



ICD-10 for Geriatrics

UConn Health



Just himagine what we can accomplish together.

Introduction

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Agenda

- Describe the challenges associated with ICD-10 implementation
- Identify the importance of physician documentation and coding
- Review examples of the impact of the changes in ICD-10

ICD-10 Resources: USA.GOV

ICD-10 Resources: CMS.GOV

<http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html>



- **About ICD-10**
- The transition to ICD-10 is required for everyone covered by the [Health Insurance Portability Accountability Act \(HIPAA\)](#). Please note, the change to ICD-10 does not affect CPT coding for outpatient procedures and physician services.
- **Road to 10: CMS Online Tool for Small Practices**
- **Jumpstart your ICD-10 transition with [Road to 10](#), an online resource built with input from providers in small practices.**
- **“Road to 10” includes specialty references and helps providers build ICD-10 action plans tailored for their practice needs.**
- **CMS Resources**
- Check out the updated [CMS ICD-10 Resources Flyer](#).
- Access three new **Medscape Education resources** that **provide guidance around the transition to ICD-10**. Continuing medical education (CME) and nursing continuing education (CE) credits are available to health care professionals who complete the learning modules. Anyone can earn a certificate of completion. If you are a first-time visitor to Medscape, you will need to create a free account to access these resources.
 - Video: [ICD-10: Getting From Here to There -- Navigating the Road Ahead](#)
 - Video: [ICD-10 and Clinical Documentation](#)
 - Expert Column: [Preparing for ICD-10: Now Is the Time](#)
- View the [ICD-10 Introduction](#) fact sheet.
- Find official resources designed to help [providers](#), [payers](#), [vendors](#), and [non-covered entities](#) with the transition to ICD-10.



Important ICD-10 Updates

- **Senator Bill Cassidy** recommended that ICD-10 penalty be delayed for two years. This essentially means that CMS will continue accepting, processing and paying claims filed in ICD-9 even post **October 1 for the next 2 years.**
- Citing estimates provided by CMS about the disruption to cash flows brought about by ICD-10, **200 % spike in denial rates and doubling of days in account receivables,** Senator Cassidy pointed out the woes of small practices who are already having a hard time deploying EHR technology and coping with recent healthcare regulations.
- **“Smaller providers are already struggling with EHRs** and will soon face those payment disruptions, not because they’re doing it wrong but because the system has changed” expressed Cassidy while encouraging HHS to show some flexibility.
- **Secretary HHS Sylvia Burwell** , **countered by saying that many large payers and providers are ready and waiting for ICD-10** and that HHS is working to provide technical assistance and training to those organizations that are not at this point prepared.
- The debate is not over yet.



Road to ICD-10

- ICD (International Classification of Diseases) System created by WHO in 1893 as worldwide standard for classifying deaths.
- Implemented worldwide with modifications by country to fit their needs.
- ICD-9 in use in the United States since 1979. ICD-10 published in 1992.
- Most recent country to implement ICD-10, Canada from 2001-2005.
- Difference in U.S., ICD used for multiple purposes besides classification.



Final Rule Issued

- ▶ On **July 31st, 2014**, The U.S. Department of Health and Human Services (HHS) issued a rule finalizing **October 1, 2015** as the new compliance date



Considerations

- **ICD-10 requires collaboration, collaboration and more collaboration between all members of the clinical and non-clinical healthcare team:**
 - Education of CDI/coder staff
 - Template revisions
 - Query revisions



The ICD-10 and CPT Connection

- CPT codes **do not** change!
- ICD-10 diagnoses correlate with CPT procedures
- Potential reimbursement implications



Uses of Enhanced Specificity of ICD-10 Future of Documentation

- Data will be collected over the next **2 years** – as well as **2 years** following implementation to feed initiatives impacting:
 - **Measurement of patient care outcomes**
 - Quality of care initiatives
 - Healthcare policy development
 - **Research related to profiling providers of healthcare *******
 - **Pay for performance initiatives**
 - **Justification of medical necessity**



