

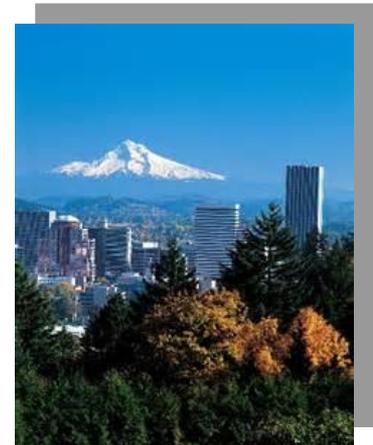
ICD-10-CM: An Overview

Presented by

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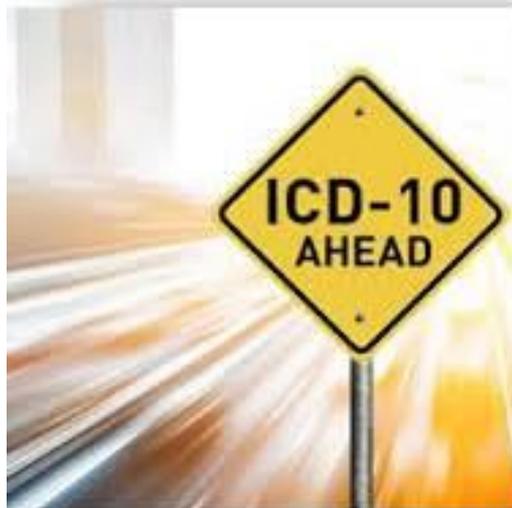


ICD-10-CM: Session Overview

- Brief history
- Overview of the code set
- Documentation
- Implementation Strategies
- Resources for next steps

CMS Video

- [CMS Introduction to ICD-10-CM](#)



ICD-10-CM: Brief History

- Published by the World Health Organization
- Maintained by National Center for Health Statistics (NCHS)
- More than 200 countries have been using ICD-10 or modified version
 - In use since 1994
- Increased granularity (specificity) in coding
 - anatomic site
 - etiology/manifestation
 - severity
 - 6th and 7th character extensions
- *Mandated use October 1, 2015*

ICD-10-CM: Brief History

- Current structure limits new additions
- Has not kept up to date with the changes that have occurred in health care technology
- Does not allow for “robust” reporting to keep up with the current health care environment
- Does not allow for consistent/comparative reporting between state, national and international levels

ICD-10-CM: Benefits

- Helps to provide clarity for visit reason
 - Specific codes for:
 - Immunizations (Z23)
 - School exams (Z02.0)
 - Sports (Z02.5)
 - Provides more detail for non-compliance with medical treatment
 - School problems
 - Failed school exams (Z55.2)
 - Educational maladjustment and discord with teachers and classmates (Z55.4)
 - Other issues:
 - Upbringing away from parents (Z62.2)
 - Inappropriate (excessive) parental pressure (Z62.6)
 - Type A behavior pattern (Z73.1)
- Opportunity to tell a complete story of the patient encounter and reasons for some chronic health conditions.*

ICD-10-CM: Benefits

- Common reliance on complete and accurate data and clinical documentation to support
 - Meaningful Use
 - Quality reporting
 - Value-based purchasing
 - Payment reform
 - Fraud prevention and detection
 - Research
- ICD 10 will improve quality of data necessary to achieve other healthcare initiatives

ICD-10-CM: Benefits

- Enhanced quality metrics
 - Mild persistent asthma, uncomplicated (J45.30)
 - Intentional under-dosing of medication due to financial hardship (Z91.120)
- Clarification on specific primary care services
 - Routine child health examination with abnormal findings (Z00.121)
 - Sports physicals (Z02.5)
 - Routine child health examination without abnormal findings (Z00.129)
- Identifying and Reporting of health risks
 - Exposure to second hand tobacco smoke (Z77.22)
 - Severe obesity due to excess calories (E66.01)

