Speaking in Code: Documentation to Support the ICD-10 Code Set

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Speaking in Code
Documentation to Support the ICD-10 Code Set

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Arlynn has been a member of the American Physical Therapy Association since 1995, where she is the current Vice President of the Home Health Section.

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Disclosure

• No relevant financial relationship exists

Objectives

Upon completion of this course, you will be able to:
1. Learn ways of communicating to physicians or staff to gain the appropriate information regarding diagnoses.
2. Understand necessary information required by coders for the more "typical" therapy conditions - CVA, fractures, joint replacements.
3. Understand documentation needed to support the 6 ambulatory deficit codes.
Content

This session will enable the learner to efficiently and effectively document disease processes. This is crucial in the ICD-10 coding system as the code set has been expanded considerably since ICD-9, requiring a much higher degree of specificity in documentation in order to allow for correct code assignment.

Back it on up…..

• Prior to the implementation of ICD-10, under the old code set of ICD-9, clinicians could “get away” with documentation such as:
  – “hip fracture”
  – “TKR”
  – “CVA with left hemi”
  – “Stage II pressure ulcer on the buttocks”
  – “Venous stasis ulcer on the calf”
• The code set allowed for vagueness in these categories, as well as numerous others.
Now that we have transitioned to the ICD-10 code set, this vagueness is no longer appropriate, as more detail is needed to locate the correct code to define the condition.

So why DID we go to ICD-10?

**Why ICD-10?**

- The ICD-9 code set used in the United States was implemented in 1979.
- Most industrialized countries moved to ICD-10 in 2008. The transition to ICD-10 was first recommended to the Department of Health and Human Services in 2003.
- The switch was critical as the ICD-9 code set had outdated terminology, lacked specificity, and was running out of room as new diagnoses and procedures were submitted annually.
• The ICD-9 code set that was used to report medical diagnoses and inpatient procedures (not required in HH) was replaced by ICD-10 on October 1, 2015.
• The code set affects all those covered by the Health Insurance Portability Accountability Act (HIPAA), not just Medicare or Medicaid claims.
• The switch to ICD-10 will enable the US to have accurate comparisons of healthcare data with other countries. ² ⁶
• The further specificity of the code set has allowed for greater tracking of mortality and morbidity. ¹ ⁶
First Objective

Learn ways of communicating to physicians or staff to gain the appropriate information regarding diagnoses.

Documentation

- The clinician’s responsibility is to document as accurately as possible the nature of the disease process or condition, as well as what services were performed that affected/were affected by these conditions.
- In order to do this, a thorough review of the referral or H&P is crucial. If the needed information is not present, it is the responsibility of the clinician to identify exactly what is needed, and to have the physician or representative contacted to gain that information. The information would then be documented into the chart, becoming part of the patient’s legal record.
Crucial: Get a good H&P/referral

Quality H&P/referrals

- Even by ICD-9 standards, the prior referral would be difficult to code if the clinician or office did not contact the physician for more specific information.
- Under ICD-10, greater and more time consuming investigation will be required by someone, and agencies need to determine where and when that point of contact will occur:
  - At the point of liaisons in the hospitals, to be certain referrals contain all needed data?
  - At Intake?
  - The “team coordinator”?
  - The clinician performing the SOC?
  - The in-house coder/QA staff?
Gathering Information

- Phone: if a call is placed to the physician, it is recommended to have ready the specific detailed questions: what caused the CVA (SAH, ICH, SDH, etc.)…what are the diagnosed residuals of the CVA…what is the wound on the left leg caused by…has the dysphagia been staged…what bone of the wrist was fractured….

  - A communication note should be entered into the EMR so that all necessary parties have access to the clarified information. This is also required documentation to support the coding in the medical chart.

Gathering Information

- E-mail: if able to use the e-mail system (HIPAA compliant) be specific in the requested information. A fill-in-the-blank or check box form works well.

- Upon receipt of the information, upload the response into the EMR.
Form example

Dr. Smith, we are requesting diagnosis clarification for Mrs. Jones to enable us to treat appropriately and code correctly. Please return the requested information ASAP.