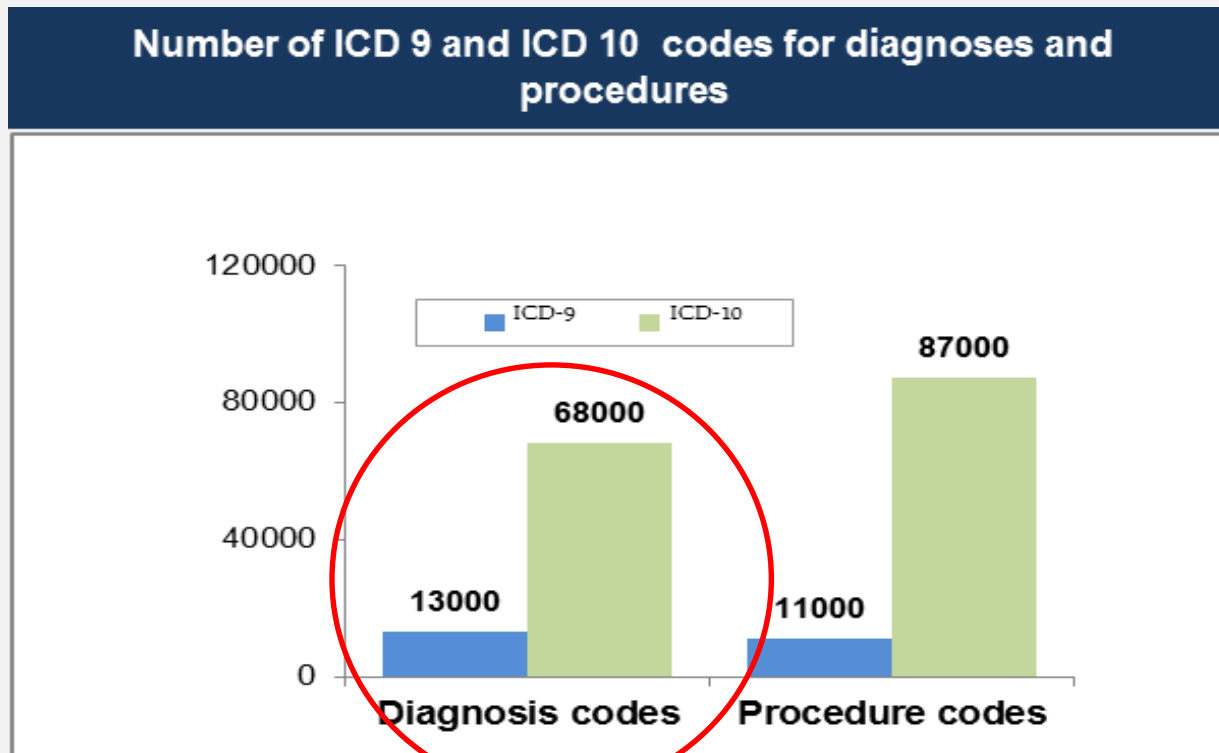
Consequences of Inadequate Documentation

Inappropriate
Payment for
Submitted
Claims

Claim Denials

Increased Risk
of Government
Audit,
Repayment
and Fines

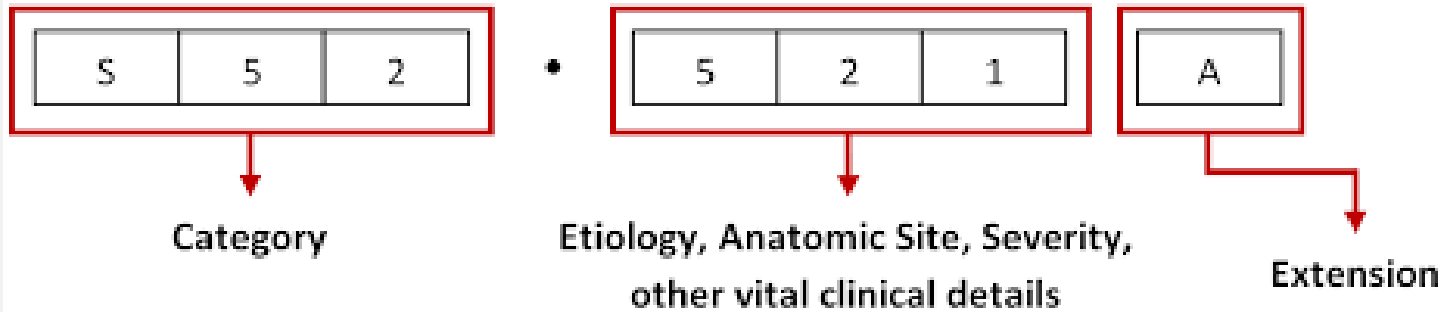
Increased Number of Codes



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)



Structure of ICD-10 codes



Think “Dummy Code”
Problem List diagnosis:

“Migraine”= G43

Adds detail as clinical picture
becomes clearer.

“Headache”= C34.090

For Injuries and Fractures:

- Initial, Subsequent, Sequela
- Open, Closed, Nonunion, etc. for fractures

- Pregnancies

Documentation in ICD-10

Requirements for Detailed Documentation for Diagnoses	
Acuity	Acute, chronic or both
Specific site	Femur trochanteric – apophyseal, greater trochanter, intertrochanteric, lesser trochanter
Laterality	Right, left, bilateral
Specific type of fractures	Displaced/non-displaced fractures, transverse, oblique, spiral, comminuted, segmental
Etiology of diagnosis	Injury/Illness due to what, how
Link must be established between manifestations and underlying diseases	Renal failure due to hypertension, diabetes, drug induced
Non-pressure skin ulcers	Site, laterality and depth of tissue involvement

Documentation in ICD-10

Requirements for Detailed Documentation for Diagnoses	
Complications of care	Intraoperative, postoperative, mechanical malfunctions, Infections (device vs. wound)
Injury details	Place of occurrence, activity causing the injury; accident details
Episode of care	Initial treatment, subsequent treatment (for routine or delayed healing), sequela
Drug reactions/interactions/adverse reactions	Poisoning (accidental/intentional/assault/undetermined), adverse effect, underdosing (due to financial hardship, age-related)
Degree of severity	Mild, moderate, severe, e.g., Malnutrition: mild, moderate, severe