ICD-10-CM: Impact

- ICD-10-CM code assignment requires the highest level of specificity in documentation
- Non-specific codes (being used today) **will** be questioned by the payors
 - Delayed payments
 - Claim denials

ICD-10-CM: Impact

- ICD-10-CM will be used by ***all healthcare providers in all settings*** to assign and/or interpret diagnoses
 - Medical
 - Behavioral Health
 - Ancillary Services



ICD-10-CM: Code Set

- ICD-10-CM includes **21 Chapters**
- *Category Code: the first 3 characters of a code; always begin with an **alpha** character*
- Code length can be 3-7 characters
 - *Not all codes will have a 5th and/or 6th digit, but may have a 7th digit*

ICD-10-CM: Code Set

ICD 9

2nd thru 5th digits all numeric

- 460 = Acute nasopharyngitis (common cold)
- V20.2 = Routine infant or child health check

ICD 10

- 3rd thru 7th digits are alpha-numeric
 - J00 = Acute nasopharyngitis (common cold)
 - Z00.129 = routine child check health examination without abnormal findings

ICD-10-CM: Code Set

- New concept with ICD-10-CM
- 6th character [placeholder]
 - Indicates *laterality*
 - Example: S62.611D denotes a displaced fracture of the proximal phalanx on the left index finger, subsequent encounter, with routine healing.

ICD-10-CM: Code Set

- “X” is used to indicate a placeholder
- If base code has 4 or 5 characters but requires a 7th character, an “X” is used as the 5th and/or 6th character(s) respectively
 - Contusion of left elbow, initial encounter
 - base code S50.02-
 - need to indicate the type of encounter
 - ICD-10 code is **S50.02XA**; why is **S50.02A** incorrect?

ICD-10-CM: Code Set

ICD-9-CM

Encounter for Vaccination:

- Many codes specific to the type of vaccine administered
- V03-V06.9

ICD-CM-10

Encounter for Vaccination:

- Z23
- Procedure codes (CPT) are required to identify the types of immunizations given

ICD-10-CM: Code Set

ICD-9-CM

- 493.92 Asthma with acute exacerbation

ICD-10-CM

- J45.20 Mild intermittent, uncomplicated
- J45.21 Mild intermittent with acute exacerbation
- J45.22 Mild intermittent with status asthmaticus
- J45.30 Mild, persistent, uncomplicated
- J45.31 Mild, persistent with acute exacerbation
- J45.50 Severe persistent, uncomplicated
- J45.51 Severe persistent with acute exacerbation

ICD-10-CM: Code Set

Acute Suppurative Otitis Media

- ICD-9-CM: 382.00
- **ICD-10-CM**
 - H66.001 right ear
 - H66.002 left ear
 - H66.003 bilateral
 - H66.004 recurrent, right ear
 - H66.005 recurrent, left ear
 - H66.006 recurrent, bilateral
 - H66.007 recurrent, unspecified ear
 - H66.009 unspecified ear

Acute Serous Otitis Media

- ICD-9-CM: 381.01
- **ICD-10-CM**
 - H65.01 right ear
 - H65.02 left ear
 - H65.03 bilateral
 - H65.04 recurrent, right ear
 - H65.05 recurrent, left ear
 - H65.06 recurrent, bilateral
 - H65.07 recurrent, unspecified ear

ICD-10-CM: Code Set

- The Alphabetic Index consists of the following parts:
 - Index of Diseases and Injury of Diseases and Injury
 - Alphabetic list of terms and corresponding code or code categories
 - Index of External Causes of Injury
 - Table of Neoplasms
 - Table of Drugs and Chemicals

ICD-10-CM: Code Set

- Main terms are *Category Codes*, which identify conditions or injuries
 - Stress Fracture
- Subterms are located under the Main terms
 - Indented to the right
 - Begin with a lower case letter
 - Are not in bold

