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DESK REFERENCE

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

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Contents

the government as well as private and commercial insurance entities, and is needed in any value-based purchasing program.

The ICD-10-CM codes that are associated with an HCC will be identified by the icon HCC next to the code. Note, in some instances, where a range of codes are identified under the topic, not all codes may be associated with an HCC. Please refer to appendix 2 for the specific codes within that range that are associated with an HCC.

☛ **IMPORTANT**

When the HCC icon appears with a range of codes, please refer to appendix 2 as not all codes within the range may be associated with an HCC. Note, in some instances, where a range of codes is identified under the topic, not all codes may be associated with an HCC.

Supporting Documentation for Reporting Procedures and Services

Medical record documentation is also essential for determining the most appropriate CPT® code. The CPT code book contains many code for procedures which, while very similar, have distinct components that differentiate them. This could be something as easily identifiable as the morphology of a lesion, or something more difficult, such as specific instrumentation. The difficulty lies in educating clinicians on the exact information needed for documentation as well as the coder or CDI experts understanding the key terms that identify these components.

Failing to adequately document medical services and procedures can lead to inaccurately reported services, claim delays, claim denials or even, after postpayment review by an insurer, recoupment of payments, or allegations of fraud and abuse.

Representatives of the American Health Information Management Association (AHIMA), American Health Quality Association (AHQA), American Hospital Association (AHA), American Medical Association (AMA), Blue Cross and Blue Shield Association (BCBSA), and America's Health Insurance Plans (AHIP) have developed several principles of medical record documentation, which include:

- The medical record should be complete and legible.
- The documentation of each patient encounter should include the date; reason for the encounter; appropriate history and physical exam; review of lab, x-ray data, and other ancillary services as appropriate; assessment; and plan for care (including discharge plan, as appropriate).
- Past and present diagnoses should be accessible to the treating or consulting healthcare professional.
- The reasons for, and results of, x-rays, lab tests, and other ancillary services should be documented or included in the medical record.
- Relevant health risk factors should be identified.
- The patient's progress, including response to treatment, change in treatment, change in diagnosis, and patient noncompliance should be documented.
- The written plan for care should include, when appropriate, treatments and medications, specifying frequency and dosage; referrals and consultations; patient and family education; and specific instructions for follow-up.

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

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/Medicare/Coding/ICD10/Downloads/2019-ICD10-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.

Acute Myocardial Infarction (AMI)

Code Axes

ST elevation (STEMI) myocardial infarction of anterior wall	**I21.Ø1, I21.Ø2, I21.Ø9** HCC QPP
ST elevation (STEMI) myocardial infarction of inferior wall	**I21.11, I21.19** HCC QPP
ST elevation (STEMI) myocardial infarction of other and unspecified sites	**I21.21, I21.29, I21.3** HCC QPP
Non-ST elevation (NSTEMI) myocardial infarction	**I21.4** HCC QPP
Acute myocardial infarction, unspecified	**I21.9** HCC
Myocardial infarction type 2	**I21.A1** HCC
Other myocardial infarction type	**I21.A9** HCC
Subsequent ST elevation (STEMI) myocardial infarction of anterior/inferior walls	**I22.Ø, I22.1** HCC
Subsequent non-ST elevation (NSTEMI) myocardial infarction	**I22.2** HCC
Subsequent ST elevation (STEMI) myocardial infarction of other/unspecified site	**I22.8, I22.9** HCC
Old myocardial infarction	**I25.2**
Intraoperative acute myocardial infarction, during cardiac surgery	**I97.79Ø**
Intraoperative acute myocardial infarction, during other surgery	**I97.791**
Postprocedural acute myocardial infarction, following cardiac surgery	**I97.19Ø**
Postprocedural acute myocardial infarction, following other surgery	**I97.191**

⇨ **I-10 ALERT**

The ICD-10-CM definition of initial acute myocardial infarction (category I21) is that with a stated duration of four weeks (28 days) or less from onset. A subsequent AMI is defined as one occurring within four weeks (28 days) of a previous AMI.

Description of Condition

Acute myocardial infarction (MI) is a leading cause of morbidity and death worldwide. Myocardial infarction occurs when reduced blood supply to the heart (myocardial ischemia) results in irreversible myocardial heart damage. Myocardial infarctions can be categorized as:

Common Clinical Diagnosis

STEMI ST elevation myocardial infarction

NSTEMI Non-ST elevation myocardial infarction

Classified by Clinical Scenario

Type 1 Spontaneous MI related to ischemia

Type 2 Secondary to Ischemia from supply and demand mismatch

Type 3 MI resulting in sudden cardiac death

Type 4a MI associated with percutaneous coronary intervention

Type 4b MI associated with in-stent thrombosis

Type 4c MI associated with a rise and/or fall of cTn values in patients with ≥50% stenosis

Type 5 MI associated with coronary artery bypass

ST elevation (STEMI) myocardial infarction (I21.Ø-, I21.1-, I21.2-, I21.3)

An ST elevation myocardial infarction (STEMI) involves electrocardiogram (ECG) evidence of the ST-segment elevation, meaning that there is active and ongoing transmural myocardial damage due to the coronary artery being totally blocked. Patients with STEMI can develop Q-waves, which indicate an area of dead myocardium and irreversible damage. STEMI AMIs reflect a higher severity level than non-STEMI AMIs.

