The ICD–10 Project: Keys to Success

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(Slides for all 3 sessions)
Main References


- ICD–10–CM Official Guidelines for Coding and Reporting–2013, Centers for Disease Control (CDC), National Center for Health Statistics
  - http://www.cdc.gov/nchs/icd/icd10cm.htm

- Centers for Medicare & Medicaid Services ICD–10 page:

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- Assorted guidelines and concepts created and/or approved by the official ICD–10 Cooperating Parties:
  - American Hospital Association (AHA),
  - American Health Information Management Association (AHIMA),
  - Centers for Medicare and Medicaid Services (CMS), and
  - National Center of Health Statistics (NCHS)
Stated objectives

- Learn differences in ICD–10–CM and PCS and roadblocks to successful implementation
- How to get your project moving if it hasn’t started yet and/or how to maintain current progress
- How to inform, educate, and support coders/billers, IT staff, HR, finance, facility leadership, etc.
- Distinguish formal strategic planning principles within your Project Plan
Agenda

- Introduction

- **Part I = ICD-10-CM**
  - General Overview
    - Layout & Code Structure (*Alphabetic and Tabular*)
    - Sample Coding Guidelines

- **Part II = CDI Overview**

- **Part III = ICD-10-PCS**
  - General Overview
    - Code Structure/Design
    - Sample Coding Guidelines and Definitions

- **Part IV = Where Do We Go From Here?**
HHS Confirms Final Implementation Date for ICD–10 for the last time?

- HHS announces original intent to consider a delay of the ICD–10 compliance date on February 15, 2012.
- The primary reasons for the proposed delay were stated to be issues with 5010 implementation and the need to carefully develop testing plans.
- On August 24, 2012 HHS announced the one year delay would move the implementation one year to October 1, 2014 for printing in the Federal Register on September 5, 2012.
  - They estimate a 10–30% increase in costs for those who already began active planning.
  - Which planning stage are you in?
- Opinion: This is a firm go–live date.
The last regular, annual updates to both ICD–9–CM and ICD–10 code sets were made on October 1, 2011.

On October 1, 2012 and October 1, 2013 there will be only limited code updates to both the ICD–9–CM and ICD–10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108–173.

On October 1, 2014, there will be only limited code updates to ICD–10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108–173. There will be no updates to ICD–9–CM, as it will no longer be used for reporting.

On October 1, 2015, regular updates to ICD–10 will begin.

Source:
Introduction

- The sky is not falling…

  While ICD–10 (CM and PCS) does pose numerous challenges to all constituents of the healthcare industry, many of the general concepts utilized to successfully select ICD–9 codes may be applied to ICD–10.

  The major challenge lies with understanding the concepts described in ICD–10–CM and ICD–10–PCS and how they translate from the codes we have become accustomed to…

  * ICD–10 will impact all aspects of the revenue cycle and requires increased proficiency with patient intake, will increase the importance of provider documentation throughout the claims process, affects third party contracting, and may increase appeals in the short–term.
Major Impact Areas

1. Organizational Awareness
2. Strategic Planning and Project Management
3. Financial Implications
4. EMR/EHR Interfaces/meaningful Use/PQRI
5. Affect on Payments – “budget neutrality”
6. Vendor Relationships
7. Education and Training

CMS Project Phases: Planning, Communications and Awareness, Assessment, Implement, Test, Transition
PART I

ICD–10–CM General Overview
Why The Need For ICD–10?

- ICD–9 does not facilitate the continued need for greater coding detail and can not continue to accommodate the addition of necessary diagnostic codes.

- Health information technology (HIT) brings with it the need to enhance the diagnostic code set to meet the international standards for which ICD was created.

- The ICD–10 code set will allow for greater measurement and tracking of quality outcomes.
  