ICD-10-CM: Code Set

- Codes can be 3 to 7 characters.
 - 1st character is *always alpha*
 - 2nd character is numeric
 - 3rd to 7th characters can be alpha-numeric
 - 3 characters followed by a decimal point then up to 3 to 4 additional characters

1 st	2 nd	3 rd	4 th	5 th	6 th	7 th
Alpha	Numeric	Alpha-Numeric	Alpha-Numeric	Alpha-Numeric	Alpha-Numeric	Alpha-Numeric

ICD-10-CM: Code Set

Condition	Look for this in alpha index:
Congenital	Anomaly
Late Effects	Sequela
Examination	Encounter
Complications of medical or surgical care	Complications

ICD-10-CM: Code Set

Steps for code selection:

- Start with the Alpha Index, and locate the diagnosis by its main term
 - Follow the instructions including sub-terms, essential modifiers and other instructional directions
- Locate the code in the Tabular Index
 - Follow the instructions including subterms, essential modifiers and all other instructional directions

* Please... ***DO NOT CODE ONLY FROM THE ALPHA INDEX!***

ICD-10-CM: Code Set [External Causes]

- Included in ICD 10 code book to provide data for injury research and evaluation of injury prevention strategies
 - Capture cause, intent, place of occurrence, activity of the patient at time of event, patient status
 - Not required when external cause is included in the code for the related
 - At this time, these codes remain “voluntary” to report

ICD-10-CM: Code Set [Table of Drugs and Chemicals]

- Lists of codes or subcategories in columns:
 - Accidental poisoning
 - Intentional self-harm poisoning
 - Poisoning by assault
 - Undetermined poisoning
 - Adverse effect
 - Under-dosing

ICD-10-CM: A Quick Review

- **All** ICD-10-CM codes are more than 3 characters.
 - True or False
- The first 3 characters are known as the _____ ?
- Cite one *Table* that is part of the Alpha Index section.

ICD-10-CM: Code Set Guidelines and Conventions for Tabular Index

- Chronological listing of ICD-10-CM codes
- 21 Chapters organized by body system or nature of injury and disease.
- Structure includes indented listing of categories, subcategories and codes

ICD-10-CM: Code Set [Excludes]

- Exclusion notes have 2 indications
- **Exclusion 1** notes mean the conditions in the note are NOT coded here
- **Exclusion 2** notes are less restrictive, they mean “not included here”. The note indicates that conditions listed are not represented by this code or category but may be reported in addition to the code or codes when both conditions are present

ICD-10-CM: Code Set [Excludes]

Excludes 1 (Do not code with)

- detergent asthma (J69.8) eosinophilic asthma
- (J82)
- lung diseases due to external agents (J60-J70)
- miner's asthma (J60)
- wheezing NOS (R06.2)
- wood asthma (J67.8)

Excludes 2 (Not included here)

- asthma with chronic obstructive pulmonary disease (J44.9)
- chronic asthmatic (obstructive) bronchitis (J44.9)
- chronic obstructive asthma (J44.9)

ICD-10-CM: Code Set [Includes]

Includes

- allergic (predominantly) asthma
- allergic bronchitis NOS
- allergic rhinitis with asthma
- atopic asthma
- extrinsic allergic asthma
- hay fever with asthma
- idiosyncratic asthma
- intrinsic non-allergic asthma
- Non-allergic asthma

ICD-10-CM: Code Set [Block or Category level instructional notes]

Use Additional Code to identify:

- exposure to environmental tobacco smoke (Z77.22)
- exposure to tobacco smoke in the perinatal period (P96.81)
- history of tobacco use (Z87.891)
- occupational exposure to environmental tobacco smoke (Z57.31)
- tobacco dependence (F17.-)
- tobacco use (Z72.0)

ICD-10-CM: Code Set [Sequencing]

- Some notes provide sequencing instruction for codes. These include conditions that may or may not have manifestations
 - Example:
 - J12 Viral pneumonia, not elsewhere classified
- Code first** associated influenza, if applicable (J09.X1, J10.0-, J11.0-)