CVA
Caused by: ☐ Cerebral infarct ☐ ICH ☐ SAH ☐ SDH
Residuals:
☐ Monoplegia ☐ Hemiplegia ☐ Aphasia ☐ Dysphasia
☐ Dysarthria ☐ Dysphagia stage _____ ☐ Vision _____
☐ Weakness ☐ Abnormal gait (not associated with mono/hemiplegia)
☐ Other ________________

Fracture
Bone involved: ___________________________
☐ Routine healing
OR
☐ Delayed healing fracture
☐ Nonunion
☐ Malunion

Joint replacement revision
Explantation due to: ____________________
Gathering Information

• Snail mail: if the only option is the US mail system, again, be specific in the requested information. A fill-in-the-blank or check box form works well.
• Upon return of the form, upload it into the EMR.

Information Gathering

• First and foremost, prior to making contact with anyone to discern further information, it is crucial to understand exactly what information is needed.
• Without becoming a coder yourself though, it can be difficult to know what specific information is needed.
• From a clinician standpoint, one of the best ways to think about the needed information is to understand what it is that you need to know in order to address the condition from a clinical perspective.
Second Objective

Understand necessary information required by coders for the more "typical" therapy conditions - CVA, fractures, joint replacements

CVA
CVA

- In ICD-9, we dealt with the language of “Late Effects”
- In ICD-10 we were introduced to a new term of “Sequelae”
  - One of the most prominent places this is used is in the I69 Category, “Sequelae of cerebrovascular disease”

Sequelae defined

“Sequela” 7th Character

- Sequela (Late Effect): Residual effect (condition produced) arising as a direct result of an acute condition
  - Examples:
    • Scar formation after a burn
    • Traumatic arthritis following previous gunshot wound
    • Quadriplegia due to spinal cord injury
    • Skin contractures due to previous burns
    • Auricular chondritis due to previous burns
    • Chronic respiratory failure following drug overdose
CVA Sequela

• In terms of CVA, the sequela (neurologic deficits):
  – Has no time limit
  – Might be present at the onset of the CVA or arise anytime thereafter
  – Must be stated by the physician

• If it is stated there are NO deficits: document that, and TIA is then coded, NOT CVA.

What to ask for, what to document…

• To care for the patient with a CVA, what do you need to know?
  – What caused the CVA? SDH, SAH, intracerebral hemorrhage, cerebral infarct, intracranial hemorrhage, etc.
  – What residuals of the CVA were stated by the physician?
  – Stated mono/hemiplegia:
    • What side was affected
      – Which is their dominant side
    • Is it upper and lower extremity, or just one limb?
    • Be certain to discern if the patient has weakness due to the CVA, or “happens” to have both weakness and a CVA dx.

• What you need to know to treat is what coders need to see in the documentation to code correctly.
The CVA categories

- Remember, accurate and specific coding leads not only to potentially better reimbursement, but globally to better research and care of conditions.
- On the inpatient side (M1011/M1017), the most common categories of CVA we typically see are:
  - I60.- : Nontraumatic SAH
  - I61.- : Nontraumatic ICH
  - I62.- : Nontraumatic SDH, extradural, intracranial hemorrhage
  - I63.- : Cerebral infarct

The CVA categories

- On the active side (M1021/M1023), where we now code sequela, again, there are the matching common 4 categories of CVA:
  - I69.0- : Nontraumatic SAH
  - I69.1- : Nontraumatic ICH
  - I69.2- : Nontraumatic SDH, extradural, intracranial hemorrhage
  - I69.3- : Cerebral infarct
• I69.32 Speech and language deficits following cerebral infarction
• I69.320 Aphasia following cerebral infarction
• I69.321 Dysphasia following cerebral infarction
• I69.322 Dysarthria following cerebral infarction
• I69.323 Fluency disorder following cerebral infarction
• I69.328 Other speech and language deficits following cerebral infarction
• I69.33 Monoplegia of upper limb following cerebral infarction
• I69.331 Monoplegia of upper limb following cerebral infarction affecting right dominant side
• I69.332 Monoplegia of upper limb following cerebral infarction affecting left dominant side
• I69.333 Monoplegia of upper limb following cerebral infarction affecting right non-dominant side
• I69.334 Monoplegia of upper limb following cerebral infarction affecting left non-dominant side
• I69.339 Monoplegia of upper limb following cerebral infarction affecting unspecified side

