Why Words Matter

Through a Family Practice 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 Family Practice Diagnoses in ICD-10-CM
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 an increase in documentation scrutiny.

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

HealthGrades - all material and images are sourced from www.healthgrades.com (accessed on 6/18/2012)

Leapfrog - all material and images are sourced from www.leapfroggroup.org (accessed on 6/18/2012)
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

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 causal agent, type, laterality, approach, episode of care, root operation, etc.


1) Code Volume Expansion in ICD-10-CM/PCS
# Introduction to ICD-10-CM Diagnosis Coding Structure

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

```
α  #  α/#  •  α/#  α/#  α/#  α/#
```

- **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 <em>(mild, moderate, severe, or unspecified; total/complete vs. partial/incomplete)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong> <em>(primary, secondary, unspecified)</em></td>
<td><strong>Episode of Care</strong> <em>(Initial, Subsequent, Sequelae)</em></td>
</tr>
<tr>
<td><strong>Acuity</strong> <em>(acute, subacute, chronic, acute on chronic, or unspecified)</em></td>
<td><strong>Laterality</strong> <em>(Right, Left, bilateral, or unspecified)</em></td>
</tr>
<tr>
<td><strong>Trimester</strong> <em>(1,2,3, unspecified)</em></td>
<td><strong>Number of fetus</strong> <em>(1-5, other)</em></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.

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 Family Practice 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

- 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
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>
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 Family Practice Diagnoses in ICD-10
**ICD-10-CM/PCS Family Practice Concepts Covered Today**

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Respiratory Conditions</td>
</tr>
<tr>
<td>2</td>
<td>Cardiac Conditions</td>
</tr>
<tr>
<td>3</td>
<td>Infections</td>
</tr>
<tr>
<td>4</td>
<td>Kidney Disease</td>
</tr>
<tr>
<td>5</td>
<td>Diabetes</td>
</tr>
<tr>
<td>6</td>
<td>Glasgow Coma Scale</td>
</tr>
</tbody>
</table>
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

Document (if present):
- Exercise-induced bronchospasm
- Cough variant asthma
- Detergent asthma
- Eosinophilic asthma
- Miners asthma
- Wood asthma
- Wheezing
- Always document tobacco exposure

Severe persistent asthma with acute exacerbation

Chronic lower respiratory diseases
(Asthma)

Type and acuity

“With”
## Severity of Asthma Classification

### Presentation of Asthma Before Treatment*

<table>
<thead>
<tr>
<th>Acuity</th>
<th>Symptoms</th>
<th>Nighttime Awakenings</th>
<th>Lung Function</th>
</tr>
</thead>
</table>
| Mild Intermittent     | • Symptoms ≤ 2x/week  
• Asymptomatic/normal PEF between exacerbations  
• Exacerbations of varying intensity are brief | ≤ 2x/month         | • FEV or PEF ≥ 80%  
predicted  
• PEF variability < 20% |
| Mild Persistent       | • Symptoms > 2x/week but < 1x per day  
• Exacerbation may affect activity | > 2x/month         | • FEV or PEF ≥ 80%  
predicted  
• PEF variability 20-30% |
| Moderate Persistent   | • Daily Symptoms  
• Daily use of inhaled short-acting beta-agonist  
• Exacerbations affect activity  
• Exacerbation ≥ 2x/week or ≥1 per day | > 1x/week          | • FEV or PEF 60-80%  
predicted  
• PEF variability >30% |
| Severe Persistent     | • Symptoms throughout the day  
• Limited physical activity  
• Frequent exacerbations | Frequent           | • FEV or PEF ≤ 60%  
predicted  
• PEF variability > 30% |

*Based on the National Heart, Lung, and Blood Institute (NHLBI) asthma severity classification scale.
Pneumonia & Influenza

