with exacerbation |
| **Secondary Dx** | J45909 Unspecified asthma, uncomplicated | J4541 Moderate persistent asthma with exacerbation |
| **MS-DRG** | 192 Chronic Obstructive Pulmonary Disease w/o CC/MCC | 191 Chronic Obstructive Pulmonary Disease w/ CC |
| **Relative Weight** | 0.7313 | 0.9321 |
| **GMLOS** | 2.7 | 3.3 |
| **SOI / ROM** | 1 – Minor / 1 - Minor | **2 – Moderate** / 1 - Minor |

Documentation for higher specificity: **Severity/Acuity**

"Exacerbation of COPD with acute moderate persistent asthma"



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# AMI Changes

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

“**PMH:** Patient suffered a STEMI involving the left circumflex coronary artery 2 weeks ago and was discharged home. Re-admitted today for a STEMI of the anterior wall.”

Patient history STEMI 2 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**

“a month ago” = > 28 Days? / ≤ 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**



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# AMI

"**PMH:** Patient suffered a STEMI involving the left circumflex coronary artery 2 weeks ago and was discharged home. Same patient is admitted today for a STEMI of the anterior wall."

| | ICD-10 |
|---|---|
| **Principal Dx** | I220 Subsequent ST elevation (STEMI) of anterior wall |
| **Secondary Dx** | I2121 ST elevation (STEMI) myocardial infarction involving left circumflex coronary artery |
| **MS-DRG** | 282 AMI, discharged alive w/o CC/MCC |
| **Relative Weight** | 0.7557 |
| **GMLOS** | 2.0 |
| **SOI / ROM** | 2 – Moderate / 2 – Moderate |

Sequencing of I22 and I21 depends on the circumstances of admission (ICD-10-CM Official Coding Guidelines Section I.C.9.e.4)

# Clinical Example – Major Depression

**Scenario:** Patient presented to the inpatient psych unit for depression. The patient reported delusions and thoughts of suicide. Per H&P, diagnosed with Major Depression. The patient indicated that she has been unable to get out of bed for a week and was recently laid off due to frequent absenteeism. Treatment includes Seroquel and Cymbalta PO with daily group and individual therapy.

**Scenario 1 - Documentation**

- Major Depression

**Scenario 2 - Best Practice Documentation**

- Single Episode Severe Major Depression

| Scenario | MS-DRG | Description | Weight | GMLOS | SOI/ROM |
|---|---|---|---|---|---|
| 1 | 881 | Depressive neuroses | 0.6618 | 3.4 | 2 / 1 |
| 2 | 885 | Psychoses | 1.0575 | 5.6 | 2 / 1 |

# Major Depression

| | ICD-9 | ICD-10 | ICD-10 Potential w/ Query |
|---|---|---|---|
| **Principal Dx** | 296.20 Major depressive affective disorder, unspecified | F32.9 Major depressive disorder, single episode, unspecified | F33.0 Major depressive disorder, single episode, mild |
| **MS-DRG** | 885 Psychoses | 881 Depressive neuroses | 885 Psychoses |
| **Relative Weight** | 1.0575 | 0.6618 | 1.0575 |
| **GMLOS** | 5.6 | 3.4 | 5.6 |
| **SOI / ROM** | 2 – Moderate / 1 - Minor | 2 – Moderate / 1 - Minor | 2 – Moderate / 1 - Minor |

Query Opportunity: **Severity**

If Depression is further specified as mild, moderate, or severe then the DRG will be 885.

Note: Only the specified types are CC's (except if in remission)



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# Clinical Example: Cerebral Infarction

**H&P:** Presented to ED obtunded with confusion and a GCS of 8. CT of the head reveals an acute infarction with severe chronic white matter disease. Assessment: Stroke. Plan: Neuro checks, admit to inpatient, and Consult Neurology.
**PN day 2:** MRI reveals right sided MCA infarct. Confusion resolved, but now with mild LLE and LUE weakness. Assessment: Acute Stroke. Plan: continue Neuro checks, initiation PO ASA, PO Zocor, and start PT/OT.

### Scenario 1 - Documentation

- Stroke
- Left sided weakness
- GCS = 8

### Scenario 2 – Opportunity

- Ischemic Infarction
- Left sided weakness secondary to CVA **(CC)**
- GCS = 8

### Scenario 3 - Best Practice Documentation

- Ischemic Infarction 2nd R MCA Stenosis
- Hemiplegia 2nd ischemic infarction **(CC)**
- GCS = E=2, V=2, M=4 **(All MCC)**

| Scenario | MS-DRG | Description | Weight | GMLOS | Exp. Mort. Rate | SOI/ROM |
|---|---|---|---|---|---|---|
| 1 | 066 | Intracranial Hemorrhage or Cerebral infarction without CC/MCC | 0.7574 | 2.4 | 1. 27% | 1 / 1 |
| 2 | 065 | Intracranial Hemorrhage or Cerebral infarction with CC | 1.0593 | 3.3 | 1.94% | 2 / 1 |
| 3 | 064 | Intracranial Hemorrhage or Cerebral infarction with MCCCC | 1.7326 | 4.5 | 7.13% | 3 / 4 |