Diagnosis Documentation Examples



Hypertension ICD-9

- 401 Essential hypertension
 - 401.0 Malignant
 - 401.1 Benign
 - 401.9 Unspecified

Hypertension ICD-10

- **I10 Essential (primary) hypertension**
 - Includes high blood pressure, hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)
 - Excludes hypertension complicating pregnancy and associated with end organ disease

Hypertension

- There is only one code for hypertension without manifestations (benign, malignant, essential, etc...) in ICD-10.
 - The code is I10
- Documentation is required for any relationship between hypertension and other diseases.
 - Hypertensive heart disease- I11
 - Hypertensive chronic kidney disease- I12



ICD-9 Dementia, unspecified, without behavioral disturbance

- 2014 ICD-9-CM Diagnosis Code **294.20**
- ICD-9-CM 294.20 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.
- Short description: Demen NOS w/o behv dstrb.



ICD-10 Dementia, unspecified, without behavioral disturbance

- ICD-9-CM 294.20 converts directly to:2015 ICD-10-CM F03.90 Unspecified dementia without behavioral disturbance.
- F03.90 is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.



ICD-10 Dementia, unspecified, without behavioral disturbance

- **Documentation Improvement**
- Acuity, Etiology of diagnosis, Severity, Link must be established between manifestations and underlying diseases, Degree of Severity
- A condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems.
- Symptoms may also include personality changes and emotional problems. There are many causes of dementia, including alzheimer disease, brain cancer, and brain injury. Dementia usually gets worse over time.

ICD-9 Memory loss

- **Memory loss 2015 ICD-9-CM Diagnosis Code 780.93**
- ICD-9-CM 780.93 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.
- **Clinical Information**
- Memory loss for events and experiences that occurred before the incident that produced the amnesia
- Partial or complete loss of memory caused by organic or psychological factors. The loss may be temporary or permanent, and may involve old or recent memories. Compare forgetting and memory decay
- Systematic and extensive loss of memory caused by organic or psychological factors. The loss may be temporary or permanent, and may involve old or recent memories

ICD-10 Memory loss

- ICD-9-CM 780.93 converts approximately to:
- 2015 [ICD-10-CM R41.2](#) Retrograde amnesia or:
2015 [ICD-10-CM R41.3](#) Other amnesia
- **Retrograde amnesia**
- R41.2 is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.

ICD-10 Memory loss

- **Documentation Improvement**
- **ICD-10-CM R41.2** Retrograde amnesia
- Acuity, Etiology of diagnosis, Severity, Link must be established between manifestations and underlying diseases, Degree of Severity
- **Clinical Information:**
- Loss of the ability to recall information that had been previously encoded in memory prior to a specified or approximate point in time. This process may be organic or psychogenic in origin.

ICD-10 Memory loss

- ICD-9-CM 780.93 converts approximately to:
- 2015 ICD-10-CM R41.3 **Other amnesia**
- **Other Amnesia**
- **R41.3** is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.



ICD-10 Memory loss

- **Documentation Improvement**
- 2015 ICD-10-CM R41.3 **Other amnesia**
- Acuity, Etiology of diagnosis, Severity, Link must be established between manifestations and underlying diseases, Degree of Severity

- **Clinical Information:**
- A disorder characterized by systematic and extensive loss of memory.
- Partial or complete loss of memory caused by organic or psychological factors. The loss may be temporary or permanent, and may involve old or recent memories. Compare forgetting and memory decay.
- Pathologic partial or complete loss of the ability to recall past experiences (amnesia, retrograde) or to form new memories (amnesia, anterograde).



ICD-9 Need for prophylactic vaccination and inoculation against influenza

- 2015 ICD-9-CM Diagnosis Code **V04.81**
- ICD-9-CM V04.81 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.
- **V04.81** is considered unacceptable as a principal diagnosis as it describes a circumstance which influences an individual's health status but not a current illness or injury, or the diagnosis may not be a specific manifestation but may be due to an underlying cause.

ICD-10 Need for prophylactic vaccination and inoculation against influenza

- ICD-9-CM V04.81 converts approximately to:
- 2015 ICD-10-CM Z23 Encounter for immunization
- Z23 is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.



ICD-10 Need for prophylactic vaccination and inoculation against influenza

- **Documentation Improvement**
- Procedure codes are required to identify the types of immunizations given.
- Code First • any routine childhood examination
- **ICD-10-CM Coding Rules:** Z23 is considered unacceptable as a principal diagnosis as it describes a circumstance which influences an individual's health status but not a current illness or injury, or the diagnosis may not be a specific manifestation but may be due to an underlying cause

ICD-9 Osteoporosis

- 2015 ICD-9-CM Diagnosis Code **733.0**
- There are 5 ICD-9-CM codes below 733.0 that define this diagnosis in greater detail. Do not use this code on a reimbursement claim