ICD-10-CM Pneumonia & Influenza Documentation Concepts

<table>
<thead>
<tr>
<th>Pneumonia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identify the organism</strong></td>
</tr>
<tr>
<td>Viral or Bacterial</td>
</tr>
<tr>
<td>Known or suspected organism</td>
</tr>
<tr>
<td>Example: “Probable pneumonia due to MRSA”</td>
</tr>
<tr>
<td><strong>Remember: Probable, likely and suspected are acceptable terms in the inpatient setting</strong></td>
</tr>
<tr>
<td><strong>Link any associated conditions to the pneumonia</strong></td>
</tr>
<tr>
<td>• Sepsis due to pneumonia</td>
</tr>
<tr>
<td>• Acute respiratory failure due to pneumonia</td>
</tr>
<tr>
<td><strong>Aspiration Pneumonia</strong></td>
</tr>
<tr>
<td>Due to</td>
</tr>
<tr>
<td>• solids or liquids</td>
</tr>
<tr>
<td>• anesthesia during labor and delivery</td>
</tr>
<tr>
<td>• anesthesia during puerperium</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Influenza</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
</tr>
<tr>
<td>• Influenza virus</td>
</tr>
<tr>
<td><strong>Associated conditions</strong></td>
</tr>
<tr>
<td>• Pneumonia</td>
</tr>
<tr>
<td>• Respiratory illness (laryngitis, pharyngitis)</td>
</tr>
<tr>
<td>• Encephalopathy</td>
</tr>
<tr>
<td>• Myocarditis</td>
</tr>
</tbody>
</table>

**Documentation Tips:**
- Remember to document tobacco use
- Do not need a positive CXR or culture
- Documentation of CAP, HCAP, FAP, or HAP doesn’t capture severity of illness
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
  Linking together 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
- Echocardiogram Findings
  If available, document findings of systolic, diastolic or combined heart failure from the echo in your progress notes and discharge summary

Heart Failure Combination Codes Examples:

- Hypertensive heart disease with heart failure
- Heart failure following surgery
Diabetes

Specificity in diabetes documentation may increase severity of patient captured in the record

<table>
<thead>
<tr>
<th>Document</th>
<th>Potential Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Diabetes</td>
<td>• DM Type 1</td>
</tr>
<tr>
<td></td>
<td>• DM Type 2</td>
</tr>
<tr>
<td></td>
<td>• DM due to underlying condition (e.g. Cushing’s syndrome)</td>
</tr>
<tr>
<td></td>
<td>• Drug/chemical induced DM (Document the drug/chemical)</td>
</tr>
<tr>
<td></td>
<td>• Gestational DM</td>
</tr>
</tbody>
</table>

| Use of Insulin                        | • Long term                                                                               |
|                                       | • Current                                                                                 |

| Any manifestations or complications related to DM | Example: Hyperglycemia, Hyperosmolarity                                        |

ICD-10-CM Key Terminology Change

- If left unspecified, diabetes will default to the DM Type 2
- It is no longer required to specify ‘controlled’ or ‘uncontrolled’ diabetes

Physician Documentation Example

ICD-10-CM allows the capture of related conditions with one code instead of multiple codes

“Type 1 diabetes with nonproliferative diabetic retinopathy”

“Type 1 diabetes with ketoacidosis without coma”
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 2DM 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.

Common Insufficient Documentation Diagnosis Lists

Impression:
- DM Type 2
- Debridement
- Foot ulcer

LINK-LINK-LINK

Best Practice Documentation

- Excisional debridement of Type 2 DM L mid foot ulcer with necrosis of muscle
Intent of Encounter: New Documentation in ICD-10-CM

Clearly document why you saw and treated the patient for each new encounter

1. Clearly document the reason for each encounter - why did you see and treat the patient

2. Encounters with no delivery
   • Document the principal condition that necessitated the encounter
   • Document all condition(s) treated or monitored