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# Glasgow Coma Scale

| GCS Score | | | | | | |
|---|---|---|---|---|---|---|
| **Criteria Type & Points** | **1** | **2** | **3** | **4** | **5** | **6** |
| **Eyes Open** | **Never[1]** | **To pain[1]** | To sound | Spontaneous | N/A | N/A |
| **Best Verbal Response** | **None[1]** | **Incomprehensible words[1]** | Inappropriate words | Confused conversation | Oriented; converses normally | N/A |
| **Best Motor Response** | **None[1]** | **Extension to painful stimuli[1]** | Abnormal flexion to painful stimuli | **Flexion withdrawal from painful stimuli[1]** | Localizes painful stimuli | Obeys commands |

**[1]Indicates MCC designation**

**Note:**

Used in conjunction with

- Traumatic Brain Injury
- Acute Cerebrovascular Disease
- Or Other Sequela of Cerebrovascular Disease

**(Reference: ICD-10-CM Official Coding Guidelines Section I.C.18.e)**

**Scale**

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

**Documentation Tip:**

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

# Rhabdomyolysis

Classified into 3 Categories:

1. **Traumatic or Muscle Compression:** e.g. crush syndrome or prolonged immobilization

2. **Nontraumatic Exertional:** e.g. marked exertion in untrained individuals, hyperthermia, or metabolic myopathies

3. **Nontraumatic Nonexertional:** e.g. drugs or toxins, infections, or electrolyte disorders.

Miller, Marc MD. “Causes of Rhabdomyolysis.” UpToDate. Wolters Kluwer, Sept. 19, 2014. http://www.uptodate.com/contents/causes-of-rhabdomyolysis

# Rhabdomyolysis

| | ICD-9 | ICD-10 | ICD-10 Potential w/ Query |
|---|---|---|---|
| **Principal Dx** | 82003 Closed Transcervical fracture, base of neck | S72041A Displaced fracture of base of neck of right femur, initial, closed | S72041A Displaced fracture of base of neck of right femur, initial, closed |
| **Secondary Dx** | 728.88 Rhabdomyolysis **(CC)** | M62.82 Rhabdomyolysis **(CC)** | T796.XXA Traumatic Ischemia of muscle **(CC)** |
| **MS-DRG** | 536 Fractures of Hip & Pelvis w/o MCC | 536 Fractures of Hip & Pelvis w/o MCC | 965 Other Multiple Significant Trauma w/o CC/MCC |
| **Relative Weight** | 0.7241 | 0.7241 | 0.9217 |
| **GMLOS** | 3.0 | 3.0 | 3.0 |
| **SOI / ROM** | 2 – Moderate / 1 - Minor | 2 – Moderate / 1 - Minor | 1 – Minor / 1 - Minor |

Query opportunity: Query for the underlying **Etiology** of the Rhabdomyolysis.



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# Clinical Example – Esophageal Hemorrhage

**Scenario:** Presented to ED with a complaint of vomiting blood. Hgb 7.8 and Hct 24.9. Treatment in the ED included 2 units of PRBC and a Sandostatin drip. ED Impression of Upper GI Bleed. H&P history of alcoholic liver cirrhosis and impression of esophageal hemorrhage and anemia. Plan Hgb & Hct Q6Hrs., continue Sandostatin drip, and consult GI. Patient undergoes EGD with impression of no active bleeding and findings of esophageal varices.

### Scenario 1 – Documentation

Esophageal Hemorrhage

Anemia

Liver Cirrhosis

### Scenario 2 - Best Practice Documentation

Alcoholic Liver Cirrhosis

Esophageal Hemorrhage d/t Esophageal Varices **(MCC)**

Acute Blood Loss Anemia **(CC)**

| Scenario | MS-DRG | Description | Weight | GMLOS | SOI/ROM |
|---|---|---|---|---|---|
| 1 | 392 | Esophagitis, Gastroenteritis & Misc. Digestive Disorders w/o MCC | 0.7400 | 2.7 | 2 / 2 |
| 2 | 432 | Cirrhosis & Alcoholic hepatitis w/ MCC | 1.6567 | 4.7 | 2 / 2 |

# Esophageal Hemorrhage

| | ICD-9 | ICD-10 | ICD-10 Potential w/ Query |
|---|---|---|---|
| **Principal Dx** | 5712 Alcoholic cirrhosis of the liver | K228 Other Specified Disease of Esophagus | K7030 Alcoholic cirrhosis of the liver |
| **Secondary Dx** | 53082 Esophageal hemorrhage | K7030 Alcoholic Cirrhosis of Liver w/o Ascites<br>D649 Anemia, unspecified<br>I8510 Secondary esophageal varices w/o bleeding **(CC)** | I8501 Esophageal varices with bleeding **(MCC)**<br>D62 Acute Post Hemorrhagic Anemia **(CC)** |
| **MS-DRG** | 432 Cirrhosis & Alcoholic hepatitis w/ MCC | 392 Esophagitis, Gastroenteritis & Misc. Digest Disorders w/o MCC | 432 Cirrhosis & Alcoholic hepatitis w/ MCC |
| **Relative Weight** | 1.6567 | 0.7400 | 1.6567 |
| **GMLOS** | 4.7 | 2.7 | 4.7 |
| **SOI / ROM** | 2 – Moderate / 2 - Moderate | 2 – Moderate / 2 - Moderate | 2 – Moderate / 2 - Moderate |

Query opportunity: Query for the underlying **Etiology** of the Esophageal Hemorrhage.



