2019

Clinical Documentation Improvement Desk Reference for ICD-10-CM and Procedure Coding
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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 health care 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 particular 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 health care 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 professionalism and significant clinical and coding knowledge. Many successful programs have one or more physician “champions,” who act both as advisors to the other staff members in the program and are liaisons with the medical staff providing the documentation.

**Physician Advisor or Liaison**

Many CDI professionals believe that a major component of a successful program is a strong physician advisor. This major role is to act as a liaison between the CDI staff members, HIM coding, and the medical staff and to facilitate accurate coding and representation of acuity and severity. As a result, the corresponding reimbursement should also be enhanced, regardless of the setting.

Just as importantly, the physician advisor is responsible for communicating with and educating the medical staff in both the general concepts of severity and acuity as they relate to documentation and coding, and in encouraging and recommending specific documentation enhancements. To accomplish these goals, the physician advisor should have knowledge related to physician performance profiling, physician E/M payment and pay for performance, and appropriate documentation for hospital reimbursement and profiling (if working in that setting). Publicly available data tools are available that can be incorporated in the CDI strategy, including the Surgical Care Improvement Project (SCIP) outcomes, risk of mortality (ROM), and severity-of-illness (SOI) data instruments. Helping other physicians become more aware of outcomes data and the documentation and coding effect on them is a very successful way of reaching those most responsible for providing the documentation upon which these data instruments are based.

Physician advisors can also emphasize the continuity of care approach to other physicians on the medical staff. This approach reinforces the fact that what is documented accurately represents not only the patient conditions, but what was done for the patient. Other physicians participating in the care of the patient need to ensure that what they review in the medical record is accurate and complete to provide additional input and/or services. Continuity of care is an essential goal of any CDI program and should be the number one reason that conflicting information in the medical record is addressed quickly and thoroughly via the CDI process.

In addition, the physician advisor should meet on a regular basis with the CDI professionals to review selected medical records, particularly those involving traditionally confusing conditions or those with a somewhat varied set of clinical definitions. Examples of these conditions include those with respiratory failure, acute blood loss anemia, renal insufficiency versus chronic kidney disease, acute kidney injury, and urosepsis. In some cases, internal definitions of these conditions can be formulated through a collaborative process. Taking a proactive stance in handling these cases that can cause confusion on the part of both CDI/coding and the medical staff can alleviate future problems and can significantly decrease the number of physician queries required.

When physician queries are necessary, the physician advisor can provide assistance in several ways. First, the physician advisor can determine whether a query is necessary based on the initial documentation in the
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 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 are also 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 the clinical definitions and information that must be documented in order to classify the condition, service, or procedure to this 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.

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Acute Myocardial Infarction (AMI)

Code Axes

<table>
<thead>
<tr>
<th>Description</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST elevation (STEMI) myocardial infarction of anterior wall</td>
<td>I21.01, I21.02, I21.09</td>
</tr>
<tr>
<td>ST elevation (STEMI) myocardial infarction of inferior wall</td>
<td>I21.11, I21.19</td>
</tr>
<tr>
<td>ST elevation (STEMI) myocardial infarction of other and unspecified sites</td>
<td>I21.21, I21.29, I21.3</td>
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<tr>
<td>Non-ST elevation (NSTEMI) myocardial infarction</td>
<td>I21.4</td>
</tr>
<tr>
<td>Acute myocardial infarction, unspecified</td>
<td>I21.9</td>
</tr>
<tr>
<td>Myocardial infarction type 2</td>
<td>I21.A1</td>
</tr>
<tr>
<td>Other myocardial infarction type</td>
<td>I21.A9</td>
</tr>
<tr>
<td>Subsequent ST elevation (STEMI) myocardial infarction of anterior/inferior walls</td>
<td>I22.0, I22.1</td>
</tr>
<tr>
<td>Subsequent non-ST elevation (NSTEMI) myocardial infarction</td>
<td>I22.2</td>
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<tr>
<td>Subsequent ST elevation (STEMI) myocardial infarction of other/unspecified site</td>
<td>I22.8, I22.9</td>
</tr>
<tr>
<td>Old myocardial infarction</td>
<td>I25.2</td>
</tr>
<tr>
<td>Intraoperative acute myocardial infarction, during cardiac surgery</td>
<td>I97.790</td>
</tr>
<tr>
<td>Intraoperative acute myocardial infarction, during other surgery</td>
<td>I97.791</td>
</tr>
<tr>
<td>Postprocedural acute myocardial infarction, following cardiac surgery</td>
<td>I97.190</td>
</tr>
<tr>
<td>Postprocedural acute myocardial infarction, following other surgery</td>
<td>I97.191</td>
</tr>
</tbody>
</table>

