Bird's Eye View of ICD-10 Documentation Gaps: Vendor analysis offers big picture look at nationwide documentation holes—and how to fill them

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Increased clinical specificity is one of the greatest advantages of moving to ICD-10-CM/PCS. With specificity comes the ability to perform granular research that can help uncover significant trends and statistics to identify causes of diseases, links between diseases, and more. While health information management (HIM) professionals are keenly aware of this benefit, many others in healthcare still need to be convinced. The most noteworthy of these is the physician community.

Perhaps it was physicians who spurred the ICD-10 delay. Maybe it was other forces. Regardless of the reason, healthcare providers now have another year to dive deeper into clinical documentation and prepare for ICD-10.

Time spent now improving clinical documentation will improve coding in ICD-9, reduce the number of claims denials for both code sets, and—when done effectively—will prevent the avalanche of physician queries anticipated when ICD-10 is implemented in October 2015.

Clinical documentation improvement (CDI) has long been a top area for HIM focus, attention, and care. Now with the delay, additional documentation improvement initiatives can take form. This article shares the lessons learned across thousands of documentation reviews to help HIM professionals pinpoint CDI targets and refine physician training plans.

Intelligence Gleaned So Far

Health information management vendor HRS has worked with hospitals nationwide to prepare for the documentation challenges inherent in ICD-10-CM/PCS. In particular, the company has helped clients identify claims for external testing, developed internal testing materials for coding staff, and performed documentation analyses to help drive physician education. Thousands of real world cases have been coded in ICD-10, and documentation analyzed.

Through HRS' reviews, distinct themes and challenges have emerged. The following is a summary of findings from HRS' work and can be used by organizations, including physician practices, to help fine-tune documentation improvement and physician education initiatives for ICD-10. The first step is to understand the most common reasons for a lack of documentation specificity.

Seven Reasons for Lack of Specificity

There are many reasons why an organization might struggle to obtain documentation specificity in ICD-10. These reasons are listed below in the order in which they tend to be most prevalent:

- Disease type is not documented
- Disease acuity is not documented
- Documentation not found at all
- Site specificity is not documented
- Disease stage is not documented
- Laterality is not documented
- One or more details for a combination code are not documented

Some organizations may struggle with all of these challenges while others may need to address only one or two. Note that each of these reasons can affect multiple ICD-10-CM/PCS codes and be problematic across specialties. Coding experts feel it is critical to perform a comprehensive documentation gap analysis to identify the specific challenges at one's specific organization and then provide education that is tailored to those challenges.

Time to Go Deeper

When using this approach, HRS has been able to identify several documentation gaps with which organizations seem to struggle across the board. Based on HRS' experience, an initial documentation gap analysis is likely to have already been conducted by most facilities. The delay gives HIM a chance to dig deeper not only into the inpatient cases, but also ambulatory, outpatient, and physician practices. For all patient types, a comprehensive cross-section of cases for documentation review is indicated to identify areas for greatest risk. This should include careful consideration of the following:

- High-risk and high-volume procedures and DRGs
- Claim rejections and payer denials
- Recovery Audit Contractor (RAC) and other review results
- Prior coding audit results
- Program for Evaluation Payment Patterns Electronic Reports, also known as PEPPER reports
- Cases with long lengths of stay

Areas for Documentation Concern

The following were identified as areas for documentation concern following a documentation analysis conducted by HRS across thousands of medical record reviews in late 2013 and early 2014.

- Rehabilitation
- Atrial Fibrillation
- Nicotine Dependence
- External Causes
- Respiratory Failure
- Glaucoma
- Transfusions
- Contrast

Top Six Diagnosis Documentation Challenges

The top six areas where diagnosis documentation may be hardest hit, according to documentation analysis conducted by HRS across thousands of medical record reviews in late 2013 and early 2014, include:

- Rehabilitation
- Atrial fibrillation
- Nicotine dependence
- External causes
- Respiratory failure
- Glaucoma

Rehabilitation

When a patient is admitted for rehabilitation, coders currently assign an appropriate ICD-9 code from category V57 as the principal diagnosis. They report an additional code to denote the condition for which the rehabilitation is performed.

In ICD-10-CM, coders will do just the opposite. The principal diagnosis is the condition for which the rehabilitation is performed. For example, a patient presents with right-sided dominant hemiplegia following a cerebrovascular infarction. Coders must report I69.351 (hemiplegia and hemiparesis following cerebral infarction affecting right dominant side) as the principal diagnosis.

If the condition is no longer present, coders must report an aftercare code as the principal diagnosis. For example, they would report Z47.1 (aftercare following joint replacement surgery) when a patient receives rehabilitation for a hip replacement due to severe degenerative osteoarthritis of the hip. This change in sequencing will affect DRG assignment. More specifically, these DRGs will shift from 945 and 946 (rehabilitation with CC/MCC and without CC/MCC respectively) to 56 and 57 (degenerative nervous system disorders with MCC and without MCC respectively) or 559, 560, and 561 (aftercare, musculoskeletal system and connective tissue with MCC, with CC, and without MCC/CC respectively).