ICD-9 Osteoporosis

- 733 Other disorders of bone and cartilage
- **Non-specific code 733.0 Osteoporosis**
- Specific code 733.00 Osteoporosis, unspecified convert 733.00
- Specific code 733.01 Senile osteoporosis convert 733.01
- Specific code 733.02 Idiopathic osteoporosis convert 733.02
- Specific code 733.03 Disuse osteoporosis convert 733.03
- Specific code 733.09 Other osteoporosis convert 733.09

ICD-10 Osteoporosis

- **Convert ICD-9-CM 733.00 to ICD-10-CM**
- ICD-9-CM 733.00 converts approximately to:
- 2015 [ICD-10-CM M81.0](#) Age-related osteoporosis without current pathological fracture
- ICD-9-CM 733.01 converts directly to:2015 [ICD-10-CM M81.0](#) Age-related osteoporosis without current pathological fracture

ICD-10 Osteoporosis

- **Convert ICD-9-CM 733.00 to ICD-10-CM**
- ICD-9-CM 733.02 converts approximately to:
- 2015 [ICD-10-CM M81.8](#) Other osteoporosis without current pathological fracture
- ICD-9-CM 733.03 converts approximately to:
- 2015 [ICD-10-CM M81.8](#) Other osteoporosis without current pathological fracture
- ICD-9-CM 733.09 converts approximately to:
- 2015 [ICD-10-CM M81.8](#) Other osteoporosis without current pathological fracture

ICD-10 Osteoporosis

- **Documentation Improvement**
- Acuity, Laterality, Specific Site, Etiology of diagnosis, Severity, Link must be established between manifestations and underlying diseases, Degree of Severity

Diabetes mellitus ICD-9

- 250 Diabetes mellitus
 - 250.0 **Diabetes mellitus without mention of complication**
 - 250.00 **type II or unspecified type, not stated as uncontrolled**
 - 250.01 type I, not stated as uncontrolled
 - 250.02 type II or unspecified type, uncontrolled
 - 250.03 type I, uncontrolled
 - 250.1 Diabetes with ketoacidosis
 - 250.2 Diabetes with hyperosmolarity
 - 250.3 Diabetes with other coma
 - 250.4 Diabetes with renal manifestations
 - 250.5 Diabetes with ophthalmic manifestations
 - 250.6 Diabetes with neurological manifestations
 - 250.7 Diabetes with peripheral circulatory disorders
 - 250.8 Diabetes with other specified manifestations
 - 250.9 Diabetes with unspecified complication



Clinical Examples – Documentation Improvement

Diabetes Mellitus

Classified by “type 1 or 2” and “other specified”

Secondary Diabetes Mellitus is further classified as:

- Due to underlying condition
- Drug or chemical induced

Gestational Diabetes is further classified as:

- Insulin controlled
- Diet controlled
- Puerpural

“Other specified” complications expanded to include:

- Neuropathic arthropathy
- Dermatitis
- Oral complications including periodontal disease and other oral disease

Diabetes mellitus

- **E11 Type II diabetes mellitus, includes diabetes NOS**
 - E11.0 with hyperosmolarity
 - E11.2 with kidney complications
 - E11.3 with ophthalmic complications
 - E11.4 with neurological complications
 - E11.5 with circulatory complications
 - E11.6 with other specified complications
 - E11.8 with unspecified complications
 - **E11.9 without complications**



Diabetes Mellitus: Complication and Manifestations

Circulatory Complication

Document Manifestation

Peripheral angiopathy with/without gangrene

Neurological Complication

Document Manifestation

Neuropathy

Mononeuropathy

Polyneuropathy

Autonomic (poly) neuropathy

Amyotrophy

Acquired Hypothyroidism ICD-10

- E03 Other hypothyroidism
 - E03.0 Congenital hypothyroidism with diffuse goiter
 - E03.1 Congenital hypothyroidism w/o diffuse goiter
 - E03.2 Hypothyroidism due to medicaments and other exogenous substances
 - E03.3 Postinfectious hypothyroidism
 - E03.4 Atrophy of thyroid (acquired)
 - E03.5 Myxedema coma
 - E03.8 Other specified hypothyroidism
 - **E03.9 Hypothyroidism, unspecified**
 - **Myxedema NOS**

Hypothyroidism Scenario

- Patient diagnosis
 - Hypothyroidism
 - Patient recently discontinued lithium due to history of bipolar depression
- Hypothyroidism (E03.9), unspecified coded

NOTE: Relationship of medications to disorders must be documented if known by the attending physician for reflection of appropriate patient acuity and quality of healthcare data. If determined to be drug related, code is E03.2.