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 can be categorized as:

- **Common Clinical Diagnosis**
  - STEMI  ST elevation myocardial infarction
  - NSTEMI  No ST elevation myocardial infarction

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. If a patient is still receiving treatment for the myocardial infarction after the four week time frame, an appropriate aftercare code should be reported.
Amyloidosis

Code Axes

Non-neuropathic heredofamilial amyloidosis E85.0
Neuropathic heredofamilial amyloidosis E85.1
Heredofamilial amyloidosis, unspecified E85.2
Secondary systemic amyloidosis E85.3
Organ-limited amyloidosis E85.4
Other amyloidosis E85.8-
Amyloidosis, unspecified E85.9

Description of Condition
Amyloidosis is a potentially fatal condition in which insoluble, fibril-like proteins (amyloid) build up in one or more organs and tissues within the body such as the heart, kidneys, liver, spleen, nervous system, or digestive tract. The material cannot be broken down and interferes with the normal function of the organ. The disease may be inflammatory, hereditary, or neoplastic in nature.

Heredofamilial amyloidosis (E85.0, E85.1, E85.2)
This is an inherited disorder caused by an abnormal recessive gene. This type of amyloidosis is most common in ethnic groups from the eastern Mediterranean region.

Key Terms
Key terms found in the documentation may include:

- Hereditary amyloid nephropathy
- Amyloid polyneuropathy (Portuguese)
- Familial
- Genetic

Secondary systemic amyloidosis (E85.3)
When another disease leads to amyloidosis, the disorder is considered secondary. Secondary amyloidosis can occur as a result of several infectious, inflammatory, and malignant conditions. Common causative conditions include tuberculosis, osteomyelitis, rheumatoid arthritis, Crohn's disease, and Castleman disease.
Atelectasis

Code Axes

- Atelectasis J98.11
- Postprocedural atelectasis J95.89 J98.11

Description of Condition

Atelectasis (J98.11)
Atelectasis is an incomplete expansion of lung segments that may result in partial or complete lung collapse. It occurs to some degree in many patients undergoing upper abdominal or thoracic surgery. Prognosis depends on prompt removal of any airway obstruction, relief of hypoxia, and re-expansion of the collapsed lung. Prolonged immobility, anesthesia, mechanical ventilation, prolonged bed rest with few changes in position, underlying lung diseases, or any condition that inhibits full lung expansion or makes deep breathing painful, with shallow breathing are risk factors.

Postprocedural atelectasis (J95.89, J98.11)
Atelectasis is an expected condition within the first 48 hours postoperatively when the patient has undergone a general anesthetic with moderately high oxygen concentrations. It is often an incidental x-ray/physical finding that is frequently self-limiting. It will usually resolve spontaneously without treatment. When it becomes symptomatic and requires work-up or additional monitoring or treatment, and it is documented as a complication of a procedure, it will be reported as a postprocedure complication.

Clinical Findings

Physical Examination
History and review of systems may include:

- Coarse lung sound and/or decreased lung sound
- Cough
- Dyspnea
- Shortness of breath
- Chest pain
- Transudate pleural effusion

Diagnostic Procedures and Services

- Imaging
  - chest x-ray
- Other
  - spirometry

CDI ALERT
When atelectasis is associated with significant findings, such as fever, or requires further diagnostic or therapeutic work up, such as chest x-ray (as part of work-up, not routinely/incidentally), urinalysis/blood culture, or respiratory therapy, or is linked to an extended hospital stay, then it is reportable.
Migraine