The “Typical” Fracture
### Changes from ICD-9 to ICD-10

<table>
<thead>
<tr>
<th>Documentation in ICD-9-CM</th>
<th>Documentation in ICD-10-CM</th>
<th>Was the fracture more involved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip fracture</td>
<td>what part of the bone was</td>
<td>malunion versus non-union</td>
</tr>
<tr>
<td></td>
<td>involved</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Right versus Left</td>
<td>is the present condition</td>
</tr>
<tr>
<td></td>
<td>open or closed</td>
<td>actually a sequela from an</td>
</tr>
<tr>
<td></td>
<td>displaced versus non-</td>
<td>earlier condition</td>
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<tr>
<td></td>
<td>displaced fx</td>
<td></td>
</tr>
<tr>
<td></td>
<td>was the healing routine or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>delayed</td>
<td></td>
</tr>
</tbody>
</table>

### Fractures

- Dependent upon the cause of the fracture and how it was treated by the physician, the coding will vary, so it is crucial to have all the necessary documentation correct and present.
  - Fracture repaired: ORIF, CRIF, etc.
  - Fracture repaired via joint replacement
  - Fracture treated non-surgically: cast, sling, brace, etc.
  - Fractures and the osteoporosis correlation
  - Vertebral fractures
    - Compression
    - Traumatic
    - Due to neoplasm
Fracture repaired via ORIF, CRIF, etc.

- Predominantly, we deal with fractures healing as expected.
- Need to document:
  - Laterality
  - Part of bone involved (distal vs proximal, etc.) Be as specific as able.

- *Aftercare codes are no longer used for injuries.*
- Coding that gets entered is the code for the fracture, with a 7th character of “D” for subsequent encounter (when routine healing is present)

Fracture repaired via joint replacement

- When the repair of a fracture is actually a joint replacement, this must be stated.
- Need to document:
  - Laterality
  - Part of bone involved
    - (distal vs proximal, etc.) Be specific as able.

- Coding that gets entered is the code for Aftercare following Joint Replacement (Z47.1), as well as the code specifying which joint was replaced (Z96.6-).
- The fracture code is only used in the inpatient side (M1011, M1017).
Fracture treated non-surgically: cast, sling, brace, etc.

- Sometimes, there is no surgical involvement. The documentation and coding is the same as if there was, however.
- Need to document:
  - Laterality
  - Part of bone involved (distal vs proximal, etc.) Be as specific as able.
- Coding that gets entered is the code for the fracture, with a 7th character of “D” for subsequent encounter (assuming routine healing).

Fractures and the osteoporosis correlation

Introduced to us in the ICD-10 system is the linking of osteoporosis to fractures.

Per the coding Guidelines³, Category M80, Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter. ...A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.
Coding Tips

• Further, in the DecisionHealth ICD-10-CM Coding Manual, there is a Coding Tip in category M84.4:
  – Spontaneous fractures occur without external blunt trauma and are almost always considered pathologic. Compression fractures are considered pathologic fractures. If the patient falls and has a compression fracture or unusual fracture, ask the physician whether it is considered trauma or pathologic.3

OP + Fractures

• SO….if you have a patient that sustained a fracture, and they have a diagnosis of osteoporosis, be certain to document the osteoporosis, as well as the nature of the injury.
The fractured hip

• For example, you get a patient in home care that had an uncontrolled descent onto the toilet seat, and fractured her right ischium.

