CDI Tips Developed to Maximize ICD-10-CM/PCS

By Gloryanne Bryant, RHIA, CDIP, CCS, CCDS; William E. Haik, MD, FCCP, CDIP; and Heidi Hillstrom, MS/HSA, MBA, RN, PHN, CCDS, CCS

Clinical documentation improvement (CDI) efforts have become a mainstay within hospitals, outpatient care facilities, physician practices, and post-acute care settings. CDI programs have a far-reaching impact on today's data-centric healthcare system. When the appropriate level of detail is available in the documentation, the documentation is then able to support codes —whether ICD-9-CM, soon-to-be-adopted ICD-10-CM/PCS, or CPT—that paint the fullest picture possible of the patient as well as the care and services provided.

The medical record is the source document and vehicle for which the documentation is captured and housed. Understanding the medical record documentation components, meanings, and uses are critical to any healthcare organization today, and its translation to the coded data takes great expertise. Specific and complete documentation enables coded data to tell the true story of patient care.

With the implementation of ICD-10-CM/PCS, CDI has new opportunities to bring together the specificity and details of the patient encounter.

ICD-10 Calls for Increased CDI Efforts, Expertise

The implementation of ICD-10-CM/PCS, a code set that involves significantly greater detail than ICD-9-CM, will lead to an increased need for the expertise of CDI specialists. Allotting a strong role for CDI in healthcare organizations will ensure an accurate and complete medical record for data capture and reporting.

Clinical documentation improvement specialists must be able to identify documentation deficiencies in order to assist physicians and medical providers in achieving documentation that accurately reflects severity of illness, risk of mortality, quality, core measures, and the physician quality reporting system.

One example of the expanded detail in ICD-10-CM involves the diagnosis of respiratory failure. Providers will need to specify whether the respiratory failure is acute or chronic and document whether the condition is either hypoxemic or hypercapnic.

Another example includes data reporting for drug underdosing. Documentation should specify if the drug underdosing was intentional or done for other reasons, such as an inability to afford the medication or a potential lack of cognitive ability to take the medication as prescribed.

As the healthcare industry ventures toward the implementation of ICD-10-CM, CDI professionals must be ready to identify the level of documentation specificity that ICD-10-CM entails. This documentation specificity will have an invaluable impact on almost all entities in healthcare.

Workgroup Develops Library of CDI ICD-10 Tips

The AHIMA CDI Workgroup—whose members include clinicians, CDI professionals, and HIM coding professionals—has created a large library of ICD-10-CM/PCS documentation tips in response to the greater specificity needs of the new code set. These tips, now available as the "ICD-10-CM/PCS Documentation Tips" in AHIMA's HIM Body of Knowledge at http://bok.ahima.org/PdfView?oid=300621, focus on the language and/or wording that will garnish greater detail and specificity of the coded data for a given diagnosis, condition, disease, and/or surgical procedure. Going through each chapter of ICD-10-CM was the initial focus of the workgroup's efforts, with expansion into the procedure coding system (PCS).

Utilizing a process of walking through the ICD-10-CM chapters, the workgroup divided up a series of documentation tips that identify key and detailed language as well as terminology in order to capture a specific ICD-10 diagnosis code or codes. In addition, the workgroup developed documentation tips specific to ICD-10-PCS.

A Clinician's Perspective

From a clinician's perspective, most of the current documentation requirements for ICD-9-CM will increase significantly following ICD-10-CM/PCS implementation. The documentation of types of heart failure (systolic and/or diastolic), pneumonia (etiologies/mechanism), or orthopedic fracture causes (pathological/traumatic), and other conditions will persist. With ICD-10-CM, however, the expanded detail encompassed by the code set will require additional documentation and specification in such areas as asthma, respiratory failure, and the causes and the types of fractures.

There are a multitude of changes occurring simultaneously within the current healthcare environment that demand physicians' attention. This library of documentation tips offers a concise tool for physicians to prepare themselves for the additional changes that await them in the transition to ICD-10-PCS. The CDI ICD-10 tips offer a straightforward overview of more specific and complete reporting requirements of the ICD-10-CM/PCS code sets.

The "Clinical Documentation Improvement ICD-10-CM/PCS Documentation Tips" paper is available in AHIMA's HIM Body of Knowledge here.

References

Centers for Medicare and Medicaid Services. "2014 ICD-10-PCS Code Tables and Index." www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-PCS.html.

National Center for Health Statistics. "ICD-10-CM Index and Tabular." 2014. www.cdc.gov/nchs/icd/icd10cm.htm.

Centers for Medicare and Medicaid Services. "ICD-10." October 29, 2014. www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10.

Gloryanne Bryant (gloryanne.h.bryant@kp.org) is the national director, coding quality, education, systems and support, national revenue cycle for Kaiser Foundation Health Plan and Hospitals. William E. Haik (william.haik@drgreview.com) is director at DRG Review. Heidi Hillstrom (heidi.hillstrom@slhduluth.com) is a CDI specialist at St. Luke's Hospital based in Duluth, MN.

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