  - ICD–9 has simply become substandard in relation to international reporting principles.
ICD–10–CM Basics

- ICD–10–CM coding guidelines will only impact those constituents of the healthcare industry who currently use ICD–9–CM (Volumes 1 and 2) to report diagnostic codes identifying signs, symptoms, established acute or chronic conditions, etc. documented by qualified care providers.
  - Physicians and other care professionals will continue to use the CPT and HCPCS–2 codes to report the services that they perform.
  - Hospitals reporting to Medicare Part A and other payors for their assorted daily inpatient/facility services will not use ICD–10–CM for payment purposes, rather they will use ICD–10–PCS.
## Comparison of Clinical Modifications

<table>
<thead>
<tr>
<th>ICD–9–CM</th>
<th>ICD–10–CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three to five characters</td>
<td>Three to seven characters</td>
</tr>
<tr>
<td>First digit is numeric but can be alpha (E or V)</td>
<td>First character always alpha</td>
</tr>
<tr>
<td>2–5 are numeric</td>
<td>All letters used except U</td>
</tr>
<tr>
<td>Always at least three digits</td>
<td>Character 2 always numeric: 3–7 can be alpha or numeric</td>
</tr>
<tr>
<td>Decimal placed after the first three characters (or with E codes, placed after the first four characters)</td>
<td>Always at least three digits and the decimal placed after the first three characters</td>
</tr>
<tr>
<td>Alpha characters are not case-sensitive</td>
<td>Alpha characters are not case-sensitive</td>
</tr>
</tbody>
</table>
ICD–10–CM/PCS Growth of Codes
Code Structure: ICD–10–CM

1st - Alpha (Except U)

2nd Numeric

3 - 7 Numeric or Alpha

“Base code”

Watch explanatory notes!

Watch for the “dummy” placeholder in the 5th and/or 6th!

Added code extensions (7th character) for obstetrics, injuries, and external causes of injury
### Example of a 7th digit and a dummy placeholder

<table>
<thead>
<tr>
<th>Injury and External Cause – Identifies Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial</strong> – receiving active treatment</td>
</tr>
<tr>
<td><strong>Subsequent</strong> – receiving routine care during healing or recovery (after active treatment)</td>
</tr>
<tr>
<td><strong>Sequela</strong> – complications or conditions arising as result of injury</td>
</tr>
</tbody>
</table>

**EXAMPLE**
- V91.07
- A burn due to water-skis on fire, *initial*
- Is it work-related?
- Place of Occurrence?
- Civilian or Military?
Some Enhancements Of ICD-10-CM

- Addition of information related to ambulatory and managed care encounters
- Expanded injury codes, grouped by anatomic site(s) rather than injury category (E-codes are no longer)
- Combination diagnosis/symptom or manifestation codes to reduce number of codes needed to fully describe conditions
- Combination codes for poisonings and external causes
- Additions of 6th and 7th characters—7th digit to describe visit encounter or sequelae for injuries and external causes
- Laterality (right, left, bilateral, etc.)
- Full code titles for 4th and 5th digits—no more need to refer back to common 4th/5th digits for full code description
- V-codes and E-Codes are no longer supplemental classifications
- Postoperative complications are now grouped anatomically
ICD–10–CM Training before go–live

- Various parties have estimated that *approximately 16 hours of coding training are likely needed for each coding manager to learn ICD–10–CM.*
  - More is required for those actively involved in coding each day

- Estimate at least 2–3 hours of in–depth education *for each specialty section* of purely coding training and that doesn’t include billing training!
  - We haven’t received any billing guidance yet which will require far more education and training for everyone in many areas of the revenue cycle

- All affected parties will need to *refresh or expand* on coders’ knowledge in the biomedical sciences (anatomy, physiology, pharmacology, and medical terminology).
Section I:

C. Chapter Specific Coding Guidelines

- Chapter 1: Infectious and Parasitic Disease (A00–B99)
- Chapter 2: Neoplasms (C00–D49)
- Chapter 3: Diseases of Blood and Blood Forming Organs (D50–D89)
- Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00–E89)
  - Diabetes is located in this section (E08–E13)
- Chapter 5: Mental and Behavioral Disorders (F01–F99)
- Chapter 6: Diseases of the Nervous System and Sense Organs (G00–G99)
- Chapter 7: Diseases of the Eye and Adnexa (H00–H59)
- Chapter 8: Diseases of the Ear and Mastoid Process (H60–H95)
- Chapter 9: Disease of the Circulatory System (I00–I99)
  - Hypertension is located in this section (I10–I15), R03.0 for elevated BP (ICD–9 code 796.2)
- Chapter 10: Diseases of the Respiratory System (J00–J99)
- Chapter 11: Diseases of the Digestive System (K00–K94)
- Chapter 12: Diseases of Skin and Subcutaneous Tissue (L00–L99)
- Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00–M99)
Section I:  
C. Chapter Specific Coding Guidelines

