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ICD-10 for Occupational Medicine

UConn Health

Just himagine what we can accomplish together.

Introduction

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Agenda

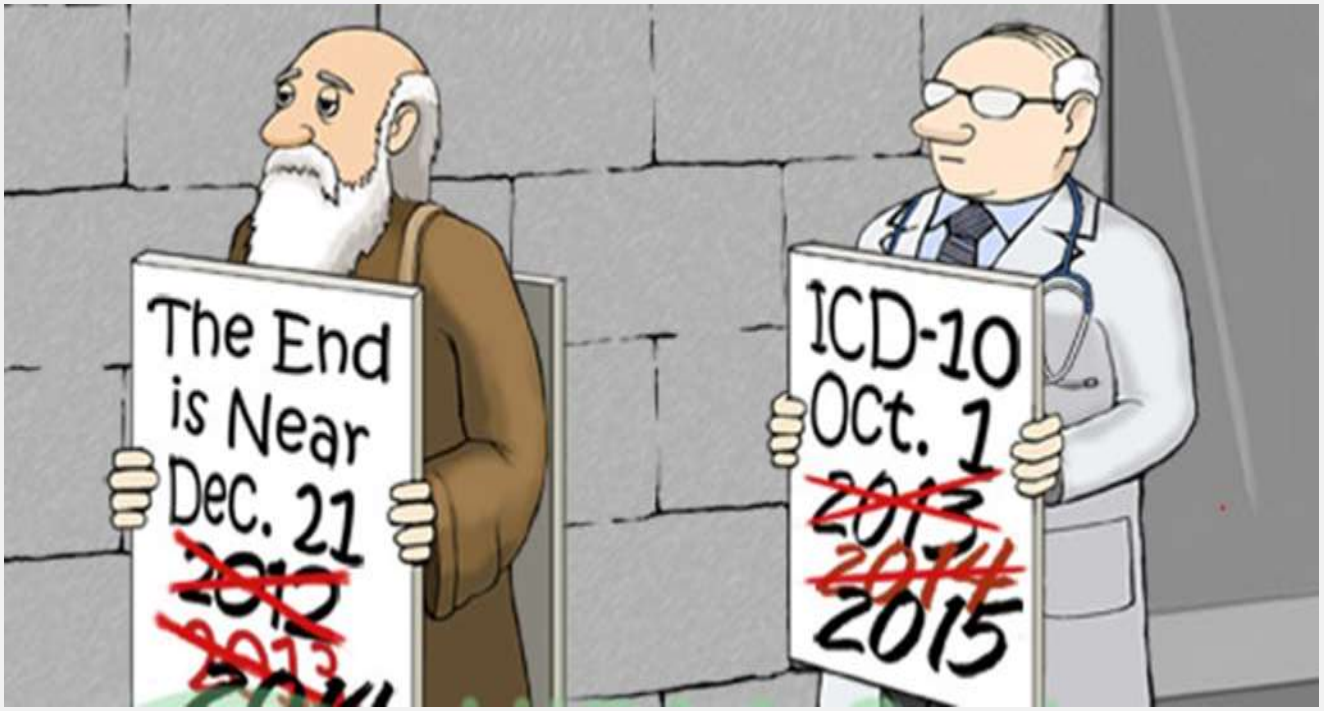
- Describe the challenges associated with ICD-10 implementation
- Identify the importance of physician documentation and coding
- Review examples of the impact of the changes in ICD-10

Road to ICD-10

- ICD System created by WHO as a standardized classification of diseases world wide
- Implemented worldwide with modifications by country to fit their needs
- ICD-9 in use in the United States since 1979
- Most recent country to implement ICD-10 was England in 1995
- ICD used in US 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



Challenges

- ICD-10 is a classification system, not a clinical language system:
  - Physician documentation - primarily directed for communication between clinicians
  - Bridging gaps between coder classification language and physician clinical documentation

