Countdown to ICD-10
114 days

SWEDISH

PROVIDENCE Health & Services

Clinical Documentation Tips

Tips, Hints & Pointers...

Issue: 2 / June 2015

Reminder:
Encounter for supervision of **normal pregnancy** has an expanded code set for ICD-10
Provider documentation will need to reflect **Gravida and Trimester** to support the specificity of these ICD-10 Diagnosis codes.

Documentation and Coding for Wound Debridement:

Documentation requirements to support **"Excisional"** debridement billing are **stringent**. Therefore, excisional ***debridement claims are targeted*** not only by recovery audit contractor (RAC) audits, but also by the ***Office of Inspector General*** (OIG) and the ***Centers for Medicare & Medicaid Services*** (CMS).

In order for an *Excisional Debridement* to be coded (and reimbursed), ***five key elements are required*** in the documentation/Procedure Note:

1) A description of the **procedure as "excisional"**
2) A description of the **instrument(s) used** to cut or excise the tissue (e.g., scissors, scalpel, and curette)
3) A description of the **tissue removed** (e.g., necrotic, devitalized or non-viable)
4) The **appearance and size** of the wound (e.g., down to fresh bleeding tissue, 7 cm x 10 cm, etc.)
5) The **depth** of the debridement (e.g., to skin, fascia, subcutaneous tissue, muscle, or bone)

THINGS YOU SHOULD KNOW:

1. ***The ICD-10 Transition date is October 1, 2015***
2. ***You don't have to use 68,000 codes:*** You don't use all 13,000 Dx codes from ICD-9, and you will not need to utilize 68,000 codes from ICD-10!
3. **The process for looking up ICD-10 codes is the same as ICD-9** (and you are already using it).
4. **Outpatient and office procedure codes aren't changing**. The transition to ICD-10 for diagnosis coding and inpatient procedure coding does not affect the use of CPT for outpatient and office coding. Your practice will continue to use CPT.

For additional information or questions, please contact:
Providence ICD-10 SharePoint Site

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DOCUMENTATION TIP:

The ISSUE **The diagnosis of Congestive Heart Failure (CHF).**

Acute or Acute on Chronic, Diastolic/Systolic or Combined CHF is considered a Major Comorbidity. Chronic Diastolic/Systolic or Combined CHF is considered a Comorbidity.

- *When patients are actively being treated for CHF (systolic, diastolic or combined) but the type of CHF is **NOT** specified, the acuity of the patient is not captured and the physician is **NOT** credited with the care needed and provided.*
- *It cannot be assumed that "CHF" is the same thing as "Acute CHF" or "Acute on Chronic CHF"*

The SOLUTION: To capture the acuity of patient care for a CHF exacerbation, please document the following when appropriate:

"Acute (Systolic/Diastolic OR Combined) CHF" OR
"Acute on Chronic (Systolic/Diastolic OR Combined) CHF".

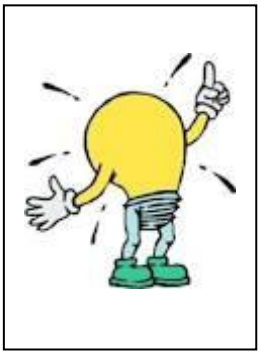
Stable, chronic CHF should be documented as:
"Chronic (Systolic/Diastolic OR Combined) CHF".

Please note: When you respond to clarifications, please exercise your independent professional judgment. A query does not imply that any particular response is desired or expected.

REMINDER
DETAILS MATTER:
Mortality Risk etc.

CHF—acute or chronic, Diastolic or Systolic

PLEASE CLARIFY ALL PATIENT CONDITIONS



DOCUMENTATION TIP:

If a patient is admitted to the hospital with a symptom,
The Provider **MUST**
By the end of the admission document, (if known) ***The cause****, and* ***link the symptom to the cause****.*

- *Link admitting presentation to known or suspected diagnoses*

Chest pain due to CAD or unstable angina
Syncope due to cardiac arrhythmia

- *Link signs and symptoms to known or suspected diagnoses*

Altered mental status due to encephalopathy
Abdominal pain, nausea or vomiting due to C.Diff

- *Link Emergency Department findings to admit note*
- *and/or H&P; Link Symptoms to Cause*

Acute hypoxic respiratory failure improved rather than in no acute distress

Saint John's CDS's **(Marilyn, Terri, Joan)**

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