- Chapter 14: Diseases of the Genitourinary System (N00–N99)
- Chapter 15: Pregnancy, Childbirth, Pueperium (O00–O9A)
  - OB, Delivery and Postpartum Services
- Chapter 16: Newborn (Perinatal) Guidelines (P00–P96)
  - Newborn services and reporting stillborns
- Chapter 17: Congenital Malformations, Deformations, and Chromosomal Abnormalities (Q00–Q99)
  - Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00–R99)
    - Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.
- Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00–T88)
- Chapter 20: External Causes of Morbidity (V01–Y99)
- Chapter 21: Factors Influencing Health Status and Contact With Health Services (Z00–Z99)
The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government’s Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD–10–CM). These guidelines should be used as a companion document to the official version of the ICD–10–CM as published on the NCHS website. The ICD–10–CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings.

These guidelines have been created and approved by the Cooperating Parties:

- American Hospital Association (AHA),
- American Health Information Management Association (AHIMA),
- Centers for Medicare and Medicaid Services (CMS, and
- National Center of Health Statistics (NCHS)

“Adherence to these guidelines is a HIPAA requirement” – USE CAUTION though as billing guidance from Medicare, Medicaid, or 3rd party payors could be different!
“A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.”

“The importance of consistent, complete documentation in the medical record cannot be overemphasized.”

“In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis.”
What Will Not Change With ICD–10–CM

- Code **reason for visit** first
- Code to the **highest level of known specificity**
- **Don’t code** “probable, suspected, questionable or rule out”
- Code **chronic diseases** as often and as long as the patient receives treatment for them
- Code coexisting conditions affecting patient care at the **time of the visit**
How To Locate An ICD–10–CM Code

To properly select a code in the classification that corresponds to a diagnosis or reason for the patient encounter, documented in a medical record must be clear...

1. First, locate the term in the Alphabetic Index
2. Next, verify the code in the Tabular List

- Always consult the instructional notations that appear in both the Index and the Tabular List
NEW for ICD-10 = Excludes–

- **Excludes 1** – used when 2 codes cannot occur together (e.g., congenital versus acquired)

- **Excludes 2** – used when 2 codes may occur together but separate documentation is required of each condition

Chest Pain:

**Alphabetic Index:**
- Pain
- Chest
- On breathing R07.1

**Tabular List:**
- R07 Pain in throat and chest
  - **Excludes 1**: epidemic myalgia (B33.0)
  - **Excludes 2**: pain in breast (N64.4)
- R07.1 Chest pain on breathing
  - Painful respiration
New for ICD–10–CM: Sequela (Late Effects)

- A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used...

- Coding of sequela generally requires two codes sequenced in the following order: The condition or nature of the sequela is sequenced first. The sequela code is sequenced second.

- An exception to the above guidelines are those instances where the code for the sequela is followed by a manifestation code identified in the Tabular List and title, or the sequela code has been expanded (at the fourth, fifth or sixth character levels) to include the manifestation(s).

- The code for the acute phase of an illness or injury that led to the sequela is never used with a code for the late effect.

SOURCE: 2012 ICD–10–CM Coding Guidelines
Part II

CDI – General Overview
ICD-10-CM/PCS Growth of Codes

[Bar chart showing growth of codes for Diagnosis and Procedure across different ICD-9-CM, ICD-10-CM, ICD-10 (WHO), ICD-9-CM, ICD-10-PCS, ICD-10 (WHO).]
Improving the clinical documentation will be a requirement of the ICD-10 transition. Does it really need to start now?

Well Melinda Tully, MSN, CCDS, CDIP, Vice President of Clinical Services & Education, J.A. Thomas & Associates, a Nuance company, illustrates the point with a standing joke in the industry: "Once physicians learn to document, you won't need [clinical documentation specialists] anymore." The likelihood of that happening has Tully predicting that the CDS position "has the biggest job security in the world."

[See also: Top 5 initiatives to make a successful ICD-10 transition]

There are plenty of diagnoses that can be better documented now, she says. And she lists five diagnoses that give documentation specialists the most problems:

- Heart failure is "the bane of existence for every documentation specialist."