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

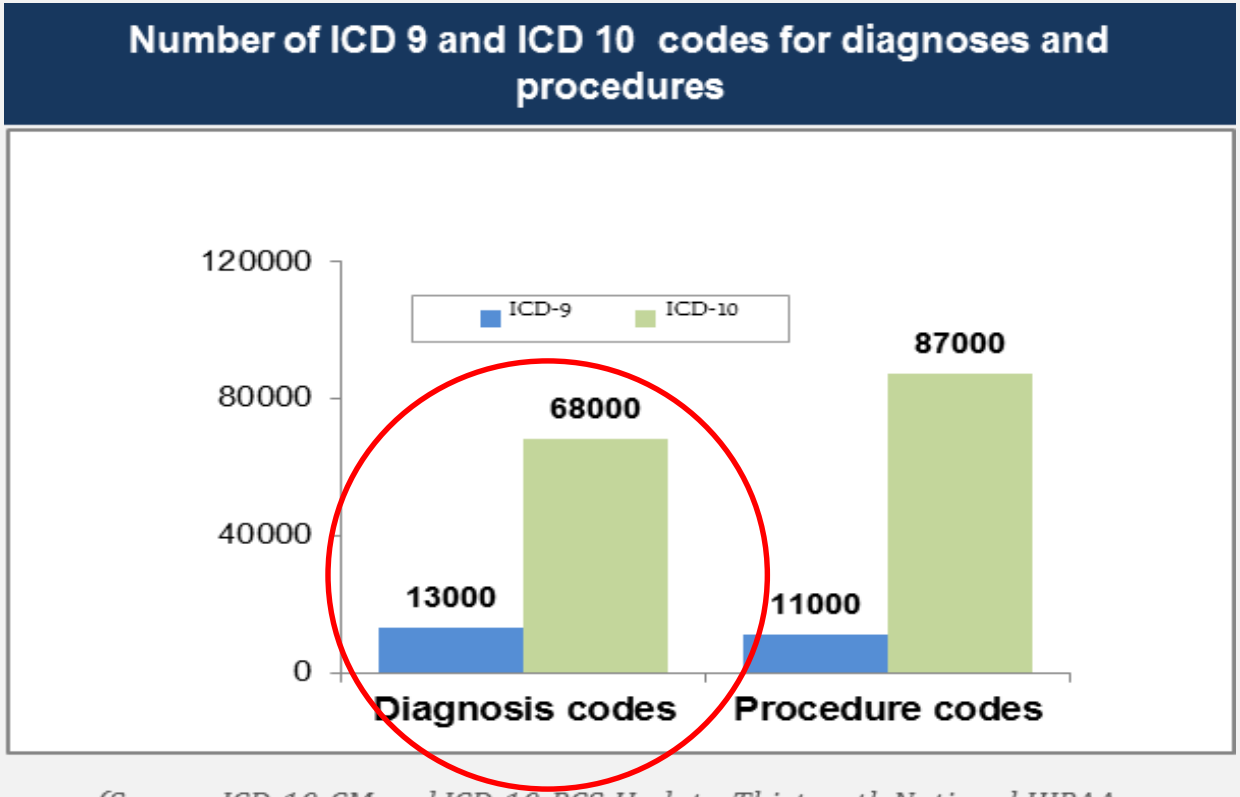
Uses of Enhanced Specificity of ICD-10

- 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

The ICD-10 and CPT Connection

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

Increased Number of Codes



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

It's Not As Bad As It Seems

- Almost 40,000 codes apply to Injury, Poisoning, and External Causes
- Over 6,300 codes apply to Musculoskeletal System and Connective Tissue
- 336 codes related to the Respiratory System

❖ **Remember**: Many of the new codes are based on laterality (over 5000 codes)and location

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

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Diagnosis Documentation Examples