Clinical Tip

AMIs may affect the anterior wall, which includes the following:

- Left main coronary artery
- Left anterior descending coronary artery
- Diagonal coronary artery
- Anteroapical, anterolateral, or anteroseptal AMIs

The inferior wall AMIs include the following:

- Right coronary artery
- Inferolateral AMI

Other areas where AMIs may occur include:

- Left circumflex coronary artery
- Apical-lateral, basal-lateral, high lateral, posterobasal, posterolateral, posteroseptal

CDI Alert

If a STEMI AMI converts to an NSTEMI due to thrombolytic therapy, it is still classified as a STEMI, due to the higher severity level of the STEMI and the fact that the patient was treated for the condition. If an NSTEMI evolves into a STEMI, then it is classified as a STEMI AMI. Review documentation carefully if both STEMI and NSTEMI appear in the medical record.

Key Terms

Key terms found in the documentation may include:

AMI with ST elevation

Cardiac infarction

Coronary artery embolism, occlusion, rupture, or thrombosis

Infarction of heart, myocardium, or ventricle

ST AMI

Transmural Q-wave infarction

Type 1 STEMI

Fracture — Nontraumatic of Spine/Vertebra

Code Axes

Fatigue fracture of vertebra, site unspecified	**M48.4Ø** QPP
Fatigue fracture of vertebra, cervical regions	**M48.41, M48.42, M48.43** QPP
Fatigue fracture of vertebra, thoracic regions	**M48.44, M48.45** QPP
Fatigue fracture of vertebra, lumbosacral regions	**M48.46, M48.47, M48.48** QPP
Collapsed vertebra, NEC, site unspecified	**M48.5Ø** HCC
Collapsed vertebra, NEC, cervical regions	**M48.51, M48.52, M48.53** HCC
Collapsed vertebra, NEC, thoracic regions	**M48.54, M48.55** HCC
Collapsed vertebra, NEC, lumbosacral regions	**M48.56, M48.57, M48.58** HCC
Age-related osteoporosis with current pathological fracture, vertebra(e)	**MØØ.ØØ** HCC QPP
Other osteoporosis with current pathological fracture, vertebra(e)	**MØØ.88** HCC QPP
Pathological fracture in neoplastic disease, vertebrae	**M84.58**
Pathological fracture in other disease, other site	**M84.68**
Personal history of (healed) osteoporosis fracture	**Z87.31Ø**

⇨ I-10 ALERT

Codes for nontraumatic fractures have been vastly expanded in ICD-10-CM, with specific codes related to cause and type of fracture (e.g., collapsed vertebra, etc.). These codes require the addition of seventh characters that specify the episode of care, such as that for initial or subsequent encounter, or that for sequela (late effect) of the fracture.

CDI ALERT

Any nontraumatic fracture must be documented specifically, including the type, cause, and age of fracture (new versus old). Specificity of site is also necessary in order to classify these cases appropriately.

Description of Condition

Fatigue fracture of vertebra (M48.4-)

Clinical Tip

A fatigue fracture is one that results from excessive activity rather than from a specific injury. This type of fracture is most commonly found in people who have engaged in unaccustomed, repetitive, vigorous activity. It is important to note that this type of fracture is not a result of a disease process and is typically found in younger patients than that involving a disease. These fractures may also be referred to as stress fractures, but the mechanism causing the fracture should be indicated.

Key Terms

Stress fracture

⇨ I-10 ALERT

The category for collapsed vertebra(e) should only be used when the underlying cause of the fracture has not been documented.

CDI ALERT

Ensure that the underlying cause of any stress or fatigue fracture is clearly documented for appropriate classification.

Clinician Note
When documentation indicates that an admission or encounter is for a procedure aimed at treating an underlying condition, the code for the underlying condition (such as a vertebral fracture) should be the first listed diagnosis. It is not necessary to indicate any signs or symptoms such as pain or neuropathy that may also be documented.

Collapsed vertebra, NEC (M48.5-)

Key Terms
Key terms found in the documentation for collapsed vertebra may include:

Collapsed vertebra NOS

Compression fracture

Wedging of vertebra NOS

Clinician Note
Review the medical record for terms such as osteoporosis, fatigue fracture, pathological fracture, stress fracture, or traumatic fracture. If present, query the physician to determine if a more specific type of vertebral fracture code is appropriate.

CDI ALERT

Review documentation carefully for mention of collapsed vertebra(e) underlying cause. For patients under the age of 50, the condition is most often due to trauma; for patients over age 60, a common cause for females is postmenopausal (age-related) osteoporosis. In elderly patients, other common causes include malignancy and/or infection, and may be the presenting clinical symptom in multiple myeloma patients.

