Utilizing ICD-10 and Your EMR to Drive Clinical Effectiveness

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Disclosure

• Speaker should disclose any relationship that could reasonably be viewed as creating a conflict of interest, or the appearance of a conflict of interest, that might bias the content of the presentation.
• John Wallace has had financial support from PPS, APTA and other APTA components for previous educational programs.
• John Wallace is employed by the BMS Practice Solutions.
We’ll cover

• Updates on the effective use of ICD-10
• Select the ICD-10 codes that most effectively communicate the patient's functional problems and the co-morbidities that describe how this episode is different from other episodes with the same PT diagnosis
• Describe how ICF can be a useful framework to organize clinical thinking and effectively select meaningful outcome measures

We’ll cover

• Incorporate the discipline of the patient care documentation process to improve patient care and clinical outcomes
• Review what payers tell us about what is important to them in demonstrating the necessity of care based on their published policies.
ICD-10 Transition

10/1/2015 turned out to be more like Y2K than the Hindenburg!

ICD-10 Conventions

• Like ICD-9, formatted into 2 main parts:
  – Index: an alphabetical list of terms and their corresponding code. Contains Main Index and Index to External Causes of Injury
  – Tabular List: A sequential alpha list of codes divided into chapters based on body system or condition. It contains categories, subcategories, and valid codes
ICD-10 code structure

1. Categories of conditions
   injuries
   encounter
   First = Alpha (chapter)
   Second = Number
   Anatomical Site

2. Subcategories
   Anatomical Site
   Severity
   Etiology
   Numeric or Alpha

3. Extension
   - Initial
   - Subsequent
     encounter
   - Sequelae
     Numeric or

Locating a code

1. Locate the term in the Alpha Index
2. Verify the code in the Tabular List
   - Be guided by the instructions in the Alpha Index
     and Tabular List
   - The Alpha Index does not usually provide the full code
   - Selection of the full code including laterality (6th
     character requirement and applicable 7th
     character can only be verified in the Tabular List
6th character: Laterality

- Some ICD-10 codes indicate laterality (left, right, or bilateral). If no bilateral code is provided, and the condition is bilateral, assign codes for both the left and right sides.
  - 0 = Unspecified or 1 = Right
  - 1 = Right or 2 = Left
  - 2 = Left or 9 = Unspecified
  - 3 = Bilateral

Note: Injury Codes usually don’t have Bilateral option. When NO Bilateral Code- use L&R

7th Character: Extension for Injuries

A- Initial Encounter: while patient is receiving initial/active treatment for condition
  – Direct Access (PT) Initial Assessment for traumatic injury/illness i.e. sprain/strain, fracture (*first visit only*)
  – Evaluation Or Treatment by New Physician
  – Example: Newly Assessed Acute Tear of Left Rotator Cuff: S43.422A
7th Character Extension for Injuries

**D** – Subsequent Encounter: After patient received active treatment of the condition and is receiving routine care during healing or recovery phase *(Used most often when not first visit)*
- F/U visits for Treatment of Injury
- Normal healing phase, after the acute condition has been treated
- Routine subsequent care following a Left ACL tear S83.512D
- Left Sub-trochanteric, Closed, Non-Displaced Fracture w/ ORIF – S72.25xD

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**S**- Sequelae Encounter: complications or conditions that arise as a direct result of an acute condition that is no longer being treated such as *(used in select cases, mostly payer driven)*:
- Right Hemiplegia (dominant side) from a traumatic subdural hematoma, no LOC (bleed was resolved) – G81.91, S06.5X0S
- Post-traumatic arthritis following old left ankle fracture – M12.572, S82.892S
7th Character Extension for Injuries

• The 7th character extension that you select for the first visit of an episode should be remain unchanged through that episode e.g.:
  – In a direct access situation, you would use the “A” for the first visit and then throughout the episode of care.
  – For a referral from a physician use the “D” for the first visit and throughout the episode of care

Chapters

1. Infectious and Parasitic Diseases (A00-B99)
2. Neoplasms (C00-D49)
3. Diseases of the Blood and Blood-forming Organs and Disorders of Immune System (D50-D89)
4. Endocrine, Nutritional, and Metabolic Diseases (E00-E89)
5. Mental, Behavioral and Neurodevelopmental Disorders (F01-F99)
Chapters

6. Diseases of Nervous System (G00-G99)
7. Diseases of Eye and Adnexa (H00-H59)
8. Diseases of Ear and Mastoid Process (H60-H95)
9. Diseases of Circulatory System (I00-I99)
10. Diseases of Respiratory System (J00-J99)
11. Diseases of Digestive System (K00-K95)