• Options:
  – fracture, traumatic > ischium  S32.60-
  – fracture, pathological > ischium  M84.454-

Vertebral fractures

Vertebral fractures are generally coded 2 ways:
1. Compression (Pathologic): M84.48X-
   – Compression (Pathologic) w/Osteoporosis: M80.08X-
2. Traumatic: S32.0-

It is generally the physician/facility documentation of the nature of the fracture that will point to the correct designation. While it may logically appear to be a traumatic fracture, due to underlying conditions, the physician may opt to designate the fracture as a compression fracture. Always follow the medical documentation.
Fractures + Cancer

• Finally, if the fracture occurred due to being weakened by a neoplasm, this should also be documented. The fracture, from category M84.5, would be coded as well as the neoplasm. The sequencing would depend on the focus of care.

The “Atypical” Fracture

But occasionally, we do get to see fractures that are not healing as expected.

The applicable 7th character will signify this:

• G subsequent encounter for closed fracture with delayed healing
• H subsequent encounter for open fracture type I or II with delayed healing
• J subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
• K subsequent encounter for closed fracture with nonunion
• M subsequent encounter for open fracture type I or II with nonunion
• N subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
• P subsequent encounter for closed fracture with malunion
• Q subsequent encounter for open fracture type I or II with malunion
• R subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
Documentation needed

- Basically, you should document exactly what the medical record indicates regarding the healing status, as well as
  - Laterality
  - Part of bone involved
- This is much the same as “typical” fractures, just with the added notation of whether it is delayed healing, malunion, or nonunion

JOINT REPLACEMENTS
Joint replacements

• This seems like it would be a very simple topic. Predominantly, it is. For the patient who went the standard route (disease process → joint replacement), the documentation and coding is simple.
  – Document the disease process as stated by the physician (OA, arthritis, avascular necrosis, secondary arthritis due to old injury)
  – Document the joint affected
  – State if any arthritic condition is remaining in the non-surgical side

Joint replacements

• The coding would be simple:
  – Z47.1 Aftercare following joint replacement surgery
  – Z96.65x Presence of (side) artificial knee joint
  – Z96.64x Presence of (side) artificial hip joint
  – Z96.61x Presence of (side) artificial shoulder joint

• The arthritis code is entered in active coding ONLY if the NONSURGICAL joint is affected.
  – The ‘x’ character is replaced by a 1, 2 or 3 dependent upon laterality/bilateral.
“2nd” Joint replacements

• But sometimes, a replacement is actually a revision to an existing prosthesis that has failed.

• What is needed for documentation:
  – What went wrong – the reason for the failure
    • Mechanical failure – dislocation, breakage, wearing down
    • Infection – reaction to the prosthesis

• T84.0 Mechanical complication of internal joint prosthesis
  – T84.01- Broken internal joint prosthesis
  – T84.02- Dislocation of internal joint prosthesis
  – T84.02x- Instability of internal knee prosthesis
  – T84.03- Mechanical loosening of internal prosthetic joint
  – T84.04- Periprosthetic fracture around internal prosthetic joint
  – T84.06- Wear of articular bearing surface of internal prosthetic joint

Basically, whatever the physician stated is what should be documented. If the language is vague, it must be clarified.
“2nd” Joint replacements

- It needs to be very clear for the coder that this is a joint replacement *revision* in order to have correct coding.
  - **Z47.3-** Aftercare *following explantation* of joint prosthesis
  - Z96.65x Presence of (side) artificial knee joint
  - Z96.64x Presence of (side) artificial hip joint
  - Z96.61x Presence of (side) artificial shoulder joint

Prosthesis is absent

- And of course, sometimes, things go wrong. Patients can have reactions to the prosthesis, or infections develop, warranting the need to remove the prosthesis and place an antibiotic spacer.
- This needs to be documented, so the coder can assign the T84.5- “complication” code properly.
- Typical aftercare codes of joint replacement (Z47.1) would not be used, as this is not the situation.
Absent joint either with or without antibiotic spacer

• Document the laterality
• Document the lack of prosthesis/joint

– Z47.3- Aftercare following explantation of joint prosthesis
– Z89.52x Acquired absence of knee joint
– Z89.62x Acquired absence of hip joint

Third Objective

Understand documentation needed to support the 6 ambulatory deficit codes.
Chapter Guidelines

Section I.C.18.a–c
Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes.