Age-related osteoporosis with current pathological fracture, vertebra(e) (M80.08-)

Clinical Tip
Osteoporosis, or a weakened state of bone density, may be caused by a number of conditions. Primary osteoporosis, which includes that designated as "age-related," may relate to a lower level of estrogen in postmenopausal women; men with decreased testosterone levels are also at risk for increased bone loss.

Key Terms
Key terms found in the documentation for age-related osteoporosis with current pathological fracture may include:

Involutional osteoporosis with current pathological fracture

Osteoporosis NOS with current pathological fracture

Osteoporosis with current fragility fracture

Osteoporotic fracture

Postmenopausal osteoporosis with current pathological fracture

Senile osteoporosis with current pathological fracture

Clinician Note
Documentation should be reviewed to determine if any major osseous defect is present as this should be reported separately. Look for terms such as bone loss or bone fragility. However, before assigning a code from M89.7- verify that this is indeed a major osseous defect.

I-10 ALERT

Codes in the subcategory for age-related osteoporosis are differentiated by the presence of a current pathological fracture and then by site, including laterality. Seventh characters are required that represent the episode of care, whether initial or subsequent, or whether healing has been routine or delayed, whether any nonunion or malunion has occurred, or whether any sequela (late effect) conditions are present.

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 be leading by eliciting a specific response, introduce new information not documented elsewhere, be "yes/no" in format, 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

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
1Ø	Lymphoma 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
33	Intestinal Obstruction/Perforation
35	Inflammatory Bowel Disease
4Ø	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
46	Severe Hematological Disorders
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
59	Major Depressive, Bipolar, and Paranoid Disorders
79	Seizure Disorders and Convulsions
8Ø	Coma, Brain Compression/Anoxic Damage
82	Respirator Dependence/Tracheostomy Status
84	Cardio-Respiratory Failure and Shock
85	Congestive Heart Failure
86	Acute Myocardial Infarction
87	Unstable Angina and Other Acute Ischemic Heart Disease
88	Angina Pectoris
96	Specified Heart Arrhythmias
99	Intracranial Hemorrhage
1ØØ	Ischemic or Unspecified Stroke
1Ø6	Atherosclerosis of the Extremities with Ulceration or Gangrene
1Ø8	Vascular Disease
111	Chronic Obstructive Pulmonary Disease
114	Aspiration and Specified Bacterial Pneumonias
115	Pneumococcal Pneumonia, Empyema, Lung Abscess
122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
134	Dialysis Status
136	Chronic Kidney Disease, Stage 5
137	Chronic Kidney Disease, Severe (Stage 4)
138	Chronic Kidney Disease, Moderate (Stage 3)
157	Pressure Ulcer w/ Necrosis to Muscle, Tendon, Bone
158	Pressure Ulcer with Full Thickness Skin Loss
161	Chronic Ulcer of Skin, Except Pressure

Code	Description	CMS-HCC Model Category	QPP Individual Measures–Claims
S06.822S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 31 minutes to 59 minutes, sequela	167	
S06.823A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	166	415, 416
S06.823S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela	167	
S06.824A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 6 hours to 24 hours, initial encounter	166	415, 416
S06.824S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of 6 hours to 24 hours, sequela	167	
S06.825A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	166	
S06.825S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela	167	
S06.826A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surv	166	
S06.826S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surv	167	
S06.829A	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, initial encounter	167	415, 416
S06.829S	Injury of left internal carotid artery, intracranial portion, not elsewhere classified with loss of consciousness of unspecified duration, sequela	167	
S06.890A	Other specified intracranial injury without loss of consciousness, initial encounter	167	415, 416
S06.890S	Other specified intracranial injury without loss of consciousness, sequela	167	
S06.891A	Other specified intracranial injury with loss of consciousness of 30 minutes or less, initial encounter	167	415, 416
S06.891S	Other specified intracranial injury with loss of consciousness of 30 minutes or less, sequela	167	
S06.892A	Other specified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, initial encounter	167	415, 416
S06.892S	Other specified intracranial injury with loss of consciousness of 31 minutes to 59 minutes, sequela	167	
S06.893A	Other specified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter	166	415, 416
S06.893S	Other specified intracranial injury with loss of consciousness of 1 hour to 5 hours 59 minutes, sequela	167	
S06.894A	Other specified intracranial injury with loss of consciousness of 6 hours to 24 hours, initial encounter	166	415, 416
S06.894S	Other specified intracranial injury with loss of consciousness of 6 hours to 24 hours, sequela	167	
S06.895A	Other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, initial encounter	166	
S06.895S	Other specified intracranial injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level, sequela	167	
S06.896A	Other specified intracranial injury with loss of consciousness greater than 24 hours without return to pre-existing conscious level with patient surviving, initial encounter	166	