How Documentation and Coding Effect Pressure Injury Rates

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8/23/18
Objectives

- Understand the impact of documentation and coding on pressure injury rates.
- Identify possible solutions to help define true clinical opportunities vs documentation and/or coding opportunities.
Rules of Coding

• “ICD-10-CM Official Guidelines for Coding and Reporting”
  • Developed by CMS and National Center for Health Statistics (NCHS)
  • Approved by the Cooperating Parties
    • AHA, AHIMA, CMS and NCHS
  • Accompany and complement official conventions and instructions in ICD-10-CM itself

• Official conventions and instructions within the ICD-10-CM itself
  • Coding and sequencing guidelines
  • Inclusion, exclusion and code with or also guidance
  • These take precedence over the Official Guidelines

• Mandated by HIPPA – to be used across all healthcare settings

• “AHA Coding Clinic”
  • Approved by the Cooperating Parties
  • Latest official coding advice to help with consistency and accuracy of code assignment
Pressure Injury Code Assignment

- Components needed to assign an accurate pressure injury code:
  - Site
  - Stage (I - 4, unstageable, unspecified)
  - Present on Admission status

- Separate codes are assigned for each pressure ulcer identified and to indicate stage progression.
  - Approximately 150 ICD-10 codes are available to identify pressure injuries
  - Laterality specificity has contributed to the increased number of codes available
Documentation and Coding Go Hand in Hand

“If it isn’t documented it can’t be coded”

- Code assignment is based on a licensed treating provider’s documentation, with a few exceptions.

- Official Guidelines for Coding and Reporting
  General Coding Guideline Chapter 12 a. 1-6:
  - Allows Coders to assign the stage of the pressure ulcer based on clinicians who are not the patient’s treating provider (e.g. WOC nurses).

- “However, the associated diagnosis (….pressure injury) must be documented by the patient’s provider.”
  - Frequently the documentation of these ulcers is noted only in the WOC notes, often they are the ones actively treating the ulcer. In the electronic record these notes are not always located within the progress note section of the chart and easily overlooked. This has been both an ICD-9 and ICD-10 issue.
  - Clinical Documentation Improvement(CDI) programs have helped providers improve the documentation of pressure ulcers through the concurrent query process. This has resulted in an increased number of coded pressure ulcers.
Present on Admission Status

• Pressure injury evolving into another stage during admission

  • **Official guidelines Chapter 12 #6:**
    • If a patient is admitted to an inpatient hospital with a pressure ulcer at one stage and it progresses to a higher stage, **two separate codes should be assigned:** one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay.

  • **Coding Clinic 4Q 2016:**
    
    **Question:** What is the correct diagnosis code and present on admission (POA) indicator for a patient admitted to the hospital with a **stage 2 pressure ulcer of the left heel that worsens during the hospitalization and becomes a stage 3 ulcer**?

    **Answer:** Assign code L89.622, Pressure ulcer of left heel, stage 2, for the site and stage of the ulcer on admission. Assign code L89.623, Pressure ulcer of left heel, stage 3, for the site and highest stage of the ulcer reported during the admission. **Report a POA indicator of “Y” for code L89.622,** Pressure ulcer of left heel, stage 2; and a **POA indicator of “N” for code L89.623,** Pressure ulcer of left heel, stage 3, to reflect that the pressure ulcer was a stage 2 on admission, but progressed to stage 3 during the hospitalization.
Unstageable Pressure Injury

AHA Coding Clinic® 4Q 2017

Question:
What are the correct ICD-10-CM codes and POA indicator for an unstageable pressure ulcer in which an eschar is removed during the patient’s stay to reveal either stage III or stage IV pressure ulcer?

Answer:
If a patient is admitted with an unstageable pressure ulcer, and the eschar is removed to reveal the stage of the ulcer, assign the code for the ulcer site with the highest stage reported during the stay with a POA indicator of “Y”. Do not assign a code for unstageable pressure ulcer, as the true stage of an unstageable ulcer cannot be determined until the slough/eschar is removed. The opening of the wound does not indicate a progression to a higher stage. The code for unstageable pressure ulcer should only be assigned when it is not possible to stage the ulcer during the current encounter.

Area of Opportunity:
- The coding of unstageable pressure ulcers of one site and the coding of the same site as a staged pressure ulcer should be reviewed.
- Refer to Coding Clinic 4Q 2017 guidance
- If the same site has been coded with an unstageable code with a POA of Y and then the same site with a stage with a POA of N this could account for additional pressure ulcers not present on admission captured.
Kennedy Ulcers

- A type of pressure injury that occurs at the end of life and is related to multiorgan failure. Most often located in sacral region.

- **Current Coding Clinic guidance: 2Qtr. 2018**
  - “Assign the appropriate code from category L89, Pressure ulcer, for a Kennedy ulcer.”
  - POA status would be “N” not present on admission
  - Proposal for creation of unique ICD-10 code to identify these is under consideration. Next Coordination and Maintenance meeting to be held on Sept. 11-12 – agenda has not been released yet.
Surveillance Data vs Coded Data

- Coded data *should have* all the pressure injuries identified via the surveillance process but the surveillance data will not have all those coded.
  - Surveillance data is once per month
  - Coded data will capture all patients discharged

**AREA of OPPORTUNITY:**
- Ensure site of pressure injury is consistently documented - buttock vs ischial vs hip; coccyx vs sacrum
Why Have Rates Increased?

- Changes between ICD-9 & ICD-10
  - # of codes
  - Guideline changes

- Implementation of Clinical Documentation Improvement (CDI) programs
  - Concurrent review of in-house records, query provider for documentation

- Changes to inclusion/exclusion criteria for PSI
  - V7.0 removes many of the exclusions included in V6.0
Data Quality vs Clinical Opportunity

Important to ensure coded data is accurate to be able to identify true clinical areas of opportunity.

- Perform pre-bill reviews of all charts coded with a Stage 3,4 or unstageable pressure injury coded with POA of N or U.
  - Verify POA status
  - Verify consistency of stage, query provider for clarification if necessary or have a one-on-one discussion
  - Look at the coding of unstageable ulcer to see if a staged ulcer of the same site is coded – only one or the other should be coded
  - Verify ischial ulcers are coded to ulcer of the buttock
- Review Official Coding Guidelines and Coding Clinics for the most updated guidance.
- Develop internal coding and documentation guidelines to promote consistency and understanding amongst coding and CDI.
Quality Departments

• CDS and Coders are often unaware of quality initiatives and the impact of coding on these initiatives.
  ✓ Educate CDI and Coders
  ✓ Stress the importance of documentation and coding of chronic conditions for risk adjustment
  ✓ Show them the effect of coding

• Assign a person to review the PSI’s inclusions and exclusions, updates or changes and monitor coding impact.
Resources

- *ICD-10-CM Official Guidelines for Coding and Reporting*

- *AHA Coding Clinic for ICD-10-CM and ICD-10 PCS, 4Q 2016, Volume 3, Number 4, Pages 143-144*

- *AHA Coding Clinic for ICD-10-CM and ICD-10-PCS, 2Q 2018, Volume 5, Number 2, Pages 21-22*
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