Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Impact of ICD-10</td>
</tr>
<tr>
<td>Requirements for Clinical Documentation</td>
</tr>
<tr>
<td>Appendix of General Materials</td>
</tr>
</tbody>
</table>
Section 1: Clinical Impact of ICD-10

Clinical Impact of ICD-10

Requirements for Clinical Documentation

Appendix: General material
With ICD-10, Appropriate Documentation can:

- Enhance communication among providers, and between physician and patient by filling in the gaps in treatment and care
- Provide an accurate representation of the severity and complexity of a patient’s illness
- Improve the quality of patient care, and the patient care experience
- Connect the pieces of the medical record together for problems, assessments, procedures, and treatments
- Support and supplement provider documentation
- Help substantiate the level of specificity required within ICD-10
- Ensure payment for the services provided
Overview

While the actual number of diagnoses has increased from ICD-9 to ICD-10, the structure and function of coding has improved to better represent the diagnosis, acuity of patients condition, and the history of the patient.

Standard ICD-10 Documentation Requirements

- Document causal agents as clearly as possible
- Document the condition as acute or chronic
- Document location with as much specificity as possible
- Document the clinical findings/indicators to support the diagnosis documented
- Document related, secondary or causal illness whenever appropriate

*Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an uncommon diagnosis*
Assessment

• **Question:** What resource is available to help ensure proper ICD-10 documentation with complicated, hard to code cases?
Assessment

• **Answer:** Guidance on tips and recommendations for proper documentation from a Clinical Documentation Improvement Specialist is available.
ICD-10 Clinical Documentation Impacts

- Timing of care
- Anatomical site specificity
- Laterality
- Disease acuity
- Combination codes with Symptoms and/or Manifestations
- Complications
- Status codes, personal and family history codes
- General – BMI, tobacco use/smoking exposure, health status
To determine how to calculate the new ICD-10 code documentation requirements, think of the acronym “CALCS” (See below). While not all 5 types of documentation will be needed in each case, remembering this acronym will help you to think through the new specifications required and document the case appropriately.

- **C** - Document *causal* agents as clearly as possible
- **A** - Document the condition as *acute* or chronic
- **L** - Document *location* with as much specificity as possible
- **C** - Document the *clinical findings*/indicators to support the diagnosis documented
- **S** - Document related, *secondary* or causal illness whenever appropriate
Comparison of ICD-9-CM and ICD-10-CM by Anatomical Site Location

**ICD-9 CM site location**
Identify site as:
- Lip
- Eyelid
- Ear/external auditory canal
- Other/unspecified parts of face
- Scalp/neck
- Trunk, except scrotum
- Upper limb, including shoulder
- Lower limb, including hip
- Other specified/overlapping sites
- Unspecified site

**ICD-10-CM site location**
- Identify stage or depth of lesion
- Melanoma in situ (Stage 0, classification TIS or epidermal layer only)
- Malignant melanoma (Stages I-IV or invasion of dermal layer)
- Identify site as
  - Lip
  - Eyelid: Right/Left/Unspecified
  - Ear/external auricular canal: Right/Left/Unspecified
  - Nose
  - Other specified parts of face
  - Unspecified parts of face
  - Scalp/neck
  - Other parts of trunk
  - Upper limb, including shoulder: Right/Left/Unspecified
  - Lower limb, including hip: Right/Left/Unspecified
  - Overlapping sites
  - Unspecified site
- Malignant neoplasms - overlapping site boundaries
- Quadrants for multiple, not contiguous tumors
International Classification of Diseases for Oncology, 3rd Edition (ICD-O-3) and ICD-10-CM

• In general ICD-0-3 follows the structure of ICD-10-CM more closely than ICD-9-CM but there are important differences.

• The topography code categories which describe the behavior of the neoplasm (e.g., malignant, benign, in situ, secondary or metastatic) are similar for malignant tumors. Notable differences exist for hematopoietic, lymphoid and reticuloendothelial tumors.