- Pneumonia is a high-volume opportunity for documentation queries.

- Renal failure is a problem "because you can document renal failure in so many different ways."

- Respiratory failure has the same issue as renal failure.

- Acute hypovolemia very often is under reported. "I have been doing this for 14 years, and you still have to ask surgeons that have just repaired a big femur fracture if you have to give them three or four units of blood if the patient had acute hypovolemia."
Why So Many Diagnosis Codes?

Greater specificity and detail:

- 34,250 (50%) of all ICD–10–CM codes are related to the musculoskeletal system.
- 17,045 (25%) of all ICD–10–CM codes are related to fractures.
- 10,582 (62%) of fracture codes distinguish right from left.
- 25,000 (36%) of all ICD–10–CM codes distinguish right from left.

Why Is Clinical Documentation Improvement Necessary?

» In ICD–9, there is 1 code for “Mechanical complication of other vascular device, implant and graft” (996.1)

> In ICD–10, there are 49 codes for “Mechanical complication of other vascular grafts”
  • T82.---- (based on type of graft–must be documented)
  • 7th digit identifies initial encounter, subsequent, sequela

» In ICD–9, there are 9 codes for Pressure Ulcers ranging from (707.00 – 707.09)
  • depth (stage) not specified

> In ICD–10, there are 150 codes for Pressure Ulcers that are all site specific and do specify depth (stage)
  • L89.---
Human Immunodeficiency Virus (HIV)

- Code only confirmed cases (*just like ICD–9–CM*)
- Provider’s assessment must state HIV “positive”
- If patient is admitted for HIV–related condition, HIV (*B20*) is sequenced as “principle diagnosis”
  - Additional *ICD–10–CM codes will be sequenced second, third, etc.*
- If the patient is admitted for unrelated condition, that condition/disease is listed as “principle” or primary.
- *Z21 (asymptomatic HIV)* is to be reported without current symptoms for HIV positive patients without active manifestations of AIDS
- When would O98.7 be necessary?
- Report R75 if inconclusive laboratory test(s)
Documentation Improvements: Streptococcal Tonsillitis / Pharyngitis

Streptococcal sore throat:

- **In ICD–9–CM,**
  - 034.0—used to report *both* streptococcal pharyngitis (*sore throat*) and streptococcal tonsillitis

- **In ICD–10–CM,**
  - J02.0—Streptococcal pharyngitis
  - J03.00—Acute streptococcal tonsillitis, unspecified
  - J03.01—Acute recurrent streptococcal tonsillitis
Streptococcal Sore Throat

- No distinction between streptococcal pharyngitis (sore throat) and streptococcal tonsillitis

- 034.0 – Streptococcal sore throat

<table>
<thead>
<tr>
<th>ICD–9–CM</th>
<th>ICD–10–CM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Documentation must specify pharyngitis (sore throat) or tonsillitis</td>
</tr>
<tr>
<td></td>
<td>Streptococcal tonsillitis must be documented as:</td>
</tr>
<tr>
<td></td>
<td>• Recurrent</td>
</tr>
<tr>
<td></td>
<td>• Not recurrent (unspecified)</td>
</tr>
<tr>
<td></td>
<td>• J02.0 – streptococcal</td>
</tr>
<tr>
<td></td>
<td>pharyngitis</td>
</tr>
</tbody>
</table>
## Scarlet Fever

<table>
<thead>
<tr>
<th>ICD–9–CM</th>
<th>ICD–10–CM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>O34.1</strong> – Scarlet Fever</td>
<td><strong>A38.0</strong> – Scarlet fever with otitis media</td>
</tr>
<tr>
<td>This is the only code in ICD–9–CM that is used to report scarlet fever</td>
<td><strong>A38.1</strong> – Scarlet fever with myocarditis</td>
</tr>
<tr>
<td>In ICD–10–CM, there are combination codes to report scarlet fever with complications</td>
<td><strong>A38.8</strong> – Scarlet fever with other complications</td>
</tr>
<tr>
<td>• Otitis media</td>
<td><strong>A38.9</strong> – Scarlet fever, uncomplicated</td>
</tr>
<tr>
<td>• Myocarditis</td>
<td>Report combination codes when appropriate.</td>
</tr>
<tr>
<td></td>
<td>In ICD–9–CM, would need to report 2 codes for scarlet fever (O34.1) and otitis media (381.00)</td>
</tr>
</tbody>
</table>
Sepsis

