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Desk Reference

Clinical Documentation Improvement for ICD-10-CM & Procedure Coding

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- To decrease the number of delayed or denied claims due to insufficient documentation
- To promote the goal of the hospital medical record being as complete as possible during an acute care admission
- To ensure appropriate reimbursement for the medically necessary services provided, regardless of the reimbursement mechanism

Hierarchical Condition Categories and CDI

As mentioned previously, CDI is important to ensure appropriate ICD-10-CM code assignment is supported. Clinical documentation is also important to support that Hierarchical Condition Category (HCC) assignment is correct, confirming correct code assignment and appropriate reimbursement.

Medicare is one of the world's largest health insurance programs, and about one-third of the beneficiaries on Medicare are enrolled in a Medicare Advantage (MA) private health care plan. Due to the great variance in the health status of Medicare beneficiaries, risk adjustment provides a means of adequately compensating those plans with large numbers of seriously ill patients while not overburdening other plans that have healthier individuals. Medicare Advantage plans have been using the Hierarchical Condition Category/risk adjustment model since 2004. Simplistically, based on the patient's condition and assignment of the correct ICD-10-CM code, the patient is classified to an HCC that has been determined to affect the cost of healthcare. Currently the following HCC models are in use:

- CMS-HCC (Medicare Advantage)
- Rx-HCC (Drugs)
- PACE/ESRD

The term "risk adjustment" is often used to describe what HCCs do. HCCs predict health care resource consumption of individuals. HCC scores are used to "risk adjust" payments to a health plan based on the level of risk the beneficiary presents to the plan. HCCs adjust payments so that there is a higher reimbursement for sicker patients.

Under the current CMS-HCC model, MA organizations collect risk adjustment (RA) data, including beneficiary diagnoses from hospital inpatient facilities, hospital outpatient facilities, and physicians during a data-collection period. MA organizations identify the diagnoses relevant to the CMS model and submit them to CMS. CMS categorizes the diagnoses into groups of clinically related diseases called HCCs and uses the HCC category, disease interactions, as well as demographic characteristics to calculate a Risk Adjustment Factor (RAF) score for each beneficiary. CMS then uses the RAF scores to adjust the monthly capitated payments to MA organizations for the next payment period.

Risk adjustment is a process of adjusting capitation payments to health plans either higher or lower to account for the differences in expected health costs of individuals. Risk adjustment is required for managed care programs that monitor changes in disease progression and population mix, set performance targets to generate outcome data, and identify patients for

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Section 2: Clinical Documentation Improvement Processes—Best Practices

As mentioned earlier, the clinical documentation improvement process should be a collaborative one in order to be successful. The healthcare setting and whether the clinical conditions treated involve only a few, such as in a specialty clinic, or encompass the entire spectrum of diseases and disorders, such as in a full-service acute care hospital, will determine the scope and breadth of the program. However, there are many attributes that are commonly seen in successful programs of any size. Many physicians have found that participating in a CDI program at their local hospital also improves documentation in the office setting as well.

There are three main components to a successful clinical documentation improvement program: assessment, implementation, and sustainability.

Assessment

The first step in any CDI program must be an assessment. The assessment will identify those areas that are compliant as well as areas where improvement is needed.

There are several steps involved in performing the CDI assessment:

- Develop a CDI team
- Develop a review process
- Identify areas of risk
- Identify the root cause

Staffing

Before an assessment can take place, a clinical documentation improvement team must be established. This team should include members from all groups involved (e.g., clinicians, coders, information technology, etc.). Each team member can provide insight into what is needed for his or her particular responsibilities.

Staff members who will work on the CDI program can come from a variety of different backgrounds. Typically they include health information management (HIM) coding professionals, compliance officers, physicians, nursing staff, and other professionals with either a coding or clinical background. Some programs involve a variety of the above-mentioned individuals and job titles are not as important as specific attributes and skills, such as: clinical knowledge of the individual code sets and the reporting guidelines associated with that code set; understanding healthcare compliance as it relates to documentation, coding, and billing; and strong written and verbal communication skills. The importance of strong verbal skills cannot be overemphasized; these staff members will be communicating with physicians on a daily basis and must convey

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Section 3: Documentation Issues

This section is organized in an easy-to-use alphabetic format according to the condition or procedure addressed.

For ICD-10-CM codes, the focus is on those diagnoses with significant differences in the type and specificity required for accurate code assignment. The Code Axes are listed, which may include the component subcategories or each code in the section to be discussed. Information related to the entire section of codes appears next, whether related to the ICD-10-CM classification itself or to the CDI process.

The CPT procedures included are those that have documentation issues as well as those for which multiple coding options are available.