Top Diagnosis Codes – Occupational Medicine

V70.5 - HEALTH EXAM-GROUP SURVEY
840.9 - SPRAIN SHOULDER/ARM NOS
V15.85 - PERSONAL HISTORY OF EXPOSURE TO POTENTIALLY HAZARDOUS BODY FLUIDS
354.0 - CARPAL TUNNEL SYNDROME
V70.3 - MED EXAM NEC-ADMIN PURP
959.5 - FINGER INJURY NOS
846.0 - SPRAIN LUMBOSACRAL
493.90 - ASTHMA W/O STATUS ASTHM
847.2 - SPRAIN LUMBAR REGION
V70.4 - EXAM-MEDICOLEGAL REASONS
V06.1 - VACCIN FOR DTP
847.0 - SPRAIN OF NECK
726.90 - ENTHESOPATHY, SITE NOS
840.8 - SPRAIN SHOULDER/ARM NEC
715.90 - OSTEOARTHROS NOS-UNSPEC
727.00 - SYNOVITIS NOS
353.0 - BRACHIAL PLEXUS LESIONS
726.32 - LATERAL EPICONDYLITIS
443.0 - RAYNAUD'S SYNDROME
844.9 - SPRAIN OF KNEE LEG NOS
726.31 - MEDIAL EPICONDYLITIS
V04.5 - VACCIN FOR RABIES
477.9 - ALLERGIC RHINITIS NOS
847.1 - SPRAIN THORACIC REGION
727.05 - TENOSYNOV HAND/WRIST NEC

Routine General Medical Exam ICD-9

- V70 General medical examination
  - V70.0 General medical examination at a health care facility, excludes
    - Health checkup of infant/child >28 d/o (V20.2)
    - Health supervision of newborn 8-28 d/o (V20.32)
    - Health supervision of newborn under 8 d/o (V20.31)
    - Preprocedural general physical exam (V72.83)

Routine General Medical Exam ICD-10

- Z00 Encounter for general exam w/o complaint, suspected or reported diagnosis
  - Z00.0 General adult medical exam
    - Z00.00 without abnormal findings
    - Z00.01 with abnormal findings
      - Use additional code to identify abnormal findings
  - Z00.1 Newborn, infant and child health exams
  - Z00.2 Period of rapid growth in childhood
  - Z00.3 Adolescent development state
  - Z00.5 Potential donor of organ and tissue
  - Z00.6 Normal comparison and control in clinical research program
  - Z00.7 Delayed growth in childhood
  - Z00.8 Other general examination

COPD ICD-9

- 490 Bronchitis
- 491 Chronic bronchitis
  - 491.0 Simple chronic bronchitis
  - 491.1 Mucopurulent chronic bronchitis
  - 491.2 Obstructive chronic bronchitis
    - 491.20 without exacerbation
    - 491.21 with (acute) exacerbation
    - 491.22 with acute bronchitis
  - 491.8 Other chronic bronchitis
  - 491.9 Unspecified chronic bronchitis
- 492 Emphysema
- 493 Asthma
- 494 Bronchiectasis
- 495 Extrinsic allergic alveolitis
- 496 Chronic airway obstruction, NEC

COPD ICD-10

Chronic lower respiratory diseases (J40-J47)

- J40 Bronchitis not specified as acute or chronic
- J41 Simple and mucopurulent chronic bronchitis
- J42 Unspecified chronic bronchitis
- J43 Emphysema
- J44 Other COPD, includes
  - J44.0 COPD acute lower respiratory infection
  - J44.1 COPD with (acute) exacerbation
  - J44.9 COPD, unspecified
- J45 Asthma
- J47 Bronchiectasis

COPD ICD-10

- J44 Other COPD, includes
  - Asthma with COPD
  - Chronic asthmatic (obstructive) bronchitis
  - Chronic bronchitis with airways obstruction
  - Chronic bronchitis with emphysema
  - Chronic emphysematous bronchitis
  - Chronic obstructive asthma
  - Chronic obstructive bronchitis
  - Chronic obstructive tracheobronchitis
  - J44.0 COPD acute lower respiratory infection
  - J44.1 COPD with (acute) exacerbation
  - J44.9 COPD, unspecified

Asthma ICD-9

493 Asthma

- 493.0 Extrinsic asthma
- 493.1 Intrinsic asthma
- 493.2 Chronic obstructive asthma
- 493.8 Other forms of asthma
- 493.9 Asthma, unspecified
  - 493.90 unspecified
  - 493.91 with status asthmaticus
  - 493.92 with (acute) exacerbation