Rehabilitation facilities must ensure that the transferring facilities provide specific documentation so the correct principal diagnosis code can be assigned. Case management education is critical, as these individuals can help remind physicians that they must document the specific reason for the admission to the rehabilitation facility.

Atrial Fibrillation

In ICD-9-CM, coders report one code (427.31) for atrial fibrillation. In ICD-10-CM, they must specify the condition as follows:

- Paroxysmal atrial fibrillation (I48.0)
- Persistent atrial fibrillation (I48.1)
- Chronic atrial fibrillation (I48.2)
- Permanent atrial fibrillation (I48.2)

HIM professionals should work with physicians now to obtain this added specificity in diagnosis type that is often lacking and that can greatly affect code assignment in ICD-10-CM.

Nicotine Dependence

In ICD-9-CM, coders can specify nicotine dependence by reporting code 305.1. In ICD-10-CM, they must choose from among 20 codes that denote this condition. These codes, included in category F17, specify whether the nicotine is from cigarettes, chewing tobacco, or some other tobacco product. They also specify whether the dependence is uncomplicated, in remission, or with withdrawal.

It will be important for physicians to link the nicotine dependence to any nicotine-induced disorders resulting from that dependence. These include, but aren't limited to, end-stage chronic obstructive pulmonary disorder, oral cancer, emphysema, or lung cancer. ICD-10-CM includes codes that specify the presence of such a disorder that is directly linked to the patient's nicotine dependence. For example, code F17.228 denotes nicotine dependence, chewing tobacco, with other nicotine-induced disorders.

These codes are important for research related to the effects of nicotine use and abuse, which continues to be an ongoing problem despite smoking cessation programs and greater awareness of the dangers of tobacco use.

Benefits of Sustained CDI Improvement for ICD-10

CDI PROGRAMS OFFER the following benefits for ICD-10 implementation, as better documentation:

- Leads to improved coding in ICD-9
- Exposes physicians to documentation gaps
- Provides time to revise EHR templates by specialty
- Reduces physician queries once ICD-10 is implemented
- Promotes rapport between doctors and CDI specialists

Where is documentation lacking?

- Disease type
- Disease acuity
- Missing documentation
- Site specificity
- Disease stage
- Laterality
- Missing combination code detail

External Causes

External cause codes are assigned as additional codes to indicate how an injury or health condition occurred, the intent (i.e., unintentional, accidental, intentional), the place where the event occurred, the activity in which the patient was engaged at the time of the event, and the patient's status (i.e., civilian, military, or volunteer). ICD-9-CM includes external cause codes in section E000-E999. In ICD-10-CM, these codes are greatly expanded and included in Chapter 20, category V01-Y99.

External cause codes are not mandatory for all. Many states and reporting agencies, however, do require some of them. The ICD-10-CM Official Guidelines for Coding and Reporting state:

> In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

Reporting external cause codes in ICD-10-CM requires specific documentation that providers can obtain during a thorough patient assessment. HIM professionals must strongly encourage documentation of the following details that may be relevant on a regular basis:

- **Room or area of a residence in which an injury or event occurs.** For example, ICD-10-CM code category Y92.01- (single-family non-institutional [private] house as the place of occurrence) further specifies the kitchen, dining room, bathroom, bedroom, private driveway, private garage, swimming pool, and garden or yard. Codes for other locations provide a similar level of granular detail.
- **Activity involving hand-held interactive electronic device.** This code, Y93.C2, will be important in terms of denoting car accidents that occur when drivers are distracted by a cell phone. These types of accidents unfortunately occur often, and perhaps the codes will allow organizations to better capture this data and eventually use it to reduce accidents.
- **Perpetrator of assault, maltreatment, or neglect.** ICD-10-CM category Y07- includes a long list of codes that denote the specific perpetrator (i.e., husband, female partner, foster mother, male cousin, or teacher). These codes should be reported for cases of confirmed abuse.

HIM professionals must review Chapter 20 of the guidelines book in its entirety to determine what codes can be frequently captured and what new documentation may be required.

Respiratory Failure

In ICD-9-CM, coders must specify whether respiratory failure is acute, chronic, or acute-on-chronic. Unspecified respiratory failure defaults to acute. In ICD-10-CM, coders must continue to make this distinction. However unspecified respiratory failure has its own code (J96.9-) and thus doesn't default to acute. This is significant, as some payers may not reimburse for this condition when it's unspecified.

Another notable change for ICD-10-CM is that coders must also capture the manifestation of the respiratory failure (i.e., with hypoxia or hypercapnia). Documentation must include these manifestations. For example, code J96.11 denotes chronic respiratory failure with hypoxia. Note that ICD-10-CM includes many other combination code diagnoses that include two diagnoses, a diagnosis with an associated secondary process (manifestation), or a diagnosis with an associated complication.