Influenza Vaccine ICD-9

V04 Need for prophylactic vaccination and inoculation against certain diseases (also separate procedure code)

V04.0 Poliomyelitis

V04.1 Smallpox

V04.2 Measles alone

V04.3 Rubella alone

V04.4 Yellow fever

V04.5 Rabies

V04.6 Mumps alone

V04.7 Common cold

V04.8 Other viral diseases

V04.81 Influenza

V04.82 RSV

V04.89 Other viral diseases

Influenza Vaccine ICD-10

Z23 Encounter for immunization

Code 1st any routine childhood examination

NOTE – Procedure codes are required to identify the types of immunizations given

Depression ICD-9

- **311 Depressive disorder, NEC**
 - Includes
 - Depressive disorder NOS
 - Depressive state NOS
 - Depression NOS

Depression ICD-10

- F32 Major depressive disorder, single episode
 - F32.0 mild
 - F32.1 moderate
 - F32.2 severe without psychotic features
 - F32.3 severe with psychotic features
 - F32.4 in partial remission
 - F32.5 in full remission
 - F32.8 – Other depressive episodes
 - F32.9 unspecified includes Depression NOS, Depressive disorder NOS, Major depression NOS
- F33 Major depressive disorder, recurrent
 - F33.0 mild
 - F33.1 moderate
 - F33.2 severe without psychotic features
 - F33.3 severe with psychotic features
 - F33.4 in remission
 - F33.40 unspecified
 - F33.41 partial remission
 - F33.42 full remission
 - F33.8 other recurrent depressive disorders
 - F33.9 unspecified

Atrial Fibrillation ICD-9

- 427.3 Atrial fibrillation and flutter
 - 427.31 Atrial fibrillation
 - 427.32 Atrial flutter

Atrial Fibrillation ICD-10

- I48 Atrial fibrillation and flutter
 - I48.0 Paroxysmal atrial fibrillation
 - I48.1 Persistent atrial fibrillation
 - I48.2 Chronic atrial fibrillation
 - I48.3 Typical atrial flutter
 - I48.4 Atypical atrial flutter
 - I48.9 Unspecified atrial fibrillation and atrial flutter
 - I48.91 Unspecified atrial fibrillation
 - I48.92 Unspecified atrial flutter

Anemia ICD-9

- 285 Other and unspecified anemias
 - 285.0 Sideroblastic anemia
 - 285.1 Acute posthemorrhagic anemia
 - 285.2 Anemia of chronic disease
 - 285.3 Antineoplastic chemotherapy induced anemia
 - 285.8 Other specified anemias
 - 285.9 Anemia, unspecified

Anemia ICD-10

- **D62 Acute posthemorrhagic anemia**
- **D64 Other anemias**
 - D64.0 Hereditary sideroblastic anemia
 - D64.1 Secondary sideroblastic anemia due to disease
 - D64.2 Secondary sideroblastic anemia due to drugs and toxins
 - D64.3 Other sideroblastic anemias
 - D64.4 Congenital dyserythropoietic anemia
 - D64.8 Other specified anemias
 - **D64.9 Anemia, unspecified**

Obesity ICD-9

- 278 Overweight, obesity, and other hyperalimentation
 - 278.0 Overweight and obesity
 - 278.00 Obesity, unspecified (Obesity NOS)
 - 278.01 Morbid obesity
 - 278.02 Overweight

Obesity

- E66 Overweight and obesity
 - E66.0 Obesity due to excess calories
 - E66.01 Morbid (severe) obesity due to excess calories, excludes E66.2
 - E66.09 Other obesity due to excess calories
 - E66.1 Drug-induced obesity
 - E66.2 Morbid (severe) obesity with alveolar hypoventilation
 - E66.3 Overweight
 - E66.8 Other obesity
 - E66.9 Obesity, unspecified (Obesity NOS)

BMI – Documentation Improvement

The BMI should also be documented and coded along with the obesity. These classifications are specific to adults or children.

- **Z68.4 – Body mass index (BMI) 40 or greater, adult.**
- **Z68.41 – Body mass index (BMI) 40.0-44.9, adult.**

Long-term Use of Medications ICD-9

V58.6 Long-term (current) drug use

V58.61 anticoagulants

V58.62 antibiotics

V58.63 antiplatelets/antithrombotics

V58.64 NSAID

V58.65 steroids

V58.66 aspirin

V58.67 insulin

V58.69 other medications



Long-term Use of Medications ICD-10

Z79 Long-term (L/T) (current) drug therapy

Z79.0 Long term use of anticoagulants and antithrombotics/antiplatelets

Z79.01 – Anticoagulants

Z79.02 – Antithrombotics/antiplatelets

Z79.1 – non-steroidal anti-inflammatories

Z79.2 – antibiotics

Z79.3 – hormonal contraceptives

Z79.4 – insulin

Z79.5 – steroids

Z79.51 – inhaled steroids

Z79.52 – systemic steroids



Long-term Use of Medications ICD-10

Z79 Long-term (L/T) (current) drug therapy

Z79.8 Other long term (current) drug therapy

Z79.81 – L/T use of agents affecting estrogen receptors and estrogen level

- Z79.810 – Selective estrogen receptor modulators (SERMs)
- Z79.811 – Aromatase inhibitors
- Z79.818 – Other agents affecting estrogen receptors and estrogen levels

Z79.82 – L/T use of aspirin

Z79.83 – L/T use of bisphosphonates

Z79.89 – Other L/T (current) drug therapy

- Z79.890 – Hormone replacement therapy (postmenopausal)
- Z79.891 – L/T (current) use of opiate analgesic
- Z79.899 – Other L/T (current) drug therapy