ICD-10-CM: Code Set [Code Also]

- *Code also* **does not** give sequencing direction
- Instructs multiple conditions may be required to fully describe the condition
- Leaves sequencing up to direction of provider based on the focus of the encounter

ICD-10-CM: Documentation

- Documentation and coding go hand-in-hand
 - Documentation supports:
 - Patient care/Care coordination
 - Medical necessity
 - Coding and reimbursement
 - Compliance
- Increased specificity in ICD-10 will likely require documentation changes

ICD-10-CM: Documentation

- ICD-10-CM/PCS codes are considerably more detailed than ICD-9-CM
 - Examples:
 - Laterality
 - Encounter type (initial, subsequent, sequela)
 - Anatomical detail
 - Type of injury
 - Severity
 - Approach

ICD-10-CM: Documentation

- Identify documentation improvement opportunities that impact various initiatives
- Examples:
 - Modifications to form or template
 - System prompts or reminders
 - Education
 - Workflow or operational process changes
 - Revenue maximization

ICD-10-CM: Documentation [EHR CDS]

- Provides ongoing learning loop for physicians regarding needed documentation elements at the time care is recorded
- Facilitates better coding accuracy, productivity, and improved reimbursement
- Reduced compliance risks
- Fewer retrospective provider queries

ICD-10-CM: Documentation [Focus Areas]

- Disease *type*
- Disease *acuity*
- Disease *stage*
- Site specificity
- Laterality

ICD-10-CM: Documentation [Tobacco]

Exposure to Smoke

- Z77.22 second hand smoke
- Z87.891 Personal History of tobacco use: Nicotine dependence not current

Nicotine Dependence

- F17.21 Cigarettes
- F17.22 Chewing tobacco
- F17.29 Other

Requires additional 6th digit

0 = uncomplicated

1 = remission

2 = withdrawal

Defining the elements:

Dependence: Increased tolerance to drugs or alcohol with a compulsion to continue taking the substance despite the cost

Withdrawal symptoms often occur upon cessation

Abuse: Problematic use of drugs or alcohol but without dependence

ICD-10-CM: Documentation [Asthma]

- *Each visit* you will need to state if asthma is:
 - uncomplicated *or*
 - acute exacerbation *or*
 - patient is in status asthmaticus
- AND**
- state the current state of the asthma
 - mild Intermittent
 - mild persistent
 - moderate persistent
 - severe persistent

ICD-10-CM: Documentation

- Depression
- Asthma
- Alcohol and Substance Abuse
- Otitis Media

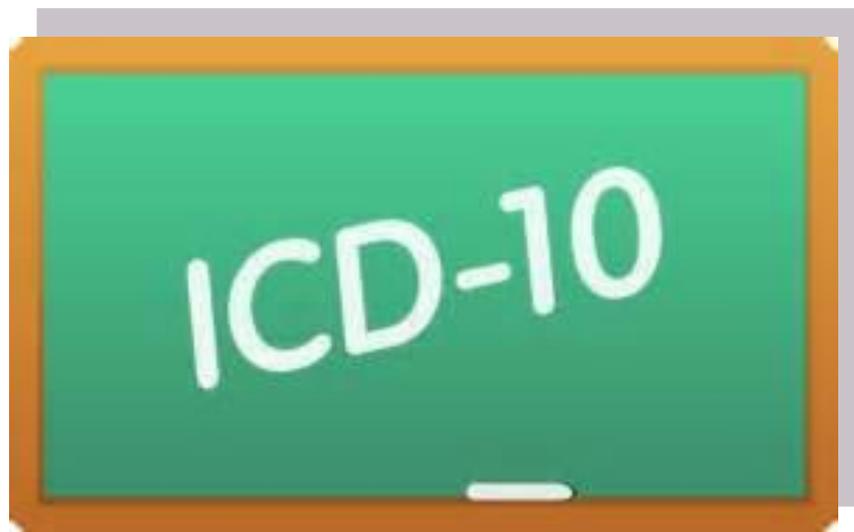
ICD-10-CM: Documentation [EHR]