Glaucoma

In ICD-9-CM, code category 365.xx denotes glaucoma. Documentation must specify the type of glaucoma as well as the stage of the disease. Bilateral glaucoma is reported as:

- Same type and stage in both eyes—report only one code for the type of glaucoma and one code for the stage
- Same type but different stages in each eye—report only one code for the type of glaucoma and one code for the highest glaucoma stage
- Different types and different stages in each eye—report one code for each type of glaucoma and one code for the highest glaucoma stage

In ICD-10-CM, codes for glaucoma also specify the affected eye and are included in two different code categories:

- H40—Glaucoma specific to type, laterality, and stage. Note that a seventh character denotes the specific stage as either unspecified, mild, moderate, severe, or indeterminate (i.e., cannot be clinically determined).
- H42—Glaucoma in disease classified elsewhere. This code category does not include any additional qualifiers and is reported secondary to the underlying condition, such as amyloidosis, Aniridia, Lowe's syndrome, Reiger's anomaly, or another specified metabolic disorder.

Note that because ICD-10-CM includes qualifiers that denote laterality, coders may need to report separate codes if the patient's glaucoma differs in terms of stage or type in each eye. For example, a patient presents with mild low-tension glaucoma in the right eye and moderate pigmentary glaucoma of the left eye. Coders would report both H40.1211 and H40.1322.

Top Six Hard Hitters for Diagnosis Documentation

	Rehabilitation	Atrial Fibrillation	Nicotine Dependence	External Causes	Respiratory Failure	Glaucoma
ICD-9	Code principal diagnosis and additional code to denote the condition.	One code (427.31) for atrial brillation.	Specify nicotine dependence (305.1).	Include external cause codes in section E000-E999.	Specify whether respiratory failure is acute, chronic, or acute on chronic. Unspeci□ed respiratory failure defaults to acute.	Documentation must specify the type of glaucoma as well as the stage.
ICD-10	Principal diagnosis is the condition for which the rehabilitation is performed.	Must specify the condition: • Paroxysmal atrial □brillation (I48.0) • Persistent atrial □brillation (I48.1) • Chronic atrial □brillation (I48.2)	Choose from among 20 codes in category F17 and specify whether dependence is uncomplicated, in remission, or with withdrawal.	Choose from greatly expanded codes (Chapter 20, category V01-Y99). Not mandatory, however many states and reporting agencies require some of them.	Same as ICD-9, but unspeci□ed respiratory failure has its own code (J96.9-) and doesn't default to acute. Also capture the manifestation of the respiratory failure (i.e., with hypoxia or hypercapnia). Documentation must include these manifestations.	Must also capture the laterality of the a□ected eye(s).
Tips	Ensure that the transferring facilities provide speci□c documentation.	Work with physicians to obtain added speci□city in diagnosis type.	Link nicotine dependence to any nicotine-induced disorders resulting from that dependence.	Review Chapter 20 and encourage detailed documentation.	ICD-10 includes many other combination code diagnoses that include two diagnoses.	Report separate codes if the patient's glaucoma di□ers in terms of stage

						or type in each eye.

Two ICD-10-PCS Documentation Gaps to Know

ICD-10-PCS will be particularly challenging because if coders cannot identify even one character in the code, they will not be able to assign any code. Coders won't have the option to default to an unspecified code. For example, many eponym codes with a singular option are now stratified, leaving coders with the often daunting task of sifting through documentation to look for necessary details. This again shows documentation is crucial.

Consider the following two ICD-10-PCS areas where documentation may be problematic:

- **Transfusions.** ICD-10-PCS specifies the exact vessel used (i.e., peripheral, central artery, or vein) as well as the product transfused (i.e., red blood cells [specify whether frozen and autologous or nonautologous], whole blood, white cells, or stem cells).
- **Contrast.** For certain ICD-10-PCS imaging procedures, the specific contrast media (i.e., high osmolar, low osmolar, or other contrast) must be documented so coders can assign a code.

Documentation Still Foundation for Coding Success

HIM professionals must push for quality documentation that supports coding and that helps accomplish the underlying goal of ICD-10-CM/PCS—to improve patient care. Coders must be able to report the most specific code possible. This is true in both ICD-9-CM and ICD-10-CM/PCS. However, doing so is more challenging in ICD-10-CM/PCS simply because there are more options from which to choose.

If your cup was half empty with regard to clinical documentation, you're probably thankful for the additional year to prepare for ICD-10. If your cup was half full, then you've already begun the journey to more granular documentation for ICD-10, revised workflows, and implemented changes to maximize the new coding system within your organization.

Continue the journey. Use the intelligence gleaned from 2013 and 2014 documentation reviews to target your CDI program and move ahead with deeper, richer, and more expanded physician training initiatives. Parlay the lessons learned into even greater improvements for all providers. Make the most of your work, continue organizational momentum, and move ahead.

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