Asthma

- J45 Asthma
  - J45.2 Mild intermittent asthma
    - J45.20 uncomplicated, NOS
    - J45.21 acute exacerbation
    - J45.22 status asthmaticus
  - J45.3 Mild persistent asthma
    - J45.30 uncomplicated, NOS
    - J45.31 acute exacerbation
    - J45.32 status asthmaticus
  - J45.4 Moderate persistent asthma
    - J45.40 uncomplicated, NOS
    - J45.41 acute exacerbation
    - J45.42 status asthmaticus
  - J45.5 Severe persistent asthma
    - J45.50 uncomplicated, NOS
    - J45.51 acute exacerbation
    - J45.52 status asthmaticus
  - J45.9 Other and unspecified asthma

Asthma

- J45.9 Other and unspecified asthma
  - J45.90 – Unspecified asthma
    - J45.901 with (acute) exacerbation
    - J45.902 with status asthmaticus
    - J45.909 uncomplicated
  - J45.99 Other asthma
    - J45.990 Exercise induced bronchospasm
    - J45.991 Cough variant asthma
    - J45.998 Other asthma

Asthma Classifications

Classified by

- Mild intermittent
- Mild persistent
- Moderate persistent
- Severe persistent
- Other and unspecified

Each classification includeS:

- Uncomplicated
- Acute exacerbation
- Status Asthmaticus

Conditions not specified will be coded to unspecified

Asthma Classifications

	Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent
Symptoms	2 or less days per week	More than 2 days per week	Daily	Throughout the day
Nighttime Awakenings	2 X's per month or less	3-4 X's per month	More than once per week but not nightly	Nightly
Rescue Inhaler Use	2 or less days per week	More than 2 days per week, but not daily	Daily	Several times per day
Interference With Normal Activity	None	Minor limitation	Some limitation	Extremely limited
Lung Function	FEV1 >80% predicted and normal between exacerbations	FEV1 >80% predicted	FEV1 60-80% predicted	FEV1 less than 60% predicted

Gastro-esophageal Reflux ICD-9

- 530.8 Other specified disorders of esophagus
  - 530.81 Esophageal reflux
    - Includes gastroesophageal reflux
    - Excludes reflux esophagitis (530.11)
  - 530.82 Esophageal hemorrhage
  - 530.83 Esophageal leukoplakia
  - 530.84 Tracheoesophageal fistula
  - 530.85 Barrett's esophagus
  - 530.86 Infection of esophagostomy
  - 530.87 Mechanical complication of esophagostomy
  - 530.89 Other

Gastro-esophageal Reflux ICD-10

- K21 Gastro-esophageal reflux disease
  - K21.0 Gastro-esophageal reflux disease with esophagitis
  - K21.1 Gastro-esophageal reflux disease without esophagitis

Acquired Hypothyroidism ICD-9

- 244 Acquired hypothyroidism
  - 244.0 Postsurgical hypothyroidism
  - 244.1 Other postablative hypothyroidism
  - 244.2 Iodine hypothyroidism
  - 244.3 Other iatrogenic hypothyroidism
  - 244.8 Other specified acquired hypothyroidism
  - 244.9 Unspecified hypothyroidism

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

Iodine Deficiency Thyroid Disorder

- Iodine Deficiency Thyroid Disorder
  - Congenital Iodine-deficiency Disorder
    - Documentation requirement
      - Neurological type
      - Myxedematous type
      - Mixed type or
      - Unspecified
  - Iodine deficiency related thyroid disorder and allied conditions
    - Documentation requirements
      - Diffuse (endemic) goiter
      - Multinodular (endemic) goiter and
      - Endemic goiter unspecified

Hypothyroidism

Congenital Hypothyroidism expanded to include:

- With and without goiter

Other (Acquired) hypothyroidism expanded to include:

- Drug induced
- Post infection
- Atrophy
- Myxedema coma

Thyroiditis/Hyperthyroidism

Thyroiditis

- Document acuity/underlying cause
  - Acute
  - Subacute
  - Chronic
  - Autoimmune
  - Drug induced

Hyperthyroidism document:

- Goiter/Nodule
  - Diffuse goiter
  - Toxic single thyroid nodule
  - Toxic multinodular goiter

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 innoculation 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

Abdominal 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

Abdominal Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.0 Acute abdomen
  - R10.1 Pain localized to upper abdomen
  - R10.2 Pelvic and perineal pain
  - R10.3 Pain localized to other parts of lower abdomen
  - R10.8 Other abdominal pain
  - R10.9 Unspecified abdominal pain