For Your Reference: Examples of Reasons for Encounters with ICD-10 Codes

• Initial/repeat prescription of: contraceptive pills, emergency contraception, injectable contraception, instruction in a natural family planning
• Sterilization reversal
• IUD (e.g. insertion, routine checking, removal, removal and reinsertion)
• Post-vasectomy sperm count
• Fallopian tube patency testing
• Female/male testing for genetic disease carrier status
• Testing of male partner of patient with recurrent pregnancy loss
• Genetic counseling
• Rh incompatibility status
• Pregnancy Test (state if its positive or negative)
• Childbirth instruction
• Elective termination of pregnancy
• Normal first pregnancy, trimester
• Antenatal screening of mother
• Care of mother immediately after delivery outside a healthcare facility
• Care of lactating mother
• Routine postpartum follow-up
Encounter for Pregnancy

Encounter for supervision of normal first pregnancy, first trimester

Z 3 4

First, Other or Unspecified

First

Other

Unspecified

Unspecified

Second

Third
Normal Pregnancy and Delivery Documentation

ICD-10-CM/PCS Documentation Required

When documenting a normal pregnancy, please specify
- First pregnancy or other pregnancy
- Include the trimester the encounter is occurring (documenting the exact number of weeks will be sufficient)

When documenting full-term uncomplicated deliveries (e.g. spontaneous, cephalic, vaginal delivery of a full term, single, live born infant), please specify
- Whether patient required minimal or no assistance
- With or without an episiotomy
- With or without fetal manipulation (rotation, version) or instruments (forceps)
### Documenting ‘Trimester’ in ICD-10-CM

#### ICD-10-CM Guidelines for Documenting Trimester

In ICD-10-CM, the provider’s documentation of the number of weeks may be used to assign the appropriate code to identify the trimester.

- Coders may not calculate the numbers of weeks or trimester from the date of Last Menstrual Period

#### Admissions

- For a “pre-existing condition”, document the trimester at the time of the encounter of the admission
- If the condition is concurrent and spans more than one trimester, you use the trimester at admission, not discharge trimester

#### Trimester documentation is not needed when

- The condition always occurs in a specific trimester

- If delivery occurs during any encounter, the time frame and documentation is “in childbirth”
Newborn Documentation

Document place of birth and type of delivery

Physicians must document “preterm (premature) newborn” and include weeks of gestation completed
  • Premature is defined as 28 completed weeks or more but less than 37 completed weeks of gestation
  • This cannot be calculated by the coder from the LMP (last menstrual period)

New ICD-10-CM terminology and time frames
  • Slow intrauterine growth replaces fetal growth retardation
    • No longer includes 2,500 grams and over
  • Short gestation & low birth weight
    • Has changed from 24 to 28 weeks
    • Extreme prematurity of newborn is less than 28 completed weeks (or <196 completed days) of gestation

The physician must document both the weight and weeks of completed gestation on all newborn records
# Injuries

## ICD-10-CM Documentation Requirements

<table>
<thead>
<tr>
<th>Anatomic site of Injury (e.g. head, neck, thorax)</th>
<th>Type of Injury (e.g. superficial, open wound, fracture, internal injury)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site Subclassification (e.g. scalp, eyelid, cervical esophagus)</td>
<td>Injury Subclassification (e.g. open, closed, partial, complete)</td>
</tr>
<tr>
<td><strong>Encounter</strong> (e.g. initial, subsequent, or sequelae)</td>
<td></td>
</tr>
</tbody>
</table>
**Traumatic Injury Documentation**

ICD-10-CM Documentation Requirements

Specify:
- Acuity
- Actual injuries, from most to least serious
- Site of injury
- Laterality
- Tissues injured
- Presence of foreign body
- Loss of function
- Associated infection
- Encounter
  - Initial, Subsequent or Sequela