Pain in Limb ICD-9

- 729 Other disorders of soft tissues
 - 729.0 Rheumatism, unspecified and fibrositis
 - 729.1 Myalgia and myositis, unspecified
 - 729.2 Neuralgia, neuritis, and radiculitis, unspecified
 - 729.3 Panniculitis, unspecified
 - 729.4 Fasciitis, unspecified
 - **729.5 Pain in limb**
 - 729.6 Residual foreign body in soft tissue
 - 729.7 Nontraumatic compartment syndrome
 - 729.8 Other musculoskeletal symptoms referable to limbs
 - 729.9 Other and unspecified disorders of soft tissue

Pain in Limb ICD-10

- **M79.6 Pain in limb, hand, foot, fingers and toes**
 - M79.60 Pain in limb, unspecified
 - M79.62 Pain in upper arm
 - M79.63 Pain in forearm
 - M79.64 Pain in hand and fingers
 - M79.65 Pain in thigh
 - M79.66 Pain in lower leg
 - M79.67 Pain in foot and toes

Pain in Limb ICD-10

- M79.6 Pain in limb, hand, foot, fingers and toes
 - M79.64 Pain in hand and fingers
 - M79.641 right hand
 - M79.642 left hand
 - M79.643 unspecified hand
 - M79.644 right finger(s)
 - M79.645 left finger(s)
 - M79.646 unspecified finger(s)

Epigastric Pain ICD-9

- **789.0 Abdominal pain**
 - 789.00 unspecified site
 - 789.01 RUQ
 - 789.02 LUQ
 - 789.03 RLQ
 - 789.04 LLQ
 - 789.05 periumbilic
 - **789.06 epigastric**
 - 789.07 generalized
 - 789.09 other specific site
 - includes multiple sites

Epigastric Pain ICD-10

- R10 Abdominal and pelvic pain
 - R10.1 **Pain localized to upper abdomen**
 - R10.10 Upper abdominal pain, unspecified
 - R10.11 Right upper quadrant pain
 - R10.12 Left upper quadrant pain
 - **R10.13 Epigastric pain**
 - **Dyspepsia NOS**
 - Excludes functional dyspepsia (K30)
 - » Indigestion

Chest Pain

Chest pain classification is further specified to ischemic or nonischemic.



Nonischemic Chest Pain ICD-9

- 786.5 Chest pain
 - 786.50 Chest pain, unspecified
 - 786.51 Precordial pain
 - 786.52 Painful respiration
 - 786.59 Other

Nonischemic Chest Pain ICD-10 Codes

- **R07** – Pain in throat and chest
 - **R07.0** – Pain in throat
 - **R07.1** – Chest pain on breathing
 - **R07.2** – Precordial pain
 - **R07.8** – Other chest pain
 - **R07.81** – Pleurodynia
 - **R07.82** – Intercostal pain
 - **R07.89** – Other chest pain
 - **R07.9** – Chest pain, unspecified

Ischemic Chest Pain ICD-10

- **I20 – Angina Pectoris**
 - **I20.0 – Unstable angina**
 - Accelerated angina
 - Crescendo angina
 - De novo effort angina
 - Intermediate coronary syndrome
 - Pre-infarction syndrome
 - Worsening effort angina
 - **I20.1 – Angina pectoris with documented spasm**
 - Angiospastic angina
 - Prinzmetal angina
 - Spasm-induced angina
 - Variant angina
 - **I20.8 – Other forms of angina pectoris**
 - Angina equivalent
 - Angina of effort
 - Coronary slow flow syndrome
 - Stenocardia
 - **I20.9 – Angina pectoris, unspecified**

Arrhythmia/Depolarization

To properly classify arrhythmia or depolarization in ICD-10-CM, ***specify the cause and type:***

- Cardiac arrest due to:
 - Underlying cardiac condition
 - Other underlying condition
 - Cause unspecified
- Paroxysmal tachycardia:
 - Re-entry ventricular arrhythmia
 - Supraventricular tachycardia
 - Ventricular tachycardia
 - Unspecified

Arrhythmia/Depolarization

Documentation Requirements (cont'd)

- Other cardiac arrhythmias:
 - Ventricular fibrillation/flutter
 - Atrial premature depolarization
 - Junctional premature depolarization
 - Ventricular premature depolarization
 - Other/unspecified depolarization
 - Sick sinus syndrome
 - Other specified/unspecified arrhythmia



Heart Failure

- To properly classify heart failure in ICD-10-CM, physicians must specify **acuity and type of coronary heart failure**:
 - systolic/diastolic or a combination of both
 - acute, chronic or acute on chronic
- Cardiac arrest is further delineated as:
 - Due to underlying cardiac condition
 - Other underlying condition
 - Cause unspecified



Heart Failure

- **Diastolic and systolic heart failure now use combination codes**
- “Congestive” is a non-essential modifier and is included in the classifications for both systolic and diastolic heart failure
- Unspecified heart failure includes:
 - CHF (NOS)
 - Biventricular failure

Pressure Ulcers

A patient is admitted with a chronic non-pressure ulcer of the leg.