Abdominal Pain ICD-10

- R10 Abdominal and pelvic pain
  - R10.8 Other abdominal pain
    - R10.81 Abdominal tenderness
      - R10.811 RUQ
      - R10.812 LUQ
      - R10.813 RLQ
      - R10.814 LLQ
      - R10.815 Periumbilic
      - R10.816 Epigastric
      - R10.817 Generalized
      - R10.819 Unspecified site
    - R10.81 Rebound abdominal tenderness
      - R10.821 RUQ
      - R10.822 LUQ
      - R10.823 RLQ
      - R10.824 LLQ
      - R10.825 Periumbilic
      - R10.826 Epigastric
      - R10.827 Generalized
      - R10.829 Unspecified site
    - R10.83 Colic
    - R10.84 Generalized abdominal pain
  - R10.9 Unspecified abdominal pain

Influenza Vaccine

- Z23 Encounter for immunization
  - Code 1st any routine childhood examination
  - NOTE – Procedure codes are required to identify the types of immunizations given

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

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

Hyperlipidemia ICD-9

- 272 Disorders of lipid metabolism
  - 272.0 Pure hypercholesterolemia
  - 272.1 Pure hyperglyceridemia
  - 272.2 Mixed hyperlipidemia
  - 272.3 Hyperchylomicronemia
  - 272.4 Other and unspecified hyperlipidemia
  - 272.5 Lipoprotein deficiencies
  - 272.6 Lipodystrophy
  - 272.7 Lipidoses
  - 272.8 Other disorders of lipoid metabolism
  - 272.9 Unspecified disorder of lipoid metabolism

Hyperlipidemia ICD-10

- E78 Disorders of lipoprotein metabolism and other lipidemias
  - E78.0 Pure hypercholesterolemia
  - E78.1 Pure hyperglyceridemia
  - E78.2 Mixed hyperlipidemia
  - E78.3 Hyperchylomicronemia
  - E78.4 Other hyperlipidemia
  - E78.5 Hyperlipidemia, unspecified
  - E78.6 Lipoprotein deficiency
  - E78.7 Disorders of bile acid and cholesterol metabolism
  - E78.8 Other disorders of lipoprotein metabolism
  - E78.9 Disorder of lipoid metabolism, unspecified

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

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

Backache ICD-9

- 724 Other and unspecified disorders of back
  - 724.0 Spinal stenosis, other than cervical
  - 724.1 Pain in thoracic spine
  - 724.2 Lumbago
  - 724.3 Sciatica
  - 724.4 Thoracic or lumbosacral neuritis or radiculitis
  - 724.5 Backache, unspecified
  - 724.6 Disorders of sacrum
  - 724.7 Disorders of coccyx
  - 724.8 Other symptoms referable to back
  - 724.9 Other unspecified back disorders

Backache ICD-10

- M54 Dorsalgia
  - M54.0 Panniculitis affecting regions of neck and back
  - M54.1 Radiculopathy
  - M54.2 Cervicalgia
  - M54.3 Sciatica
  - M54.4 Lumbago with sciatica
  - M54.5 Low back pain
    - Includes Loin pain, Lumbago NOS
  - M54.6 Pain in thoracic spine
  - M54.8 Other dorsalgia
  - M54.9 Dorsalgia, 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.

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

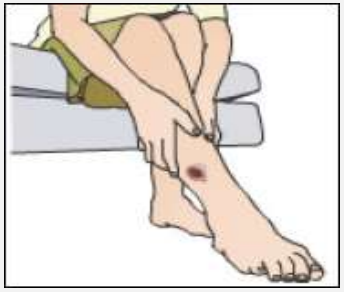
Heart Failure

- **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)



