Clinical Documentation Improvement Eases the Transition to ICD-10

By Lou Ann Wiedemann, MS, RHIA, CHDA, CDIP, CPEHR, FAHIMA

Reactions within the healthcare community to the ICD-10-CM/PCS implementation delay are varied. Many clinical documentation improvement (CDI) specialists are already well into ICD-10-CM/PCS code set education and may see the delay as a frustrating set back, while others view it as an opportunity for more training and education. While the delay will clearly impact every organization, using sound CDI processes can ease the transition to the new code set.

Without clear clinical documentation in the health record, accurate code assignment cannot be achieved. The amplified granularity of ICD-10-CM/PCS makes this statement all the more important. CDI specialists must conduct a thorough review of the entire health record, in a short amount of time, to determine the specific reason for patient care or admission. The volume and complexity of codes within the new code set will likely increase the need for additional documentation.

Defining the ICD-10-CM/PCS Leap

CDI specialists have a unique opportunity within the code set transition that other care professionals may not realize. The goal of a CDI program is to promote clear and accurate documentation, and that goal remains the same whether the code set is ICD-9-CM or ICD-10-CM/PCS. Essentially, the CDI program creates a win regardless of the code set.

ICD-10-CM is the set of diagnostic codes that will be utilized in all healthcare settings beginning October 1, 2015, increasing the number of applicable codes from more than 14,000 in ICD-9 to more than 69,000. ICD-10-PCS is the set of procedure codes that will be utilized for hospital inpatient claims beginning in October 2015, increasing the number of applicable codes from 3,800 to more than 71,000. Many of the code assignments for procedures are defined within the system. The physician is not expected to use the exact terms in the PCS code description when documenting, nor is the CDI specialist required to query the physician when the correlation between the documentation and the defined PCS terms is not clear. Providers need to be reassured that the way in which documentation occurs is not expected to change. The change is related to the need to add detail.

Documentation Detail is Important

CDI programs can begin by reviewing current documentation for the following specificities. If this specific documentation is not found, querying for this information today can begin to ensure compliance by the 2015 implementation date:

- Side of dominance
    - Left, right, or ambidextrous
- Laterality
    - All paired organs or structures
- Ordinality
    - Is this an initial or subsequent visit?
    - Is the diagnosis a sequela of the initial event?
- Asthma severity classification scale

    - Intermittent
    - Mild persistent
    - Moderate persistent
    - Severe persistent
- Glasgow Coma Scale
    - Needs a score from each of the three assessment areas (not a total score)
        - Eye opening
        - Verbal response
        - Motor response
- Gustilo open fracture classification
    - I, II, IIIA, IIIB, IIIC
- Seizures
    - General seizures will require type specificity
- Trimester of pregnancy
    - Default to the trimester when the complication occurred, not the discharge trimester when an admission crosses trimesters
- Substance identification
    - Related to adverse effects, poisoning or toxic effect
- Acute myocardial infarction (MI)
    - Document MI age using weeks, not days or months
    - Document the anatomic location
    - Document any consequences of the MI
- Altered mental status
    - Identify baseline mental status
    - Identify age of onset
    - Coding of degenerative disease, such as Alzheimer's, requires knowledge of the age of onset
- Anemia
    - Specify the cause
    - Specify the malignant disease
    - Specify any adverse effect of treatment
- Hypertension and heart disease
    - Document the relationship between hypertension and heart disease
- Underdosing
    - Document the relationship between a disease process and the patient's inability or failure to take prescribed medications
- Adverse effects and poisoning

    - Identify the intent:
        - Accidental, intentional self-harm, assault, or undetermined
        - Unknown or unspecified codes to accidental intent
- Chronic kidney disease
    - Identify the severity:
        - Stage 1, Stage 2, Stage 3, Stage 4, Stage 5
        - End stage renal disease should be documented as such (not as a stage)
- Respiratory failure
    - Identify acute, chronic, or unspecified
    - Identify whether the failure is hypoxic or hypercapnic

Physician engagement and input have been critical success factors for CDI programs, and successful ICD-10-CM/PCS implementation will be no different. Presenting the new code set as a clinical initiative with active physician involvement can change the way the program and ICD-10-CM/PCS is viewed, easing the transition for everyone involved.

References

AHIMA. "Using CDI Program to Improve Acute Care Clinical Documentation in Preparation for ICD-10-CM/PCS." *Journal of AHIMA* 84, no. 6 (June 2013): 56-61.

AHIMA. "ICD-10-CM/PCS 101 for CDI."

Adamopoulos, Helen. "Engaging Physicians to Prepare for ICD-10: Best Practices From Baptist Health." *Beckers Hospital Review*. November 25, 2013.

Gloryanne, Bryant and Debi Primeau. "CDI and ICD-10 Readiness." *CHIA Journal*. August 2012. http://californiahia.org/sites/californiahia.org/files/docs/CDQarticles/2012-08-cdi-and-ICD10.pdf.

Malvin, Rachel. "A Strong CDI Program Will Ease Transition to ICD-10." *Effect Magazine*. Spring 2011.

Lou Ann Wiedemann (lou-ann.wiedemann@ahima.org) is a senior director of HIM practice excellence at AHIMA.

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