The definitive diagnosis code should be sequenced before the symptom code. Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

Gait

In ICD-9, we basically had three options for coding – 719.7 for Difficulty in Walking, 781.2 Abnormal Gait and 781.3 Ataxia.

In ICD-10, the option has expanded to 6 categories, so descriptive documentation and correct verbiage is important to assign codes appropriately.

- **R26.0** Ataxic gait
- **R26.1** Paralytic gait
- **R26.2** Difficulty in walking, not elsewhere classified
- **R26.8** Other abnormalities of gait and mobility
  - **R26.81** Unsteadiness on feet
  - **R26.89** Other abnormalities of gait and mobility
- **R26.9** Unspecified abnormalities of gait and mobility
- **R27.0** Ataxia, unspecified
Further Defined….

• R26.0 Ataxic gait.
  – Clarifying term: Staggering gait.
  – Staggering gait that is distorted or impaired in some way from the normal voluntary movements of walking.

Further Defined….

• R26.1 Paralytic gait
  – Clarifying term: Spastic gait
  – A paralytic gait is an abnormal, spastic way of walking in which a person maintains the legs close together, dragging the feet or toes, and lacking flexibility in the ankles and knees. A person with a spastic gait typically has weak legs that are stiffer than normal. The person will walk without flexing and bending the legs normally. Long term contractions will cause the person to drag the feet or toes, usually on one side. This is a symptom usually associated with another condition such as cerebral palsy, multiple sclerosis, or a brain tumor, or it can be a sequela of stroke or cerebral abscess.
Further Defined…

• R26.2 Difficulty in walking, not elsewhere classified
• R26.81 Unsteadiness on feet
• R26.89 Other abnormalities of gait and mobility
• R26.9 Unspecified abnormalities of gait and mobility

• For all those listed above:
  – Clarifying terms: none
  – Further definition: none

Further Defined…

• R27.0 Ataxia, unspecified
  – Clarifying terms: none
  – Further definition: codes in this category (R27) include problems related to equilibrium (vestibular/balance coordination) and nonequilibrium (nonvestibular coordination) issues. This results from neurological conditions or can indirectly result from orthopedic corrective treatment.³
Secondary Gait Deficit?

• If you suspect a patient’s abnormal gait is actually a late effect of an improperly healed fracture, query the physician. The H&P (or patient) might indicate there’s an old fracture (a year ago or more) and the patient is still experiencing problems, says Trish Twombly, HCS-D, senior director for DecisionHealth in Gaithersburg, Md. However, the doctor must confirm any diagnosis of a late effect; you can never assume.4

To gait or not to gait….

• A patient with Parkinsons is referred to PT for gait abnormality.
  – While the gait abnormality may be the therapist’s working diagnosis, what would actually be coded is the Parkinsons, as abnormal gait is integral to the disease process.

• A patient with a LE joint fracture/replacement is seen for home care.
  – In this situation, code the condition, not the gait problem.

• If a patient has difficulty walking associated with a chronic condition of the bone or joint, R26.2 (difficulty in walking, not elsewhere classified) is the appropriate code to use.
Coding Gait

- But…if the gait codes will be used (and there are many times they are appropriate), government auditors agree therapists must provide clear documentation of the gait deficits and support therapeutic intervention for gait training.8
  - Support need to restore functional abilities
  - Design/establish a safe maintenance program to improve ability to walk
  - Depict prior and current functional abilities, limitations, and/or safety dependence during gait.

What gait documentation ISN’T

- Watch for red flags: Watch for words or statements that suggest the case doesn't meet the criteria for "medically reasonable and necessary services". They'll likely result in denials.
- The phrases include:
  - "increase gait tolerance"
  - "improve gait endurance"
  - "reminded patient again to slow down and ask for assistance when walking"
  - "easy fatigability when walking"
  - "increase out-of-bed/upright tolerance"
  - "gait instruction was repeated today"
  - "improvement in gait with increased distance"
References