Chapters

12. Diseases of skin and Subcutaneous Tissue (L00-L99)
13. Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
14. Diseases of Genitourinary System (N00-N99)
15. Pregnancy, Childbirth, and the Puerperium (O00-O9A)
Chapters

16. Certain Conditions Origination in Perinatal Period (P00-P96)
17. Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00-Q99)
18. Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, NEC (R00-R99)

Chapters

19. Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88): 7th character
20. External Causes of Morbidity (V01-Y99)
21. Factors Influencing Health Status and Contact with Health Services (Z00Z99)
Admissions/Encounters for Rehabilitation

First diagnosis should be the condition being treated or chiefly responsible for the episode of care.

• Example:
Patient presents for treatment of Right hemiplegia following CVA. Code Hemiplegia and hemiparesis following CVA affecting Rt dominate side I69.351

Admissions/Encounters for Rehabilitation

If the condition is no longer present, you may report the appropriate aftercare code as the primary diagnosis:

• Example:
If a patient with severe degenerative hip osteoarthritis had THR, Report the code for Aftercare following joint replacement surgery Z47.1 and location Presence of artificial hip joint on the right Z96.641
Admissions/Encounters for Rehabilitation

- ICD 10 Coding Guidance required guidelines:
  - If a definite diagnosis(s) is established, use as primary diagnosis
  - Signs and symptoms integral to this diagnosis should not be coded.
  - Any conditions or complexities (comorbidities) not commonly associated with the primary diagnosis(s) should be assigned as additional codes.

ICD-10 Official Guidelines

- Use of Symptoms Codes
  - Codes that describe symptoms and signs are acceptable only when a related definitive diagnosis is not available or established
  - Direct Access
ICD-10 Official Guidelines

• Use of Symptoms Codes
  – Signs and symptoms that are associated routinely with a disease process or injury should not be assigned as additional diagnoses codes, unless instructed within the Tabular Index

ICD-10 Official Guidelines

• Use of Symptoms Codes
  – ICD-10 contains a number of combination codes that identify both a definitive diagnosis and common symptoms of that diagnosis. Additional codes should not be assigned
    e.g. I69.351 Hemiplegia and hemiparesis following CVA affecting right dominate side
ICD-10 Official Guidelines

• Repeated Falls
  – R29.6 Repeated Falls is for use when a patient has recently fallen and the reason is being investigated
  – Z91.81 History of Falling, is for use when a patient has fallen in the past and is at risk for future falls. It may be appropriate to use both together.

ICD-10 Official Guidelines

• Aftercare Codes (Z Codes)
  – Cover situations in which the initial treatment of a disease or injury has been removed, and the patient requires continued care during healing or recovery phase. Do not use Aftercare Codes if treatment is directed at a current acute disease. Use the appropriate diagnosis code for the active problem.
ICD-10 Official Guidelines

• Aftercare Codes (Z codes)
  – For injuries, do not use aftercare codes if the injury is still present. Assign the acute injury code from Chapter 19 with the appropriate 7th character code for a Subsequent encounter (D).

ICD-10 Official Guidelines

• Aftercare Codes (Z codes)
  – Aftercare Codes are generally first-listed to explain the specific reason for the encounter.
  – Aftercare Codes should be used in conjunction with other diagnostic codes to provide better detail on the specifics of the aftercare, unless directed otherwise in the Tabular Index.
ICD-10 Official Guidelines

• Aftercare Codes (Z codes)
  – Example of use of aftercare codes for Right TKR;
    1. Z47.1 Aftercare following joint replacement surgery
    2. Z96.651 Presence of right artificial knee joint
    3. M17.11 Unilateral primary osteoarthritis, right knee

Coding patient severity and involvement
Using diagnostic codes to reflect what’s wrong with your patient

– Conditions: primary diagnosis
  • What you are treating or the “PT diagnosis”

– Complexities: secondary and other diagnoses
  • complicating factors that may influence treatment e.g. may influence the type, frequency, intensity, &/or duration of treatment.