• ICD-0-3 has much more detail on the histological categories than ICD-10

• Both can be mapped to SNOMED-CT terminology with some success but identified limitations
Section 2: Requirements for Clinical Documentation

Clinical Impact of ICD-10

Requirements for Clinical Documentation

Appendix: General material
Cancer Staging - National Cancer Institute

• The common elements considered in most staging systems are as follows:
  – Site of the primary tumor
  – Tumor size and number of tumors
  – Lymph node involvement (spread of cancer into lymph nodes)
  – Cell type and tumor grade* (how closely they cancer cells resemble normal tissue cells)
  – The presence or absence of metastasis
# Cancer Staging - National Cancer Institute
(continued)

<table>
<thead>
<tr>
<th>Primary Tumor (T)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>Primary tumor cannot be evaluated</td>
</tr>
<tr>
<td>T0</td>
<td>No evidence of primary tumor</td>
</tr>
<tr>
<td>Tis</td>
<td>Carcinoma in situ (CIS; abnormal cells are present but have not spread to neighboring tissue; although not cancer, CIS may become cancer and is sometimes called pre-invasive cancer)</td>
</tr>
<tr>
<td>T1, T2, T3, T4</td>
<td>Size and/or extent of the primary tumor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Lymph Nodes (N)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NX</td>
<td>Regional lymph nodes cannot be evaluated</td>
</tr>
<tr>
<td>N0</td>
<td>No regional lymph node involvement</td>
</tr>
<tr>
<td>N1, N2, N3</td>
<td>Involvement of regional lymph nodes (number of lymph nodes and/or extent of spread)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distant Metastasis (M)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MX</td>
<td>Distant metastasis cannot be evaluated</td>
</tr>
<tr>
<td>M0</td>
<td>No distant metastasis</td>
</tr>
<tr>
<td>M1</td>
<td>Distant metastasis is present</td>
</tr>
</tbody>
</table>
Staging

Stage IVA: The cancer has spread to a single distant part of the body, such as the liver or lungs (any T, any N, M1a)

- TNM is an abbreviation for tumor (T), node (N), and metastasis (M).
  - For colorectal cancer, “T” describes how deeply the primary (first) tumor has grown into the bowel lining. (Tumor, T)
  - N describes if the tumor spread to the lymph nodes (Node, N)
  - M describes if the cancer has metastasized to other parts of the body (Metastasis, M)

- T3: The tumor has grown through the muscularis propria and into the subserosa or into tissues surrounding the colon or rectum

- N0: There is no spread to regional lymph nodes

- M1b: The cancer has spread to more than one part of the body other than the colon or rectum [liver]
Documenting Lymphoma

- ICD-10 will require more explicit information as it relates to morphology (e.g. T-cell lineage or involvement exists with a specific lymphoma)
- Code categories for lymphoma include: C81 Hodgkin lymphoma, C82 Follicular lymphoma, C83 Non-follicular lymphoma, C84 Mature T/Nkcell lymphomas, C85 Other specified and unspecified types of non-Hodgkin lymphoma, C86 Other specified types of T/NK cell lymphoma.

**Documentation Specifications and Examples**

- **Cause** - Identify the type of Lymphoma
  - i.e., Hodgkin's, Follicular lymphoma, Mantle cell lymphoma, etc.
- **Acuity** - Specify the acuity of the disease
  - i.e., acute or chronic
- **Location** - Specific affected node or organ
Documenting Leukemia

**Documentation Specifications and Examples**

- **Cause:** Identify the type of Leukemia  
  E.g., Lymphoid, Myeloid, Monocytic
- **Acuity:** Specify the acuity of the disease  
  • i.e., acute or chronic

*Specify remission status  
  e.g., in remission, achieved remission, failed remission or relapse.

**Important Note:** ICD-10-CM differentiates between Leukemia, Multiple Myeloma, and Malignant Plasma Cell Neoplasms in remission rather than “cured,” which would be a personal history

- Code categories for lymphoma include C91 Lymphoid leukemia, C92 Myeloid leukemia, C93 Monocytic leukemia, C94 Other leukemia of specified cell type
Assessment

• **Question:** In addition to cause and acuity, what needs to be documented to accurate code a case of Leukemia?
Assessment

• **Answer:** The patients remission status needs to be documented in addition to the cause and acuity.
Guideline for anemia associated with malignancy

- The "ICD-10-CM Official Guidelines for Coding and Reporting" includes a section on coding guidelines for neoplasms. Most notably, the ICD-10-CM sequencing guideline for anemia associated with malignancy.
- When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis.