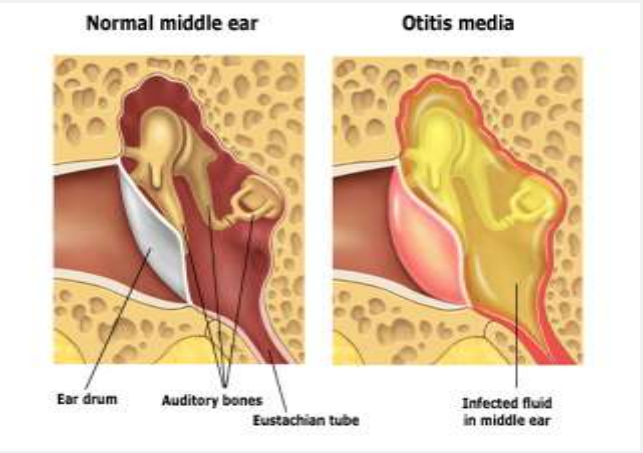
Pressure Ulcers ICD-10 Code Examples

Pressure Ulcers

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

- **L97.101 –** Non-pressure chronic ulcer of unspecific 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



Otitis Media

In ICD-10-CM for Otitis Media conditions, the physician should specify laterality and type: with effusion or nonpurulent, allergic, catarrhal, exudative, post measles, purulent, secretory, suppurative, etc. as well as acuity (acute or chronic).

Episodes of Care

ICD-10-CM relies more heavily on categorizing the episodes of care for injuries and illnesses. ***Detailed documentation is required***

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.

Open Wounds/Lacerations

Below is an example of the classification differences between ICD-9-CM Diagnosis and ICD-10-CM for an open wound or laceration of the thumb with a foreign body.

ICD-9-CM Diagnosis

883.1 Complicated open wound of the finger.

ICD-10-CM

S61.021A Laceration with foreign body of right thumb without damage to nail, initial encounter.

Much more descriptive of the injury allowing for reflection of patient acuity, outcome/prognosis, evaluation as well as follow up expectations.

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

Underdosing of drugs specifies documentation of intentional or unintentional underdosing:

- Intentional underdosing
  - Due to financial hardship
  - Other reasons
- Unintentional underdosing
  - Age-related debility
  - Other reasons

Separate "Z" code that is submitted alongside the code for underdosing.

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Procedure Documentation Examples

Overview of ICD-10-PCS

- PCS stands for ***Procedure Classification System***
- It is a *multiaxial 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***

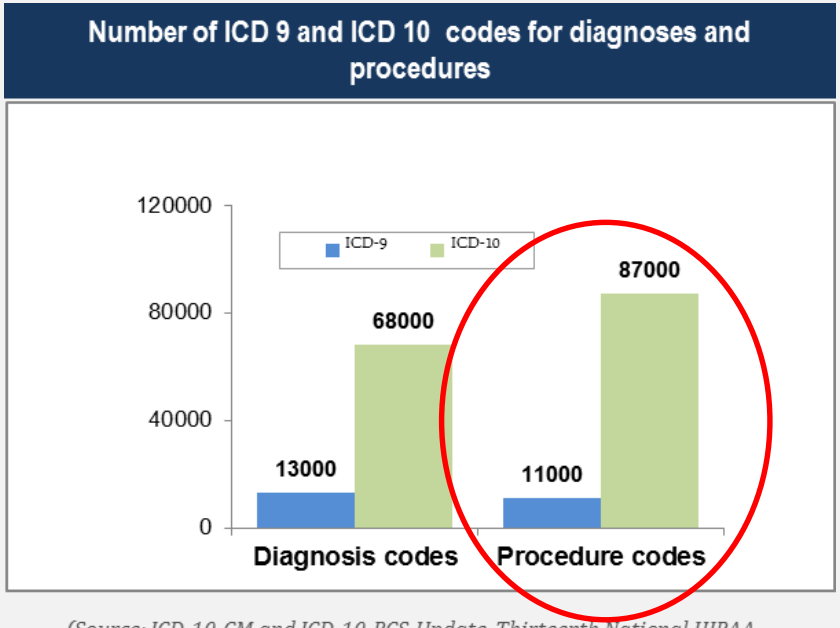
Overview of ICD-10-PCS

- 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



(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

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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?

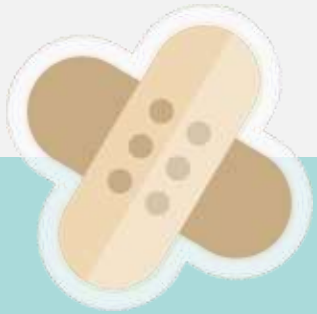
A Physician response, ***'see notes'*** does not fulfill the request generated by the query.

- 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?