Each topic includes clinical definitions that indicate differentiating factors that can affect code assignment. Clinical data such as physical examination findings, laboratory tests commonly ordered, and/or abnormal laboratory findings, ancillary testing provided, therapeutic procedures performed, common medications, and other significant information that may support reporting the condition may also be included. A Clinician Documentation Checklist that displays the clinical factors that the clinician should document is also provided.

In addition to the elements listed above, within each of the topics covered the following components may also appear:

Clinical Tip: Provides clinical definitions and information that will help classify the condition, service, or procedure to a particular code or ICD-10-CM subcategory.

Documentation Tip: Provides information regarding specific elements that are needed in the documentation to differentiate the condition or procedure from other similar conditions or procedures.

CPT Alert: Identifies information that may be found in the documentation that could possibly affect procedure code assignment.

CDI Alert: Contains helpful tips for the CDI professional or other staff member who may be reviewing the physician documentation. Suggestions for ensuring the most appropriate and complete documentation appear here.

I-10 Alert: Provides information that, when found in the clinical documentation, could affect ICD-10-CM code assignment.

Key Terms: Lists synonyms or other clinical terms that may be documented in the medical record that are also classified to the code.

Clinician Note: Shares tips related to documentation for the physician practice setting, which may impact professional component reimbursement and quality initiatives.

⇨ I-10 ALERT

The *ICD-10-CM Official Guidelines for Coding and Reporting* provides useful information regarding documentation requirements, as well as reporting guidelines for the ICD-10-CM classification system. The official guidelines may be accessed at https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines.pdf.

CDI ALERT

Contains helpful tips for the CDI professional or other staff member who may be reviewing the physician documentation. Suggestions for ensuring the most appropriate and complete documentation appear here.

⇨ I-10 ALERT

Alerts the user to classification concepts unique to this code subcategory or code section along with assignment tips and/or differentiating factors. Instructions for additional coding requirements may also appear here.

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Anemia — Iron-Deficiency

Code Axes

Iron deficiency anemia secondary to blood loss (chronic)	**D5Ø.Ø**
Other and unspecified iron deficiency anemias	**D5Ø.8, D5Ø.9**

CDI ALERT

Ensure that the anemia is specified as chronic (and not acute posthemorrhagic) to assign codes from this category.

Description of Condition

Iron deficiency anemia secondary to blood loss (chronic) (D5Ø.Ø)

Iron deficiency anemia due to chronic blood loss most commonly results from a recurrent bleeding lesion in the gastrointestinal tract, such as a gastric ulcer or diverticulitis. Note that acute posthemorrhagic anemia is excluded from this category. The two conditions are clinically very dissimilar and have different causes.

Key Terms

Key terms found in the documentation may include:

Asiderotic anemia
Chlorosis
Chronic blood loss anemia
Chronic posthemorrhagic anemia (D5Ø.Ø)
Hypoferric anemia
Hypochromic or microcytic anemia
IDA due to inadequate nutrition
Idiopathic hypochromic anemia

CDI ALERT

Laboratory work-up typically reveals depleted iron stores and small, pale red blood cells (RBC), erythrocyte count less reduced than hemoglobin, serum ferritin below 12 ng/mL, low serum iron, and increased total iron-binding capacity. The physician must document the underlying cause of the anemia; no cause and effect may be assumed.

Other and unspecified iron deficiency anemias (D5Ø.8, D5Ø.9)

These classifications are available when the documentation indicates conditions that either have no specific code assignment, or there is no specific documentation for the condition. Iron deficiency anemia secondary to inadequate dietary iron intake is indexed to code D5Ø.8.

Key Terms

Key terms found in the documentation may include:

IDA due to inadequate nutrition
Iron deficiency anemia due to inadequate dietary iron intake
Refractory sideropenic anemia

Clinical Findings

Physical Examination

History and review of systems may include:

- Signs and symptoms
  - fatigue

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- loss of stamina
- shortness of breath
- weakness and pallor

Diagnostic Procedures and Services

- Laboratory
  - CBC: low hemoglobin and hematocrit are below normal levels (In early stages, the hemoglobin may be normal.)
  - serum iron
  - total iron binding
  - iron saturation
  - serum ferritin
  - bone marrow evaluation
  - The World Health Organization (WHO) outlines anemia based on the following hemoglobin levels:
- Men <13.0 g/dl
- Women <12.0 g/dl
- Pregnant women <11.0 g/dl

Note: In uncomplicated iron deficiency anemia the ferritin and serum iron levels are below normal while the TIBC may be elevated. Iron saturation results are either normal or low.

Therapeutic Procedures and Services

In most instances iron supplements are provided either in the oral or intramuscular method.