Represented by:
  • diagnoses as comorbidities
  • patient factors such as age, severity, acuity, multiple conditions, and motivation, or by social circumstances such as the support of significant other or the availability of transportation to therapy
Coding patient severity and involvement

• Goal of diagnosis coding
  – Include all complexities that may affect the severity of the patient’s condition and ultimately affect the type, frequency, intensity, &/or duration of treatment
  – These help to clarify and justify the resources required to treat the patient as they cause changes in the intensity of treatment and number of visits in the episode of care
  – May eventually obviate the need for records

Coding patient severity and involvement

• How do you know what diagnostic codes to include?
  – Ask your self this question: What makes this patient with this primary condition different than the usual patient with this condition?
Elements of critical decision making

The therapist needs to consider the following factors:

– The effect of treatment on the patient’s primary condition
– The patient’s complexities: comorbidities in the form of other current (non-PT) conditions, preexisting conditions, and social situation
– The status of the patient’s comorbidities and primary condition on ability to function

What we’ll cover

• What payers need to know
• Issues with EMRs
• Medicare POC documentation requirements
• Incorporating requirements into documentation
• Documenting skilled care vs. maintenance, *Jimmo vs. Sebelius*
Why this is important

- Payers are reviewing more records because it’s easier and they know the documentation isn’t great.
- Recovery audit activity has proven highly effective at fighting abuse and fraud and has increased as a result:
  - CMS, commercial and WC payers all jumping in
- Payers are focused on the need to pay and the provider’s responsibility to demonstrate the need.

You need to understand the “Community Standard”

Payers and attorneys rely on “community standard” when evaluating medical record completeness. The Community Standard is established by a review of policies and regulations of:

- Professional associations e.g. APTA
- Larger payers e.g. Blue Cross, Medicare MACs
- Government agencies: CMS
Why EMRs can help

• EMRs are very good at
  – Establishing and tracking required elements of the medical record
  – Making sure the required elements exist in each record
  – Counting and Sorting
  – Manipulating data
  – Reporting
  – Providing legibility

Why EMRs may not help as much

• EMRs may be good at
  – Output design
  – Forcing/guiding compliance
  – Forcing/guiding business rules and decision making
  – Forcing/guiding clinical decision making
  – How often these are updated, whether this is the responsibility of the vendor or the user largely determines the adequacy and dependability of the app for compliance purposes
The truth about EMRs

- The problem with legibility
- Who is reading your records at the payer
- Obsession with impairment information
- Clinical decision making and assessment specific to the patient are critical elements of providing evidence of skilled care
- Therapists believe that if they complete the fields, they have created a quality record

What EMRs can and can’t do

- Can
  – Force required elements, document types and track and sort
- Cannot
  – Provide patient specific insights and analysis
  – Demonstrate skilled care without proper input
  – Forecast outcomes and identify clinical exceptions
  – Explain outlier results

*Only therapists can make and document these judgments*
The essential problems

• The good (and bad) news: the notes are legible
• Without purposeful activity, therapists can write nearly identical notes for a patent or multiple patients via the use of pick lists and templates
• Therapist over rely on the EMR to make the case for skilled care by relying on volumes of impairment data and the completion of required document types rather than considering the elements of skilled care specific to the patient.

The essential problems

• Therapists can be obsessed with templates and “pre-loaded” pages that can apply to all patients with a particular diagnosis or problem to decrease time required to create the medical record
• The combination of non-patient specific aids can create notes that do not adequately support skilled care based on individual patient needs
Establishing Medical Necessity and Skilled care

- Medicare has strict but well defined definitions of
  - Medical necessity
  - Skilled care
  - Rehabilitative care
  - Maintenance care
- These must be addressed individually for each patient

Requirements for care

- Patient must be under the care of a physician (an order is not required)
- A Plan of Care (POC) must be established by the therapist
- POC must be signed by the Physician within first 30 days
- POC must be recertified after 90 days, or sooner if POC duration was written for <90 days
Reasonable and Necessary
• The services shall be considered under **accepted standards of medical practice** to be a specific and effective treatment for the patient’s condition. As evidenced by
  – Medicare Manuals 100-03 and 100-04
  – Contractors LCDs and CMS LCDs
  – Guidelines and literature of professions of PT, OT, Speech

Reasonable and Necessary
• The services shall be of such a level of **complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed only by a therapist**, or in the case of physical therapy and occupational therapy, by and under the supervision of a therapist.
Reasonably and Necessary

• Services that do not require the performance or supervision of a therapist are not skilled and are not considered reasonable or necessary therapy services, even if they are performed or supervised by a qualified professional.

Reasonably and Necessary

• While a beneficiary’s particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary’s diagnosis or prognosis cannot be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel.
Rehabilitative Therapy

• Services designed to address recovery or improvement in function or restoration to a previous level of health and well-being.

• Evaluation, re-evaluation and assessment documented in the Progress Report should describe objective measurements which, when compared, **show improvements in function, decrease in severity or rationalization for an optimistic outlook to justify continued treatment.**

Rehabilitative Therapy

• Rehabilitative therapy **requires the skills of a therapist** to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation.