» New changes when reporting Sepsis, SIRS, Septicemia, and Septic Shock:
   > In ICD–10–CM, “septicemia” is replaced with “sepsis”
   > An unqualified diagnosis of septicemia will be reported A41.9 (sepsis, unspecified) if the infection or causal organism is not further specified
   > Most common form of sepsis is streptococcal sepsis
     • A40.0– Sepsis due to streptococcus, Group A
     • A40.1– Sepsis due to streptococcus, Group B
     • A40.3– Sepsis due to streptococcus pneumoniae
     • A40.8– Other streptococcal sepsis
     • A40.9– Streptococcal sepsis, unspecified
   > R65.2 should only be used as a secondary diagnosis if “severe” sepsis or an acute organ dysfunction is documented

» Reporting will depend on:
   > Postprocedural?
   > Occurrence
Diabetes Coding in ICD-10:
E08 Diabetes due to underlying condition
E09 Drug or chemical induced diabetes
E10 Type I diabetes
E11 Type II diabetes
E13 Other specified diabetes
E14 Unspecified diabetes

Combination codes listed under each category include manifestations so there is likely no need to list them separately
Diabetes documentation and coding will need to include:

➤➤ Type or cause of diabetes:
   -- Type 1
   -- Type 2
   -- Due to drugs or chemicals
   -- Due to underlying condition
   -- Other specified diabetes

➤➤ Body system complications related to diabetes, such as kidney or neurological complications

➤➤ Combination codes include diabetes and the manifestation

➤➤ Specific complications, such as:
   -- Chronic kidney disease
   -- Foot ulcer
   -- Hypoglycemia without coma

SOURCE: AHIMA Documentation Tip Sheet: Diabetes –
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049431_hcsp?dDocName=bok1_049431#clinical
Diabetes– Clinical Example

A 68 year old woman with poorly controlled DM II presents with an ulcer on her left foot. There is a significant breakdown of the skin. The patient is insulin dependent and has a history of non-compliance. Patient acknowledges that she is still not following her diet. Random blood glucose taken this office visit is 300 mg/dL. A1c = 9.0%.

- **ICD–9**
  - 250.82 Diabetes with other specified manifestations
  - 707.15 Ulcer of lower limbs, except pressure ulcer, ulcer of other part of the foot
  - V58.67 Long term use of insulin
  - V15.81 Non–compliance with medical treatment

- **ICD–10**
  - E11.621 **Type 2** diabetes mellitus with foot ulcer
  - E11.65 **Type 2** diabetes mellitus with hyperglycemia
  - L97.522 Non–pressure chronic ulcer of other part of left foot
  - Z79.4 Long term (current) use of Insulin
  - Z91.11 Patient’s noncompliance with dietary regimen

- **Source: InQuiseek Consulting**
Some Specific Differences
(Document to Support HTN & DM Coding)

- **Unspecified hypertension:**
  - ICD–9–CM 401.9
  - ICD–10–CM I110

- **Diabetes:**
  - ICD–9–CM (Type II, not controlled) 250.00
  - ICD–10–CM (Type II, not controlled) E11.9
  - ICD–9–CM (unspecified, not controlled) 250.02
  - ICD–10–CM (unspecified, not controlled) E11.65
Chapter 9: Diseases of Circulatory System

Myocardial Infarctions (MI)

» From onset regardless of setting:
   > - In ICD–9: 8 weeks
   > - In ICD–10: 4 weeks (28 days)

» Otherwise use aftercare codes or I25.2 for ____________

» I121.01 ST Elevation (STEMI) myocardial infarction of anterior wall involving left main coronary artery.

» When are I22 and I21 used together?

**Also code, tobacco use or exposure or history of use if ____________.

Hypertensive Heart and Chronic Kidney Disease (CKD)

- New combination codes
- Hypertensive heart and hypertensive kidney disease must be stated in diagnosis.