- In ICD-9-CM Diagnosis, seven (7) codes specify the site of the lower limb.
- **In ICD-10-CM, more than 100 codes are used to delineate:**
 - Site of the chronic non-pressure ulcer
 - Laterality
 - Depth of ulcer of the lower limb (e.g., limited to breakdown of skin, with fat layer exposed, with necrosis of muscle, with necrosis of bone and unspecified severity)





Non Pressure Ulcers ICD-10 Code Examples

Non Pressure Ulcers

L97.10 – Non-pressure chronic ulcer of unspecified thigh

L97.101 – Non-pressure chronic ulcer of unspecified thigh, limited to skin breakdown

L97.102 – Non-pressure chronic ulcer of unspecified thigh, with fat layer exposed

L97.103 – Non-pressure chronic ulcer of unspecified thigh, with necrosis of muscle

L97.104 – Non-pressure chronic ulcer of unspecified thigh, with necrosis of bone

L97.109 – Non-pressure chronic ulcer of unspecified thigh, with unspecified severity



Right, left, unspecified lower limbs with all the above complications are specified in ICD-10-CM

Episodes of Care

- *ICD-10-CM relies more heavily on categorizing the episodes of care for injuries.*
 - Initial
 - Subsequent
 - Sequela

Fractures

- Classification also includes episodes of care:
 - Initial
 - Subsequent
 - Sequela
- Gustilo-Anderson is required for some open fractures utilizing a 7th character in the code
- ***Fractures not indicated as open or closed will be classified as a closed fracture***
- ***Fracture modifiers are “displaced” (default if not further specified) and “non-displaced”***
- **Fracture cause must be documented**
 - Traumatic or nontraumatic?



Episodes of Care w/Fractures

Fractures in ICD-10-CM:

- Open Fracture of the Right Wrist, Initial Encounter – S62.101**B**

Character	
A	Initial Encounter/Closed Fracture
B	Initial Encounter/Open Fracture
D	Subsequent Encounter/Fracture Routine Healing
E	Subsequent Encounter for Open Fracture, Type I or II Routine Healing
G	Subsequent Encounter/Fracture Delayed Healing
K	Subsequent Encounter/Fracture Nonunion
P	Subsequent Encounter/Fracture Malunion
S	Sequela

Fractures/Injuries – General Rule

- Documentation of the initial injury must be consistent for each visit with episode of care information:
 - Each record must stand on its own.
 - Documentation from previous records will not be used / must be re-iterated in current note.
 - No aftercare or follow-up classification for fractures or injuries (V codes in ICD-9-CM Diagnosis) – in ICD-10-CM use “subsequent” code.



Underdosing



Underdosing – new concept in ICD-10

- Taking less of a medication than prescribed by physician or manufacturer's instruction
 - Noncompliance
 - Complication of care

Underdosing – *Documentation Needed:*

- If a patient is purposely stopping or altering their medication regimen this needs to be documented to provided accurate coding



UNDERDOSING



- New concept in ICD-10 that can be used to document patient compliance with medications
- Identify condition being treated, medication, and why they are not taking it as prescribed
- May be Intentional OR Unintentional
 - Financial hardship
 - Other reasons
 - Age-related debility
 - Other reasons



Reimagine Healthcare.

Procedure Documentation Examples



Overview of ICD-10-PCS

- PCS stands for **Procedure Classification System**
- It is a *multi-axial system with a 7 character alphanumeric code* classification providing a **unique code** for all substantially different procedures and with **easy expandability**, *incorporating new procedures, technologies and devices utilized in medical/surgical procedures*
- The *classification for the general surgery procedures has undergone significant revision focusing primarily on section, body system, root operation, body part, approach, device and qualifier*

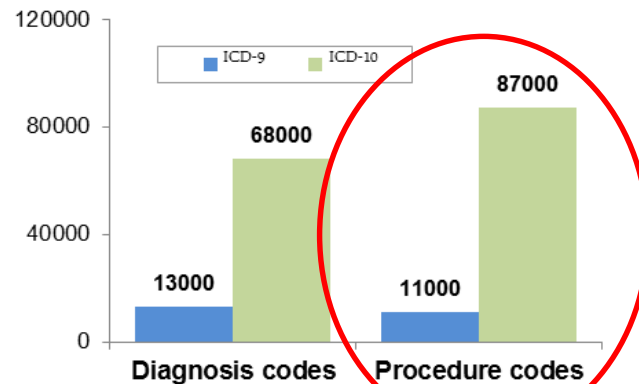
Overview of ICD-10-PCS

- The ICD-9-PCS procedure classification system does not allow for adequate expansion to accommodate new technologies and the advancement of procedures performed or devices utilized in procedures
- Basic principles used when developing the system were that **no diagnostic information is included** in the procedure description (i.e., no codes for procedures exclusive to aneurysms, cleft lip, strictures or neoplasms, etc.)
- This procedure classification system is only utilized in the **inpatient hospital setting**



ICD-10-PCS

Number of ICD 9 and ICD 10 codes for diagnoses and procedures



(Source: ICD-10-CM and ICD-10-PCS Update, Thirteenth National HIPAA Summit, 9/26/2006; Rand Study, March 2004)

ICD-10 procedure codes will require additional and significant detail in surgical reporting