In severe cases a blood transfusion may be performed.

Medication List

- Carbonyl iron (Feosol)
- Ferrous sulfate (Feratab, Fer-Iron, Slow-FE)
- Iron sucrose (Venofer)

Clinician Documentation Checklist

Clinician documentation should indicate the following:

- Type of iron deficient anemia
  - secondary to blood loss
  - due to inadequate dietary iron intake
  - due to inadequate nutrition
  - asiderotic
  - chlorosis
  - hypoferric
  - idiopathic hypochromic
  - refractory sideropenic
  - acute, chronic, acute on chronic

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Epilepsy and Recurrent Seizures

Code Axes

Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset	**G40.0-** HCC
Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures	**G40.1-** HCC
Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures	**G40.2-** HCC
Generalized idiopathic epilepsy and epileptic syndromes	**G40.3-** HCC
Absence epileptic syndrome	**G40.A-** HCC
Juvenile myoclonic epilepsy (impulsive petit mal)	**G40.B-** HCC
Other generalized epilepsy and epileptic syndromes	**G40.4-** HCC
Epileptic seizures related to external causes	**G40.5-** HCC
Other epilepsy and recurrent seizures	**G40.8-** HCC
Epilepsy, unspecified	**G40.9-** HCC

I-10 ALERT

There is an additional classification axis for the presence of status epilepticus. Sixth characters are found throughout the subcategory representing this condition.

Clinical Tip

The following definitions should be used for all subclassifications related to epilepsy and epileptic syndromes:

Status epilepticus: Typically defined as one continuous, unremitting seizure lasting longer than 30 minutes, or recurrent seizures without regaining consciousness between seizures for greater than 30 minutes. The condition is always considered a medical emergency.

Intractable epilepsy: There is not a universal definition for this complication, but it appears that most agree that a definition of drug-resistant epilepsy is a failure of adequate trials of two tolerated and appropriately chosen and used antiepileptic drug (AED) schedules.

CDI ALERT

Ensure that not only is the type of epilepsy or recurrent seizure documented, but that the details related to status epilepticus and intractable epilepsy are also present in the medical record.

Key Terms

Key terms found in the documentation for intractable epilepsy may include:

- Pharmacoresistant (pharmacologically resistant) epilepsy
- Poorly controlled epilepsy
- Refractory (medically) epilepsy
- Treatment resistant epilepsy

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Migraine

Code Axes

Migraine without aura	**G43.Ø-**
Migraine with aura	**G43.1-**
Hemiplegic migraine	**G43.4-**
Persistent migraine aura without cerebral infarction	**G43.5-**
Persistent migraine aura with cerebral infarction	**G43.6-**
Chronic migraine without aura	**G43.7-**
Cyclical vomiting in migraine	**G43.A-**
Ophthalmoplegic migraine	**G43.B-**
Periodic headache syndromes in child or adult	**G43.C-**
Abdominal migraine	**G43.D-**
Other migraine	**G43.8-**
Migraine, unspecified	**G43.9-**

CDI ALERT

Migraine as adverse effect of medication: documentation must link the nature of the adverse effect as the type of migraine and state the drug or classification, when known.

Clinical Tip

Migraine is defined as a moderate to severe headache that is intermittent, lasts four to 72 hours, and is throbbing in quality. Some patients experience nausea and become sensitive to lights and noise, in association with the headache. Migraine mechanisms are believed to involve chemical substances such as serotonin, increased stickiness of blood platelets, alterations in cerebral blood flow, and increased irritability of the nerve cells in the brain.

The following definitions should be used for all subclassifications related to migraine:

Intractable migraine: Sustained and severe migraine headaches, along with their manifestations, that are not adequately controlled by standard outpatient treatments. Other terms may include: pharmacoresistant, pharmacologically resistant, treatment resistant, medically refractory, or poorly controlled.

Status migrainosus: A debilitating migraine headache lasting more than 72 hours.

Migraine with aura: A less common type of migraine that includes symptoms or feelings that occur immediately preceding a migraine headache. The symptoms are also called a prodrome, which may last for five to 20 minutes, or may continue with the headache. Some of the most common prodromes include the following:

- Blind spots or scotomas
- Weakness
- Hallucinations
- Blindness in half of the visual field in one or both eyes (hemianopsia)

I-10 ALERT

Not all subcategories include codes that relate the presence of status migrainosus but all subcategories do include codes that relate the presence of intractability. Ensure that both of these are clearly documented in the medical record, when applicable.