**Example:** Female patient comes in today due to severe anemia due to right breast carcinoma of the central portion.

Principle Diagnosis:  
C50.111 Malignant neoplasm of central portion of right female breast  
Secondary Diagnosis:  
D63.0 Anemia in neoplastic disease
Documenting Anemia

**Cause:**
- Identify the type of anemia
  - e.g., nutritional, hemolytic, aplastic, blood loss, etc.
- Describe hemolytic anemias as being hereditary, acquired, enzyme disorders, autoimmune, or non-autoimmune
- Detail the underlying cause or provide a statement indicating “unknown cause”
  - e.g., chronic kidney disease, trauma, ulcer, chemotherapy, etc.
- List the name and purpose of substances causing anemia
  - e.g., medications
- Provide the name of the deficient vitamin(s) and/or mineral(s) for nutritional anemias
  - e.g., low vitamin B12 level to pernicious anemia

**Acuity:** Specify the acuity of the disease
- i.e., acute or chronic

**Clinical Findings:** Link any laboratory findings to a related diagnosis
Like ICD-9-CM, in ICD-10-CM, depression is coded by type. The ICD-9 code for unspecified depression, ICD-9-CM 311 Depressive disorder NOS, includes the clinical terms “depressive state” and “depression.” In ICD-10-CM, there is no unique code for “depression” without any further detail. Unqualified use of the word depression in the medical record is classified to major depression in ICD-10.

If a patient is not formally diagnosed, consider potentially using a signs or symptom code. See as examples

- R45.2 Unhappiness
- R45.3 Demoralization and apathy
- R45.4 Irritability and anger
- R45.7 State of emotional shock and stress, unspecified

Note “and” means “and/or”.

If relevant, list any late effects or current injuries related to past events (e.g., fall from dizziness secondary to lithium level)

List any alcohol or drug use, abuse or dependence
Documenting Anxiety

• There is an unspecified anxiety code in ICD-10-CM, but there are potentially new codes in places other than the mental health chapter that may provide a better picture of the patient’s situation. See examples
  – Z56.1 Change of job
  – Z56.3 Stressful work schedule
  – Z60.0 Problems of adjustment to life-cycle transitions

• Consider potential use of symptom codes when patient has not been formally diagnosed. See examples
  – R45.0 Nervousness
  – R45.1 Restlessness and agitation
  – R45.82 Worries
Assessment

- **Question:** When patients have not been diagnosed with anxiety, what can be an appropriate alternative for documenting the right codes to capture the patient’s condition?
Assessment

• **Answer:** Entering the symptom codes
Documenting Diabetes

- Biggest changes for diabetes documentation → elimination of controlled/uncontrolled
- Documenting the patient presentation allows coder to capture the necessary information to fully code the patient’s condition
- IMPORTANT: Document a LINK between DM and manifestations or complications
- Think of the diabetes codes in building blocks, building from one block to the next for complete documentation:

**Diabetes Mellitus**

- **Cause or Type**
  - Secondary to Underlying Condition
  - Drug or Chemical Induced
  - Type 1
  - Type 2
  - Other

- **Presence of Manifestations or Complications**
  Examples:
  - Kidney
  - Neuro
  - Circulatory

- **Specific Complications**
  Examples:
  - Polyneuropathy
  - Hyperglycemia with coma
  - Cataract

- **Insulin Dependence**
  - NIDDM
  - IDDM

*Note: Document if insulin overdosing or underdosing is related to an insulin pump malfunction*
Diabetes (continued)

- If there are complications/manifestations of the diabetes, additional details may be necessary for the following conditions:

  - Arthropyathy
  - Site of ulcer
  - Severity of retinopathy
  - With/without macular edema
  - Stage of CKD
  - Gangrene
  - Hyperglycemia
ICD-10-CM Example of Revised Classification

- Hypertension is no longer classified by type - benign, malignant, or unspecified

- I10 Essential (primary) hypertension replaces:
  - 401.0 Malignant essential hypertension
  - 401.1 Benign essential hypertension
  - 401.9 Unspecified essential hypertension

- The following are the available categories for hypertensive conditions in ICD-10-CM. In some cases you may need to note if heart failure is present (e.g., I11) and the type of heart failure.
  - I10, Essential (primary) hypertension
  - I11, Hypertensive heart disease
  - I12, Hypertensive chronic kidney disease
  - I13, Hypertensive heart and chronic kidney disease, and
  - I15, Secondary hypertension

- I10 is used when hypertension is not further specified/associated with/caused by another disease process such as chronic kidney disease
Documenting Pain

• **Cause:**
  – Identify the cause (e.g., trauma)
  – Differentiate between panniculitis and radiculopathy

• **Acuity:** State the acuity (i.e., acute or chronic)

• **Location:**
  – Detail the following when patients are admitted for pain management or control
    • Psychological pain
    • The site of the pain
  – For back pain
    • Specify the site (e.g., low back, thoracic, cervical, etc.)
    • State the laterality when applicable (i.e., right, left, or bilateral)

• **Secondary Illnesses:** Detail when lumbago is accompanied by sciatica
Documenting Underdosing

Important Note: Underdosing is a new concept for ICD-10.