- Key ICD-10 characteristics
 - ICD-10 is a “dramatic departure” from current practice
 - Surgical codes lack decimals
 - The new code set will allow for incorporation of new procedures and technologies
 - Terminology is precisely defined and used consistently across all codes

Debridement

- Some providers **may** refer to a debridement procedure using scissors as selective debridement. ***This is not the same as excisional debridement.***
- Documenting ***debridement with a sharp instrument does not qualify as excisional debridement.***
- ***Physicians must document whether debridement is excisional or nonexcisional along with specifying the deepest layer debrided.***

ICD-10-PCS Debridement

Patient present for non-excisional debridement of subcutaneous tissue, open wound, right foot

ICD-10-PCS

0JDQ0ZZ

- Extraction of Right Foot Subcutaneous Tissue and Fascia, Open Approach



ICD-10-PCS Table – Debridement

Section	0 Medical and Surgical		
Body System	J Subcutaneous Tissue and Fascia		
Operation	D Extraction: Pulling or stripping out or off all or a portion of a body part by the use of force		
Body Part	Approach	Device	Qualifier
0 Subcutaneous Tissue and Fascia, Scalp			
1 Subcutaneous Tissue and Fascia, Face			
4 Subcutaneous Tissue and Fascia, Anterior Neck			
5 Subcutaneous Tissue and Fascia, Posterior Neck			
6 Subcutaneous Tissue and Fascia, Chest			
7 Subcutaneous Tissue and Fascia, Back			
8 Subcutaneous Tissue and Fascia, Abdomen			
9 Subcutaneous Tissue and Fascia, Buttock			
B Subcutaneous Tissue and Fascia, Perineum			
C Subcutaneous Tissue and Fascia, Pelvic Region			
D Subcutaneous Tissue and Fascia, Right Upper Arm	0 Open	Z No Device	Z No Qualifier
F Subcutaneous Tissue and Fascia, Left Upper Arm	3 Percutaneous		
G Subcutaneous Tissue and Fascia, Right Lower Arm			
H Subcutaneous Tissue and Fascia, Left Lower Arm			
J Subcutaneous Tissue and Fascia, Right Hand			
K Subcutaneous Tissue and Fascia, Left Hand			
L Subcutaneous Tissue and Fascia, Right Upper Leg			
M Subcutaneous Tissue and Fascia, Left Upper Leg			
N Subcutaneous Tissue and Fascia, Right Lower Leg			
P Subcutaneous Tissue and Fascia, Left Lower Leg			
Q Subcutaneous Tissue and Fascia, Right Foot			
R Subcutaneous Tissue and Fascia, Left Foot			

ICD-10-PCS Debridement

1st	2nd	3rd	4th	5th	6th	7th
Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
0	J	D	Q	0	Z	Z

The ICD-10-PCS code structure tells a story

Physician Queries



Query...why?

A query is a communication tool used to clarify documentation in the health record for accurate code assignment.



The desired outcome from a query is an update of a health record to better reflect a practitioner's intent and clinical thought processes, documented in a manner that supports accurate code assignment.

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query...when?

A query is written when the Health record Documentation:

- Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- Provides a diagnosis without underlying clinical validation
- Is unclear for present on admission indicator assignment

“A proper query process ensures that appropriate documentation appears in the health record”

Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query...when?

“A proper query process ensures that appropriate documentation appears in the health record”



Article citation: AHIMA. "Guidelines for Achieving a Compliant Query Practice." Journal of AHIMA 84

Query... answer?

- Coding data is incorporated into the information used by insurance companies to determine which physicians they are going to contract.
- *Coded information is made available to consumers on various platforms, such as HealthGrades, which uses coding data as well as other information to 'rate' facility and provider service*



Query...answer how?

Queries are generated to elicit more information from the Provider.

- A response is **necessary** from the provider to fulfill this process.



- **A signature alone on a generated query does not fulfill this requirement.**

Query...answer how?

Queries are generated in various formats depending on the information being requested:

- **Written response format**
 - Requesting provider to freehand a response
- **Multiple Choice format**
 - Requesting provider select one of the offered responses



Please sign Queries!

Query... answer how?

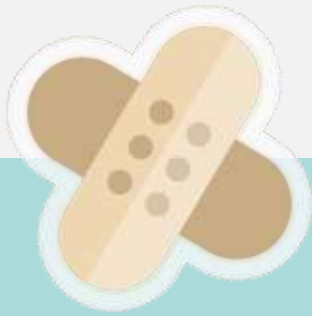
A Physician response, 'see notes' does not fulfill the request generated by the query.

- The coder has already reviewed the notes and Medical Record Documentation
- *Although the response may seem 'obvious' coders are only 'reporters' of the medical record and **cannot code a diagnosis** that is **not documented by the Provider.***



Summary

- The **transition to ICD-10 classification systems on October 1, 2015** will have a significant impact on physician documentation
- The classification systems allow for greater specificity, resulting in:
 - Comprehensive data for research
 - Development of standards for evidence-based medicine
 - Public health programs
 - Reimbursement for services rendered
 - Identification of accurate severity of illness



Questions?