Code Axes

- Migraine without aura G43.0
- 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 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

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

Description of Condition

Migraine without and with aura (G43.0-, 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.
# 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

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HIV/AIDS</td>
</tr>
<tr>
<td>2</td>
<td>Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock</td>
</tr>
<tr>
<td>8</td>
<td>Metastatic Cancer and Acute Leukemia</td>
</tr>
<tr>
<td>9</td>
<td>Lung and Other Severe Cancers</td>
</tr>
<tr>
<td>10</td>
<td>Lymphoma and Other Cancers</td>
</tr>
<tr>
<td>12</td>
<td>Breast, Prostate, and Other Cancers and Tumors</td>
</tr>
<tr>
<td>17</td>
<td>Diabetes with Acute Complications</td>
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<tr>
<td>18</td>
<td>Diabetes with Chronic Complications</td>
</tr>
<tr>
<td>19</td>
<td>Diabetes without Complication</td>
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<td>21</td>
<td>Protein-Calorie Malnutrition</td>
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<td>22</td>
<td>Morbid Obesity</td>
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<td>23</td>
<td>Other Significant Endocrine and Metabolic Disorders</td>
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<td>33</td>
<td>Intestinal Obstruction/Perforation</td>
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<td>35</td>
<td>Inflammatory Bowel Disease</td>
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<tr>
<td>40</td>
<td>Rheumatoid Arthritis and Inflammatory Connective Tissue Disease</td>
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<td>46</td>
<td>Severe Hematological Disorders</td>
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<td>54</td>
<td>Drug/Alcohol Psychosis</td>
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<td>55</td>
<td>Drug/Alcohol Dependence</td>
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<td>79</td>
<td>Seizure Disorders and Convulsions</td>
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<td>82</td>
<td>Respirator Dependence/Tracheostomy Status</td>
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<td>84</td>
<td>Cardio-Respiratory Failure and Shock</td>
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<td>85</td>
<td>Congestive Heart Failure</td>
</tr>
<tr>
<td>86</td>
<td>Acute Myocardial Infarction</td>
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<td>87</td>
<td>Unstable Angina, Other Acute Ischemic Heart Disease</td>
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<td>88</td>
<td>Angina Pectoris</td>
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<td>96</td>
<td>Specified Heart Arrhythmias</td>
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<td>99</td>
<td>Cerebral Hemorrhage</td>
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<td>100</td>
<td>Ischemic or Unspecified Stroke</td>
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<td>106</td>
<td>Atherosclerosis of the Extremities with Ulceration or Gangrene</td>
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<td>108</td>
<td>Vascular Disease</td>
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<td>111</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>114</td>
<td>Aspiration and Specified Bacterial Pneumonias</td>
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<td>122</td>
<td>Proliferative Diabetic Retinopathy and Vitreous Hemorrhage</td>
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<td>136</td>
<td>Chronic Kidney Disease (Stage 5)</td>
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<td>157</td>
<td>Pressure Ulcer w/ Necrosis to Muscle, Tendon, Bone</td>
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<td>158</td>
<td>Pressure Ulcer with Full Thickness Skin Loss</td>
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<td>161</td>
<td>Chronic Ulcer of Skin, Except Pressure</td>
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<td>166</td>
<td>Severe Head Injury</td>
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<td>167</td>
<td>Major Head Injury</td>
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<td>169</td>
<td>Vertebral Fractures without Spinal Cord Injury</td>
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<td>170</td>
<td>Hip Fracture/Dislocation</td>
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<tr>
<td>176</td>
<td>Complication of Specified Implanted Device or Graft</td>
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### Appendix 2: HCC and QPP Associated Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>CMS-HCC Model Category</th>
<th>QPP Individual Measures–Claims</th>
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<tr>
<td>C50.421</td>
<td>Malignant neoplasm of upper-outer quadrant of right male breast</td>
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<td>C50.429</td>
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<td>C50.511</td>
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<td>C50.512</td>
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<td>C50.519</td>
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<td>C50.522</td>
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<td>C50.529</td>
<td>Malignant neoplasm of lower-outer quadrant of unspecified male breast</td>
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