<table>
<thead>
<tr>
<th>ICD-10-CM Injury Terminology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrasion</td>
</tr>
<tr>
<td>Amputation</td>
</tr>
<tr>
<td>Avulsion</td>
</tr>
<tr>
<td>Bite</td>
</tr>
<tr>
<td>Blast injury</td>
</tr>
<tr>
<td>Blister</td>
</tr>
<tr>
<td>Burn (%)</td>
</tr>
<tr>
<td>Concussion</td>
</tr>
<tr>
<td>Contusion</td>
</tr>
<tr>
<td>Corrosion (%)</td>
</tr>
<tr>
<td>Crush injury</td>
</tr>
<tr>
<td>Dislocation</td>
</tr>
<tr>
<td>External constriction</td>
</tr>
<tr>
<td>Fracture</td>
</tr>
<tr>
<td>Frostbite</td>
</tr>
<tr>
<td>Insect bite</td>
</tr>
<tr>
<td>Laceration</td>
</tr>
<tr>
<td>Penetrating wound</td>
</tr>
<tr>
<td>Puncture wound</td>
</tr>
<tr>
<td>Sprain</td>
</tr>
<tr>
<td>Strain</td>
</tr>
<tr>
<td>Superficial foreign body</td>
</tr>
</tbody>
</table>

**All other terminology will likely result in a query**
Head Injury Documentation

In addition to usual documentation, the following must be documented by the physician:

- **Loss of consciousness**
  - Duration in minutes
  - Level of consciousness upon arousal (did the patient return to baseline?)

- **Coma scale** – can be captured at various times throughout the encounter
  - In the field EMT or ambulance
  - At arrival to the emergency department
  - At the time of hospital admission
  - 24 hours or more after admission
  - Unspecified time

- **Is there associated:**
  - Skull fracture
  - Traumatic cerebral edema
  - Hemorrhage
    - Epidural, subdural or subarachnoid
  - Documentation of “midline shift” does not have an ICD-10-CM code
  - Terms such as “compression of the brain” or “brain herniation” will provide additional severity of illness for the encounter
## Fractures

<table>
<thead>
<tr>
<th>ICD-10-CM Traumatic Fracture Documentation Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific anatomical location</strong></td>
</tr>
<tr>
<td>Open¹ or Closed</td>
</tr>
<tr>
<td><strong>Displaced or Nondisplaced</strong></td>
</tr>
<tr>
<td>Extension (Episode of Care)</td>
</tr>
<tr>
<td>(Initial, Subsequent, Sequelae)</td>
</tr>
<tr>
<td><strong>Type/Severity</strong></td>
</tr>
<tr>
<td>Compound, Delayed Union, Depressed, Elevated,</td>
</tr>
<tr>
<td>Greenstick, Impacted, Late Effects, Linear,</td>
</tr>
<tr>
<td>Malunion, Missile, Nonunion, Oblique, Puncture,</td>
</tr>
<tr>
<td>Segmental, Sequelae, Simple, Transverse, etc.)</td>
</tr>
<tr>
<td><strong>Laterality</strong></td>
</tr>
<tr>
<td>Right/Left/bilateral/unspecified</td>
</tr>
<tr>
<td><strong>Routine versus Delayed Healing</strong></td>
</tr>
<tr>
<td>Nonunion/Malunion</td>
</tr>
<tr>
<td><strong>List other related injuries</strong></td>
</tr>
<tr>
<td>(tendons, nerves, arteries, veins, etc.)</td>
</tr>
<tr>
<td><strong>Specify any associated or underlying disease</strong></td>
</tr>
<tr>
<td>(e.g. osteoporosis)</td>
</tr>
<tr>
<td><strong>Information regarding the activity, location,</strong></td>
</tr>
<tr>
<td>(e.g. skiing accident on Boyne Mountain)</td>
</tr>
</tbody>
</table>

¹) Gustilo Classification System
Traumatic Fractures
ICD-10-CM Documentation Requirements

- Specific anatomical site
- Specify Laterality
- Specify type of fracture
  - Displaced
  - Non-displaced

*Note: if not specified, the type of fracture defaults to displaced*

- 7th characters are required to capture the following:
  - Open or closed. Closed is the default
  - Open also requires documentation of Gustilo Type I, II, IIIA, IIIB, IIIC
  - Episode of care
    - Initial, Subsequent or Sequelae
      - Subsequent encounters require documentation of:
        - routine healing
        - delayed healing
        - nonunion
        - malunion
## Gustilo Open Fractures Classification