- Templates should not be too prescriptive, complicated, or time-consuming to use
- *Educate providers on the use of EHR templates*
- Establish regular review process to maintain master list of templates
- Ensure template is being used
- Verify information is still relevant; identify necessary updates; *involve providers*
- Will streamline standardized reporting

ICD-10-CM: Documentation

Break

ICD-10-CM: Coding Exercises



ICD-10-CM: Exercise 1

- Well Child Check for a 14 year old; no abnormal findings noted
- ICD-10 code is...
- **Z00.129**

ICD-10-CM: Exercise 2

- Wound (puncture) on the left foot from stepping on a foreign object; no complications noted; initial encounter
- ICD-10 code is...
- **S91.342A**

ICD-10-CM: Exercise 3

- Mild persistent asthma, acute exacerbation; patient is also a smoker
- ICD-10 code is...
- **J45.31; Z72.0**

ICD-10-CM: Exercise 4

- Sprain of right knee; ACL; re-injured
- ICD-10 code is...
- **S83.511D**

ICD-10-CM: Exercise 5

- Patient is seen for acute, recurrent, serous otitis media in the right ear
- ICD 10 code is...
- **H65.04**

ICD-10-CM: Exercise 6

- Adjustment reaction, with anxiety and depressed mood
- ICD-10 code is...
- **F43.23**

ICD-10-CM: Implementation Strategies

- **Plan Your Journey**

- **Train Your Team**

- Your support staff will be a big part of your success. Create an action plan containing steps to get your team trained.

- **Update Your Processes**

- Reviewing current clinical documentation practices is an important step in your transition. Use an action plan to walk through the steps to update your policies, procedures, forms, and templates.

- **Engage Your Vendors & Payers**

- Collaboration with technology vendors and payers is key.

- **Test Your Systems and Processes**

- Testing is an important component of the ICD-10 transition.

ICD-10-CM: Implementation Strategies [Discovery]

- Determine where you currently use ICD-9 coding
 - Encounter form/Superbill
 - **Reporting** (Grant, State, Research, other)
 - Reimbursement
 - Referrals
- Review current documentation
 - Dual code
 - Does documentation support ICD-10 changes?
 - If not what can you do to improve?

ICD-10-CM: Implementation Strategies [Gap Analysis]

- Evaluate medical record samples to determine whether documentation supports level of detail found in ICD-10-CM
 - Sampling techniques could include: random samples, by clinical specialty
 - Top diagnoses
 - Diagnostic or procedural categories known to represent documentation problems with ICD-9-CM

ICD-10-CM: Implementation Strategies [Impact Analysis]

- **Budget**
 - What are the costs associated with this change
 - Training
 - Payor delays
 - Contingency plan
- **Claims**
 - Vendor readiness
 - Current diagnosis usage (when is the cut over?)
 - Payor readiness
- **Training**
 - Provider readiness
 - Coder/Biller readiness
 - Reporting readiness

ICD-10-CM: Implementation Strategies [Action Plans]

- Office processes
 - Superbill/encounter form
 - Top diagnosis cross-walk
 - Systems using diagnosis codes
 - Reporting
 - Documentation
- Vendor Readiness
 - Check with fiduciary to ensure your systems are included in their process
 - EHR
 - Practice Management System
 - Clearing House
 - Payors

ICD-10-CM: Resources

- Resources for your ICD-10 Implementation Project
Centers for Medicare and Medicaid
<http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10>
- American Health Information Management Association
<http://www.ahima.org/education/onlineed/Programs/ICD10>
- American Academy of Professional Coders: Training/Resources
<https://www.aapc.com/icd-10/>
- Contexo Media: Training and Books
<http://www.codingbooks.com/products/coding-books/icd-10.html>
- Optum Coding Books



Need help?

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THANK YOU!