» I13.0 Hypertensive heart and chronic kidney disease with heart failure and stage 1–4 chronic kidney disease or unspecified stage chronic kidney disease.
# Documentation Improvements: Pain in Joint (Laterality)

<table>
<thead>
<tr>
<th>Pain in Joint</th>
<th>5&lt;sup&gt;th&lt;/sup&gt; digit</th>
<th>Joint</th>
</tr>
</thead>
<tbody>
<tr>
<td>719.4 X</td>
<td>1</td>
<td>Shoulder</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Upper arm</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Forearm</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Hand</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Pelvis/hip</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Lower leg</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Ankle/foot</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Other specified</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Unspecified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pain in Joint</th>
<th>Laterality</th>
<th>Joint</th>
</tr>
</thead>
<tbody>
<tr>
<td>M25.51 X</td>
<td>1, 2, 9</td>
<td>Shoulder</td>
</tr>
<tr>
<td>M25.52 X</td>
<td>1, 2, 9</td>
<td>Elbow</td>
</tr>
<tr>
<td>M25.53 X</td>
<td>1, 2, 9</td>
<td>Wrist</td>
</tr>
<tr>
<td>M25.55 X</td>
<td>1, 2, 9</td>
<td>Hip</td>
</tr>
<tr>
<td>M25.56 X</td>
<td>1, 2, 9</td>
<td>Knee</td>
</tr>
<tr>
<td>M25.57 X</td>
<td>1, 2, 9</td>
<td>Ankle and Foot</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1=Right</th>
<th>2=Left</th>
</tr>
</thead>
<tbody>
<tr>
<td>9=UNSPEC</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue

» Use “multiple sites” codes if a condition affects more than one bone, joint, or muscle

» If a condition affects the end of a bone where the joint is located, the site designation is the bone not the joint

» Look out for acute traumatic, chronic, or recurrent

» 7th digits identify Active treatment (A) vs. Subsequent (D) treatment which are different than complications such as non-unions or malunions

» Fractures not open or closed should be coded as _______

» Fractures not displaced or non-displaced are coded as _____

> See the Coding of Traumatic Fractures in Chapter 19 – S-codes
> When to use M80?
Chapter 15: Pregnancy, Childbirth, and the Puerperium

- If a condition is documented as incidental to the pregnancy, use code Z33.1 instead of a code from this section
  - Routine outpatient care uses Z34, why use O09 and Z37?
- These codes are never used for the newborn’s record
- If there is a complication with a fetus, 7th digits may be used for number of fetuses, if known or documented
- 7th digits are used for trimester of occurrence
- If an inpatient admission occurs that spans more than one trimester, then use the 7th digit for when the condition ____________ (started or when discharged?)
Chapter 18: Symptoms, signs, and abnormal clinical and lab findings, not elsewhere classified

- **789.00** – Abdominal pain, unspecified site
- **789.03** – Abdominal pain, right lower quadrant
- **789.04** – Abdominal pain, left lower quadrant
- **789.07** – Abdominal pain, generalized

- **R10.9** – Unspecified abdominal pain
- **R10.0** – Acute abdomen (severe abdominal pain)
- **R10.30** – Lower abdominal pain, unspecified
- **R10.31** – Right lower quadrant pain
- **R10.32** – Left lower quadrant pain
- **R10.84** – Abdominal pain, generalized
Documentation Improvements: Back Pain, Radiculitis & Neck Pain

- **724.2** – Lumbago
- **724.4** – Thoracic or lumbosacral neuritis or radiculitis, unspecified
- **723.1** – Cervicalgia
- **M54.5** – Low back pain
- **M51.14** – Intervertebral disc disorders with radiculopathy, thoracic region
- **M51.15** – Thoracolumbar region
- **M51.16** – Lumbar
- **M51.17** – Lumbosacral
- **M54.14** – Radiculopathy, thoracic
- **M54.15** – Thoracolumbar
- **M54.16** – Lumbar
- **M54.17** – Lumbosacral
- **M54.2** – Cervicalgia
How Can You Prepare?

- Incorporate into query templates:
  - Glasgow (Coma Scale)
    - Need a score from each of the three assessment areas, NOT a total score
      - Eye opening
      - Verbal response
      - Motor response
  - Gustilo Open Fracture Classification
    - I, II, III, IIIA, IIIB, or IIIC
How Can You Prepare?