Required ICD-10-CM Documentation for Open Fractures

<table>
<thead>
<tr>
<th>Grade</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Open fracture, clean wound, wound &lt;1 cm in length</td>
</tr>
<tr>
<td>II</td>
<td>Open fracture, wound &gt; 1 cm in length without extensive soft-tissue damage, flaps, avulsions</td>
</tr>
<tr>
<td>III</td>
<td>Open fracture with extensive soft-tissue laceration, damage, or loss or an open segmental fracture. This type also includes open fractures caused by farm injuries, fractures requiring vascular repair, or fractures that have been open for 8 hours prior to treatment</td>
</tr>
<tr>
<td>IIIA</td>
<td>Type III fracture with adequate periosteal coverage of the fracture bone despite the extensive soft-tissue laceration or damage</td>
</tr>
<tr>
<td>IIIB</td>
<td>Type III fracture with extensive soft-tissue loss and periosteal stripping and bone damage. Usually associated with massive contamination. Will often need further soft-tissue coverage procedure (i.e. free or rotational flap)</td>
</tr>
<tr>
<td>IIIC</td>
<td>Type III fracture associated with an arterial injury requiring repair, irrespective of degree of soft-tissue injury.</td>
</tr>
</tbody>
</table>
## Pathological Fractures Comparison

<table>
<thead>
<tr>
<th></th>
<th>ICD-9-CM vs. ICD-10-CM Documentation Requirements for Pathological Fractures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ICD-9-CM</strong></td>
<td>Number of Codes: 8</td>
</tr>
<tr>
<td><strong>General Site Documentation:</strong></td>
<td>Humerus, distal radius &amp; ulna, vertebrae, neck of femur, other specified site of femur, tibia, other specific, and unspecified</td>
</tr>
<tr>
<td><strong>ICD-10-CM</strong></td>
<td>Number of Codes: Hundreds of Options</td>
</tr>
<tr>
<td><strong>Documentation Required:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>Etiology:</strong> osteoporosis, neoplastic, other specified disease, unspecified etiology or NOS</td>
</tr>
<tr>
<td></td>
<td>• <strong>Age of fracture:</strong> new vs old</td>
</tr>
<tr>
<td></td>
<td>• <strong>Specific Site:</strong> All the options for ICD-9-CM plus hand &amp; finger, shoulder, femur &amp; pelvis, ankle, foot &amp; toe</td>
</tr>
<tr>
<td></td>
<td>• <strong>Laterality:</strong> Right, Left, Unspecified</td>
</tr>
<tr>
<td></td>
<td>• <strong>Encounter type:</strong> Initial, subsequent, with or without mention of delayed healing, nonunion or malunion</td>
</tr>
</tbody>
</table>
Fractures

Greenstick fracture of shaft radius, right arm, subsequent encounter for routine healing (cast change)
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 – previously called Addiction
    • If yes, patient’s SOI is higher = Comorbid condition (CC)
• Current status:
  • In remission
  • With intoxication
  • With withdrawal
• Document any behavior disorders associated with the substance problem
  • 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

Mental & behavioral disorders d/t psychoactive substance use

Type of Use

Behavioral disorder

Abuse

Dependence

Use

Intoxication unspecified

Intoxication with delirium

Intoxication with perceptual disturbance
Summary of Best Practice Documentation 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
- Link suspected cause/organism to the pneumonia or other disease process
- Specify acuity and type of Congestive Heart Failure
- Trimester counted from 1st day of last menstrual period
- Include trimester of pregnancy for complications and reproductive encounters
- Identify complications for each fetus by number
- Link associated conditions or make it clear if a second disease is not related to the pregnancy
- When documenting an injury, define the episode of care as initial, subsequent, or sequelae
- Open fractures need documentation using the Gustillo Classification System
- Pathological fracture must be further classified by etiology (e.g. neoplastic disease, osteoporosis, drug-induced)