• **Services that can be safely and effectively furnished by nonskilled personnel or by PTA without supervision are not rehabilitative therapy**
Maintenance Programs

- Skilled therapy services that do not meet the criteria for rehabilitative therapy may be covered in certain circumstances as maintenance therapy under a maintenance program.
- The goals of a maintenance program would be, for example, to maintain functional status or to prevent or slow further deterioration in function.

Maintenance Programs

Skilled therapy services related to a reasonable and necessary maintenance program are covered in the following circumstances:
- Establish or design a program to maintain the current condition or to prevent or slow further decline
- Also covers periodic reevaluations or reassessments
Maintenance Programs

• Skilled therapy services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of safe and effective services in a maintenance program.

Maintenance Programs

• Such skilled care is necessary for the performance of a safe and effective maintenance program only when:
  – the therapy procedures are required to maintain the patient’s current function or
  – to prevent or slow further deterioration
  – and are of such complexity and sophistication that the skills of a qualified therapist are required to furnish the therapy procedure;
Maintenance Programs

• Such skilled care is necessary for the performance of a safe and effective maintenance program only when:
  – the particular patient’s special medical complications require the skills of a qualified therapist to furnish a therapy service required to maintain the patient’s current function or
  – to prevent or slow further deterioration, even if the skills of a therapist are not ordinarily needed to perform such therapy procedures.

Maintenance Programs

• The deciding factors are always whether the services are
  – considered reasonable, effective treatments for the patient’s condition and require the skills of a therapist, or
  – whether they can be safely and effectively carried out by nonskilled personnel or caregivers.
Maintenance Programs

• Objective measures and tests in the form of valid and reliable functional tests and patient surveys are essential to making the case for the effectiveness of skilled care in the provision of maintenance programs.
  – This has been an essential element of Medicare’s documentation requirements since 2007 but most therapists did not comply
  – The result: increased RAC activity and the FLR program

Required documents in the Medicare program

• Evaluation and POC
• Certification and re-certification (if indicated)
• Progress Reports and D/C Progress Reports – may be included in Treatment Notes if required elements are included
• Treatment Notes for each treatment day
• Optional Therapy Cap Justification Statement
Elements of critical decision making

The therapist needs to consider the following factors:

– The effect of treatment on the patient’s primary condition
– The patient’s complexities: comorbidities in the form of other current (non-PT) conditions, preexisting conditions, and social situation
– The status of the patient’s comorbidities and primary condition on ability to function

Elements of critical decision making for maintenance therapy

– The probability that changes in function will result in increased impairments, more activity/participation restrictions if therapy is stopped
– The ability of the patient with the help of unskilled assistance, to manage a program to maintain function.
– Whether the skills of a therapist are necessary for the patient to carry out the program.
Elements of critical decision making

Documenting clinical reasoning is evidenced through consideration of
1. Analysis of scores of functional assessment
2. Objective data on impairments like pain, strength, ROM, balance etc.
3. Impact of comorbidities and social/environmental factors on the patient’s function and ability to participate

Documentation strategy

Capturing clinical insight and analysis:

- The difficulties:
  - What to write
  - How to say it
  - Preserving the patient-specific nature
  - Helping the reviewer draw the same clinical conclusions based on what you report about your assessment and clinical reasoning
Documentation strategy

Answer the questions payers want to know each time you document:

1. What did you do?
2. Why did you do it?
3. How is it helping and how do you know?
4. How much more or longer do you need to do it?

These must be specific to each patient

Thinking like a reviewer

• Why ICF can help you
  – International Classification of Functioning, Disability and Health
  – *functioning* refers to all body functions, activities and participation,
  – *disability* is similarly an umbrella term for impairments, activity limitations and participation restrictions.
International Classification of Function (ICF)

Health Conditions

Body Function and Structure Impairments

Activities Limitations

Participation Restrictions

Environmental Factors

Personal Factors

Figure 1: ICF Model

Health Condition

Body Functions and Structures (impairments) (bones, ligaments, muscles sensation, circulation, etc)

Activity (Limitation) (speaking, walking, jumping, etc)

Participation (Restriction) (work, social, athletic, etc roles)

Environmental Factors (living conditions, occupational situation, social circumstances, climate, etc)

Personal Factors (age, comorbidities, personality, etc)

ICF

The diagram identifies the three levels of human functioning classified by ICF:

– At the level of body or body part, the whole person, and the whole person in a social context.
– Disability involves dysfunctioning at one or more of these same levels: impairments, activity limitations and participation restrictions.

ICF: Terms to focus your thinking

• **Impairments** are problems in body function or structure such as a significant deviation or loss.