- Begin adding the following to queries:
  - Differentiation between general and focal seizures
    - General seizures require type specificity
    - Identify intractable (treatment-resistant) seizures
  - Trimester of pregnancy
    - Default to the trimester when the complication occurred, not the discharge trimester when an admission crosses trimesters
  - Identification of the substance related to adverse effect, poisoning, or toxic effect
Part III

ICD–10–PCS General Overview
ICD–10–PCS Basics

- ICD–10–PCS coding guidelines will only impact those constituents of the healthcare industry who currently use ICD–9–CM (Volume 3) to report inpatient procedures
  - PCS codes are expected to be mapped or tied to various DRGs that are tied to payments and cost reports
  - Physicians and other care professionals will continue to use the CPT, HCPCS–2, and ICD–10–CM codes to report their professional services in an outpatient basis and to services they provide to hospital and other facility inpatients
Many of the terms used to construct PCS codes are defined within the system. It is the coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.

Example: When the physician documents “partial resection,” the coder can independently correlate “partial resection” to the root operation Excision without querying the physician for clarification.
Extirpation represents a range of procedures where the body part itself is not the focus of the procedure. Instead, the objective is to remove solid material such as a foreign body, thrombus, or calculus from the body part.

- Note the potential confusion if a provider uses the words “excision” or “removal” in the medical record in conjunction with a procedure that should be reported as an extirpation!
General Structure of the PCS

- All codes in PCS are seven characters
- Letters O and I not used in PCS
  - Numbers 0 and 1 used
- Each character value has a specific meaning
- Meanings can change by section
- Section provides first character value
  (medical/surgical, medical-surgical related, and ancillary)
Overall ICD–10 PCS Organization


### Three sections of the ICD–10 PCS

- Medical–Surgical
- Medical–Surgical Related
- Ancillary
A quick peek at an ICD–10–PCS table

<table>
<thead>
<tr>
<th>Body Part Character 4</th>
<th>Approach Character 5</th>
<th>Device Character 6</th>
<th>Qualifier Character 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Cerebral Ventricle</td>
<td>0 Open</td>
<td>7 Autologous</td>
<td>0 Nasopharynx</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tissue Substitute</td>
<td>1 Mastoid Sinus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J Synthetic</td>
<td>2 Atrium</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substitute</td>
<td>3 Blood Vessel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>K Nonautologous</td>
<td>4 Pleural Cavity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tissue Substitute</td>
<td>5 Intestine</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6 Peritoneal Cavity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>7 Urinary Tract</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>8 Bone Marrow</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>B Cerebral Cisterns</td>
</tr>
<tr>
<td>U Spinal Canal</td>
<td>0 Open</td>
<td>7 Autologous</td>
<td>4 Pleural Cavity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tissue Substitute</td>
<td>6 Peritoneal Cavity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J Synthetic</td>
<td>7 Urinary Tract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Substitute</td>
<td>9 Fallopian Tube</td>
</tr>
<tr>
<td></td>
<td></td>
<td>K Nonautologous</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tissue Substitute</td>
<td></td>
</tr>
</tbody>
</table>

The values of characters 1 through 3 are provided at the top of each table. Four columns contain the applicable values for characters 4 through 7.
ICD–10–PCS: Medical–Surgical Code Structure

Objective of procedure
- 31 Root operations
- Arranged by similar attributes
- Multiple codes
- **CAUTION:** They are easily confused and may differ from the documentation!

Root Operations Examples:
- Bypass
- Drainage
- Extirpation
- Resection
- Inspection
- Removal
Study your Root Operation Guidelines

Section

- B3.1a  • Full definition
- B3.1b  • Integral to procedure
- B3.2   • Multiple procedures
- B3.3   • Discontinued procedures
- B3.4   • Biopsy followed by treatment
- B3.5   • Overlapping body layers
ICD–10–PCS: Selecting the Approach

<table>
<thead>
<tr>
<th>Character 1</th>
<th>Character 2</th>
<th>Character 3</th>
<th>Character 4</th>
<th>Character 5</th>
<th>Character 6</th>
<th>Character 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section</td>
<td>Body System</td>
<td>Root Operation</td>
<td>Body Part</td>
<td>Approach</td>
<td>Device</td>
<td>Qualifier</td>
</tr>
</tbody>
</table>

Through the skin or mucous membranes
- Open
- Percutaneous
- Percutaneous Endoscopic