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# Clinical Example – Hepatic Encephalopathy

**Scenario:** Presented to ED obtunded with ammonia level of 110, and a positive troponin. History of alcoholic liver cirrhosis and severe non-operable CAD. H&P impression of hepatic encephalopathy and Acute NSTEMI. Plan consist of Lactulose PO TID and Cardiology consult. Cardiology recommend maximize medical therapy. Patient's mentation improved throughout admission. Upon discharge A&Ox4 and ammonia level of 30.

**Scenario 1 – Documentation**

NSTEMI

Hepatic Encephalopathy

**Scenario 2 - Best Practice Documentation**

NSTEMI

Hepatic Encephalopathy with Coma **(MCC)**

| Scenario | MS-DRG | Description | Weight | GMLOS | SOI/ROM |
|---|---|---|---|---|---|
| 1 | 282 | Acute Myocardial Infarction d/c alive w/o CC/MCC | 0.7557 | 2.0 | 1 / 1 |
| 2 | 280 | Acute Myocardial Infarction d/c alive w/ MCC | 1.6971 | 4.5 | 3 / 2 |

# Hepatic Encephalopathy

| | ICD-9 | ICD-10 | ICD-10 Potential w/ Query |
|---|---|---|---|
| **Principal Dx** | 41071 NSTEMI myocardial infarction | I214 NSTEMI myocardial infarction | I214 NSTEMI myocardial infarction |
| **Secondary Dx** | 5722 Hepatic encephalopathy | K7290 Hepatic failure, unspecified w/o coma | K7291 Hepatic failure, unspecified w/ coma **(MCC)** |
| **MS-DRG** | 280 Acute MI d/c alive w/o MCC | 282 AMI Infarction d/c alive w/o CC/MCC | 280 AMI Infarction d/c alive w/ MCC |
| **Relative Weight** | 1.6971 | 0.7557 | 1.6971 |
| **GMLOS** | 4.5 | 2.0 | 4.5 |
| **SOI / ROM** | 2 – Moderate / 1 – Minor | 1 – Minor / 1 – Minor | 3 – Major / 2 - Moderate |

Query Opportunity: **Severity or Associated Manifestation**

Hepatic Encephalopathy codes to Hepatic Failure. If specified as with Coma **or** Acute, would remain a MCC.



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# Clinical Example – Debility/Weakness

**Scenario:** 83 y.o. male presented after multiple falls at home and his caretaker reports patient unable to care for self. H&P impression of progressive debility and failure to thrive. Plan consist of Case Management consult for SNF placement and initiate PT/OT.

**Scenario 1 – Documentation**

Debility

**Scenario 2 - Best Practice Documentation**

Senile Debility

| Scenario | MS-DRG | Description | Weight | GMLOS | SOI/ROM |
|---|---|---|---|---|---|
| 1 | 948 | Signs & Symptoms w/o MCC | 0.7356 | 2.7 | 1 / 1 |
| 2 | 884 | Organic Disturbances & Mental Retardation | 1.1483 | 4.3 | 1 / 1 |



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# Debility/Weakness

| | ICD-9 | ICD-10 | ICD-10 Potential w/ Query |
|---|---|---|---|
| **Principal Dx** | 799.3 Debility, unspecified | R53.81 Other Malaise | R54 Age Related Physical Debility |
| **MS-DRG** | 948 Signs & Symptoms w/o MCC | 948 Signs & Symptoms w/o MCC | 884 Organic Disturbances & Mental Retardation |
| **Relative Weight** | 0.7356 | 0.7356 | 1.1483 |
| **GMLOS** | 2.7 | 2.7 | 4.3 |
| **SOI / ROM** | 1 – Minor / 1 – Minor | 1 – Minor / 1 – Minor | 1 – Minor / 1 – Minor |

Query opportunity: Further specify the **Etiology** of the generalized weakness or debility. If due to age related/senile debility, the DRG shifts to 884.



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# Summary of the Teaching Points

## Key Lessons Learned

- Best Practice is to clarify the:
  - Severity and episode of Major Depression
  - Individual Glasgow Coma Score subcategory
  - Etiology of rhabdomyolysis
  - Etiology of the esophageal hemorrhage
  - Acuity and coma status of Hepatic Encephalopathy
  - Etiology of general weakness

# Upcoming Webconference

***Upcoming Sessions:***

- 3/24/2016 at 2 pm EST:
  The Impact ICD-10 Specificity on Surgical DRG Assignment



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# The Anthelio Team

## *Questions?*

***Please do not hesitate to contact us with any questions or comments…***


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