Specifications and Examples

- **Cause:**
  - Document the cause of underdosing
  - Reason code explains why the patient is not taking the medication

- **Clinical Findings:** Document the outcome of underdosing

- **Secondary Illness:** The components of underdosing codes include:
  - Medical condition is sequenced first.
  - Under-dosing code is listed as a secondary diagnosis.
  - Reason code explains why the patient is not taking the medication
If a patient presents with a condition that is related to under-dosing, it is important to document the condition and a LINK to the medication:

### Medical Condition
Examples:
- Infection
- Hyperglycemia
- Hypertension
- Seizure
- Mania

### Identification of Underdosing as Cause
Examples:
- Antibiotic
- Antidiabetic
- Hormonal agents
- Anti-epileptic
- Antihypertensive

### Cause of Underdosing
Includes:
- Intentional
- Unintentional
- Financial Hardship
- Age-related dementia
Appendix - General Materials

Clinical Impact of ICD-10

Requirements for Clinical Documentation

Appendix - General Materials
Tobacco Use Documentation Changes

- ICD-10 documentation requires a terminology change for the capture of tobacco use
  - Current tobacco use documentation changes to nicotine use documentation
  - Documentation must also include tobacco use and types of second hand tobacco smoke (e.g., from parent, at work, perinatal) including, but not limited to:
    - History of nicotine dependence
    - Problems related to lifestyle, tobacco use NOS
    - Problems related to physical environment, exposure to environmental tobacco smoke (acute, chronic)
  - Type of nicotine needs to be documented (cigarette, chewing tobacco, other tobacco product)

Note: The physician must determine and document a patient’s:
- Tobacco abuse/dependence
- Whether tobacco use status is in remission/withdrawal/uncomplicated
Body Mass Index Documentation Changes

• The classification for overweight and obesity has been expanded in terms of specificity in ICD-10-CM to include:
  – Obesity due to excess calories
  – Morbid (severe) obesity due to excess calories
  – Other obesity due to excess calories
  – Drug induced obesity
  – Morbid (severe) obesity due to alveolar hypoventilation
  – Overweight
  – Other obesity
  – Obesity unspecified

• An additional code (“Z68-”) is used to identify the body mass index (BMI), if known
• Ensure drug listing is denoted if potential exists for drug induced obesity
• Both ICD-9 and ICD-10 recognize a BMI of 40+ as morbid obesity, or BMI 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes.
Body Mass Index

Many quality measures as well as ICD-10 diagnoses require documentation of weight status

BMI categories include:

- $\leq 19$
- 20-40 (each whole number)
- 40-44
- 45-49
- 50-60
- $\geq 70$

**Important Note:**

**Who can Document BMI?**

- Coding guidelines allow any clinician to capture and record a patient’s BMI
- However, the provider is ultimately responsible for the completeness of diagnosis documentation
- Find where BMI is routinely captured at your facility and partner with other clinicians to ensure this is properly documented

**NOTE:** In pediatric patients, document their weight percentile
Overweight/Obesity

Overweight → should be accompanied by documentation of BMI

Obesity → Is further subdivided into three groups:

From Excess Calorie Intake
- Severe
- Morbid

Drug Induced
- Identify causal agent

With Alveolar
- Hypoventilation
• **Question:** When documenting an obesity, it is important to further describe the case as a result of specific causes and as associated with a specific condition/complication. What are the three major specifications associated with obesity that need to be documented?
Assessment

- **Answer:** ICD-10 requires the documentation of obesity with 1 or more of the following descriptors:
  - From excess calorie intake (cause)
  - Drug-induced (cause)
  - With Aveolar (secondary illness/complication)
Documentation Conclusion

While the actual number of diagnosis codes has increased from ICD-9 to ICD-10, the structure and function of coding has improved to better represent the diagnosis and acuity of patients with respiratory illness.

• Document causal agents as clearly as possible. This includes the type and a LINK to the underlying condition.
• Document the condition as acute or chronic
• Document location with as much specificity as possible
• Document the clinical findings/indicators to support the diagnosis documented
• Document related, secondary or causal illness whenever appropriate. This include a clear LINK to the cause and documenting comorbidities with detail that will show their impact on patient condition even if it is not the primary problem.

*Partner with the Clinical Documentation Improvement Specialist if you have questions, are queried, are documenting an uncommon diagnosis.