Through an orifice
- Via Natural or Artificial Opening
- Via Natural or Artificial Opening Endoscopic
- Via Natural or Artificial Opening With Percutaneous Endoscopic Assistance
Part III

Where Do We Go From Here?
Checklist For Planning ICD–10 Transition

- Per CMS, here is a checklist for smooth transition:
  - Identify all electronic and paper systems/tools that encompass ICD–9 codes (identify changes to workflow processes)
    - Templates and forms
    - Practice management systems & EHR
    - Public health and quality reporting initiatives (e.g., PQRI)
  - Communicate with vendors to ensure accommodations for both version 5010 and ICD–10 codes
    - Check to see if system upgrades are included in agreement
  - Open lines of communication with your vendors
    - Payers, clearinghouses, billing service companies, etc.
  - Check with payers to determine any potential changes to contracts, fee schedules and reimbursement
  - Assess your staff training needs – use eLearning!!!
  - Budget time and cost of implementation
    - Software updates, reprinting forms, staff training, etc.
  - Conduct test transactions
How can I “map” to the new codes?

- **General Equivalence Mapping (GEM)** –
  - Conversion of ICD–9 codes to ICD–10 codes
    - Require more specificity of documentation (e.g., LT/RT)
    - Many providers have never really mastered ICD–9 coding principles – major challenge for ICD–10
    - GEMs can be accessed at CMS website:
    - It’s important to mention that though some ICD–9–CM codes can be mapped “one to one” many ICD–9–CM codes will map to a multitude of ICD–10 listings and vice versa
    - Don’t depend on GEMS too much, use your own instincts, experience, and shared knowledge!
**When should clinical documentation be a focus?**

- **Bottom line:** Clinical documentation by providers in paper and electronic records will be crucial to justify the application of ICD-10 codes, but clinical documentation improvement should already be an active part of your compliance efforts today.

- Health care organizations will incur money and time expenses related to:
  - Provider and coder awareness and coding training
  - IT vendor programming/maintenance/upgrades
  - Loss of productivity **beyond** the eventual go-live date

**Now or later?**
ICD-10 Headache Size

- **(5, encephalitis) Government CMS CDC**
- **(4, migraine) Health Insurance Plans**
  - Change claims processing systems
  - Model impacts to payments
  - Update policies and tables
  - Correctly understand all codes
- **(3, cluster) Hospitals**
  - Change claims submission systems
  - Deal with impacts in cash flow
  - Correctly encode charts
- **(2, sinus) Billing Agencies**
  - Change systems that submit codes
  - Change systems that display codes
- *(1, tension) Physicians*
Sign up to Get the Latest Information on ICD-10

- CMS ICD-10 Industry Email Updates – Immediately notifies subscribers of important information and reminders about the Version 5010 and ICD-10 transition
  - To register, scroll down to the “Related Links Inside CMS” section

- ICD-10 Latest News Page Watch – Sends an e-mail notification when information on the web page is changed or updated
  - To register, scroll down to the “Related Links Inside CMS” section

SOURCE: Centers for Medicare and Medicaid Services  ICD-10 Public Presentation on August 3, 2011  [available at CMS.gov](http://www.cms.gov)
Keeping up to date at CMS.gov?

CMS Implementation Planning

CMS has commissioned implementation reports and impact analyses for its internal use in preparing for the upgrade to Version 5010 and transition to ICD-10.

Key results are posted here to provide insights for other organizations as they plan.

Industry Readiness Assessments and Listening Session
CMS is working closely with researchers and with industry groups representing providers, payers, and vendors to assess and support Version 5010 and ICD-10 progress.

Activities to gauge and assist with industry preparedness include:

• An online survey of approximately 600 providers, payers, and vendors. Survey results showed widespread awareness of the version 5010 upgrade and ICD-10 transition among all three groups.

For more information, see the CMS ICD-10 Frequently Asked Questions (FAQs) located in the FAQ menu.
There are tons of free resources...

...and we are all in this together!
Stated objectives

- Learn differences in ICD–10–CM and PCS and roadblocks to successful implementation
- How to get your project moving if it hasn’t started yet and/or how to maintain current progress
- How to inform, educate, and support coders/billers, IT staff, HR, finance, facility leadership, etc.
- Distinguish formal strategic planning principles within your Project Plan
Where do we go from here?

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