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- Seeing zigzag patterns (fortification)
- Seeing flashing lights (scintilla)
- Feeling prickling skin (paresthesia)

Description of Condition

Migraine without and with aura (G43.Ø-, G43.1-)

Clinical Tip
Migraine is defined as a moderate to severe headache that it is intermittent, lasts four to 72 hours, and is throbbing in quality. Some patients experience nausea and become sensitive to lights and noise, in association with the headache. Migraine mechanisms are believed to involve chemical substances such as serotonin, increased stickiness of blood platelets, alterations in cerebral blood flow and increased irritability of the nerve cells in the brain. A migraine with aura is a less common type of migraine that includes symptoms or feelings that occur immediately preceding a migraine headache. The symptoms are also called a prodrome, which may last for five to 20 minutes, or may continue with the headache.

Key Terms
Key terms found in the documentation may include:

Basilar migraine

Classical migraine

Common migraine

Migraine equivalents

Migraine preceded or accompanied by transient focal neurological phenomena

Migraine triggered seizures

Migraine with acute-onset aura

Migraine with aura without headache (migraine equivalents)

Migraine with prolonged aura

Migraine with typical aura

Retinal migraine

Without aura

Clinician Note
Ensure that all related conditions are coded appropriately, particularly if seizure activity is documented.

CDI ALERT

Ensure that not only are conditions related to intractability and status migrainosus clearly documented, but if any associated seizure activity is present, it should be documented and classified separately.

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Appendix 1: Physician Query Samples

The major purpose of queries is to obtain clarification when documentation in the health record impacts an externally reportable data element and is illegible, incomplete, unclear, inconsistent, or imprecise. As noted earlier in this manual, queries should not lead the provider to a specific diagnosis or response; introduce new information not documented elsewhere; reference directly or indirectly any financial, severity of illness, or risk of mortality impact of the query response; or appear to question a provider's clinical judgment.

The query examples that follow here are intended to provide those actively working with physicians in clinical documentation improvement activities, to encourage accurate and appropriate documentation.

Anemia Clarification

Dr. Davis:

This patient was admitted with a duodenal bleed per your admission note. At that time, her hemoglobin was 7.4gm/dl and her hematocrit was 22.6 percent. The H&P states "anemia." After admission, the patient was treated with two units packed red blood cells (PRBC).

Can your diagnosis of anemia be further specified to any of the following?:

Acute blood loss anemia: ______________________________

Chronic blood loss anemia: ______________________________

Other type of anemia: ______________________________

Unable to determine: ______________________________

Please document any clarification in the progress notes or on the discharge summary.

Signature ______________________________

Date ______________________________

Thank you,

John Jay

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Appendix 2: HCC and QPP Associated Codes

The following lists include the number and official description of the HCC or QPP measures referenced in the table below. To save space the official descriptions have been provided once in this list. The table includes CPT codes, ICD-10-CM codes, and any applicable HCC and/or QPP measures for **topics covered in this book.** Note that to save space, some ICD-10-CM codes ranges are listed within certain topics in the body of this book. The individual code should be verified in this table.

CMS-HCC Model Category

1	HIV/AIDS
2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
6	Opportunistic Infections
8	Metastatic Cancer and Acute Leukemia
9	Lung and Other Severe Cancers
10	Lymphoma and Other Cancers
11	Colorectal, Bladder, and Other Cancers
12	Breast, Prostate, and Other Cancers and Tumors
17	Diabetes with Acute Complications
18	Diabetes with Chronic Complications
19	Diabetes without Complication
21	Protein-Calorie Malnutrition
22	Morbid Obesity
23	Other Significant Endocrine and Metabolic Disorders
27	End-Stage Liver Disease
28	Cirrhosis of Liver
29	Chronic Hepatitis
33	Intestinal Obstruction/Perforation
34	Chronic Pancreatitis
35	Inflammatory Bowel Disease
39	Bone/Joint/Muscle Infections/Necrosis
40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
46	Severe Hematological Disorders
47	Disorders of Immunity
48	Coagulation Defects and Other Specified Hematological Disorders
51	Dementia With Complications
52	Dementia Without Complications
54	Substance Use with Psychotic Complications
55	Substance Use Disorder, Moderate/Severe, or Substance Use with Complications
56	Substance Use Disorder, Mild, Except Alcohol and Cannabis
57	Schizophrenia
58	Reactive and Unspecified Psychosis
59	Major Depressive, Bipolar, and Paranoid Disorders
60	Personality Disorders
70	Quadriplegia
71	Paraplegia
72	Spinal Cord Disorders/Injuries
73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease
74	Cerebral Palsy
75	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
76	Muscular Dystrophy
77	Multiple Sclerosis
78	Parkinson's and Huntington's Diseases
79	Seizure Disorders and Convulsions
80	Coma, Brain Compression/Anoxic Damage

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