• **Activity** is the execution of a task or action by an individual.

• **Participation** is involvement in a life situation.

• **Activity Limitations** are difficulties an individual may have in executing activities.

• **Participation Restrictions** are problems an individual may experience in involvement in life situations.
Patellofemoral Pain Example

• Pick the right measure: one that’s valid in your patient population....
  – LEFS
  – Initial visit score: 52/80
  – After 3 weeks (7 visits): 72/80

See PTNOW.org for suggestions of measures valid in your patient population
ICF: Terms to focus your thinking

Your primary objectives in documentation:
• Identify patient specific impairments
• Link these impairments to patient specific problems in the evaluation process
• Demonstrate the effect on function by identifying Activity Limitations and Participation Restrictions
• Measure these with OTMs and demonstrate progress or maintenance of function

Evaluation: Essential questions

• Reason for the referral?
• Has there been a change in activity level or medical condition (especially if condition is chronic)?
• Identified the impairments and resulting activity limitations and participation restrictions?
• Is baseline functional status objectively measured?
Documentation Information to Meet Medicare Requirements

• Evaluation, Re-evaluation, and Plan of Care
  – Evaluation or Eval including the POC should document the necessity for a course of therapy through objective findings and subjective patient self-reporting.
  – Can be done only by a therapist
  – May include objective measurements or observations made by assistants within their scope of practice but clinical assessment and judgment is the responsibility of the therapist.
  – Should include a list of conditions and complexities, and, when not obvious, describe their impact on the prognosis and plan for treatment.

• Evaluation continued
  – Include the body part and all conditions and complexities that may impact treatment
  – Complexities may include:
    • Comorbidities
    • Premorbid functional levels
    • Date of onset
    • Current functional levels
    • Functional Limitation G-codes and modifiers required
Diagnosis

Represents a label that identifies the impact of a condition and complexities on the patient's ability to function

• At the movement system level
• At the whole person level

These affect activities and participation and quality of life and should lead naturally to patient problems

Documentation Information to Meet Medicare Requirements

**Plan of Care** should contain:
- Summary of patient problems, prior level of function, and pertinent medical history
- Diagnosis(s) that require physical therapy
- Therapeutic interventions to be used
- Frequency of treatment (“tapering” is allowed)
- Duration of treatment in weeks
- Long term treatment goals (*these must be specific and measurable*)
- Functional Limitation G-codes and modifiers required
- **Must be signed and dated by therapist and physician**
POC
Record clinical reasoning to connect the dots from/to:

– Impairments identified in the evaluation
– Interventions that address the impairments
– Activity limitations/Participation Restrictions caused by the impairments ( = decreased function)
– Measure the current level of function
– Design goals that address the activity limitations/participation restrictions that can be measured with OTMs

POC Goals

• Goals are not impairment based
• They are measureable by re-evaluation or assessment use of OTMs
• Related to activity limitations and participation restrictions identified
• Include anticipated timeframes for achievement
• State in functional terms specific to the patient
POC Goals

- Related to the outcome of the episode not the certification period
- Patient focused
- Identify the skilled activities or interventions needed to achieve the goals
- Each goal should be tied to a specific problem
- Each goal should have measureable function
- How will it improve quality of life

Arthritis

- Pain – McGill Quest, VAS, WOMAC
- Strength – dynamometer
- Postural Evaluation
- Sit to stand
- Walking
- Balance
- Dexterity – pegboard test
- Dressing
- Eating
- Socializing
- Hobbies

Environmental Factors

Personal Factors

Physical Performance Test (PPT)

Health ABC Performance-Based Measures

Beg Balance Test
Goal examples

- Improve ROM to WNL and strength to 4/5 in 2 weeks
- Improved balance so patient can do ADLs independently in 2 weeks
- UE functional improvement as evidence by change in Dash Score from 50 to 35 in 2 weeks
- Improve standing balance with TUG changing from 20 sec to 12 sec in 2 weeks
Prognosis

- The prognosis is the determination of the predicted optimal level of improvement in function reflected in the goals and
- the amount of time needed to reach that level, and
- may include a prediction of levels of improvement that may be reached at various intervals during the course of therapy.

Guide to Physical Therapist Practice

Prognosis

- prognosis conveys the physical therapist’s professional judgment for
  - the patient’s/client’s predicted functional outcome and
  - the required duration of services to obtain this functional outcome.
Prognosis

• It is important to differentiate between the patient’s/client’s medical prognosis and his/her rehabilitation prognosis.
• It is important to consider the prognosis for the entire episode of care and not just one specific timeframe
• Document your clinical reasoning reflecting these points

Questions and comments....

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