June 2015

ICD-10 for Oral and Maxillofacial Surgery

UConn Health

Just himagine what we can accomplish together.

Introduction

Dr. Frank Turner

ICD-10 Implementation Physician Advisor

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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

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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

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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

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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

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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

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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

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The ICD-10 and CPT Connection

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

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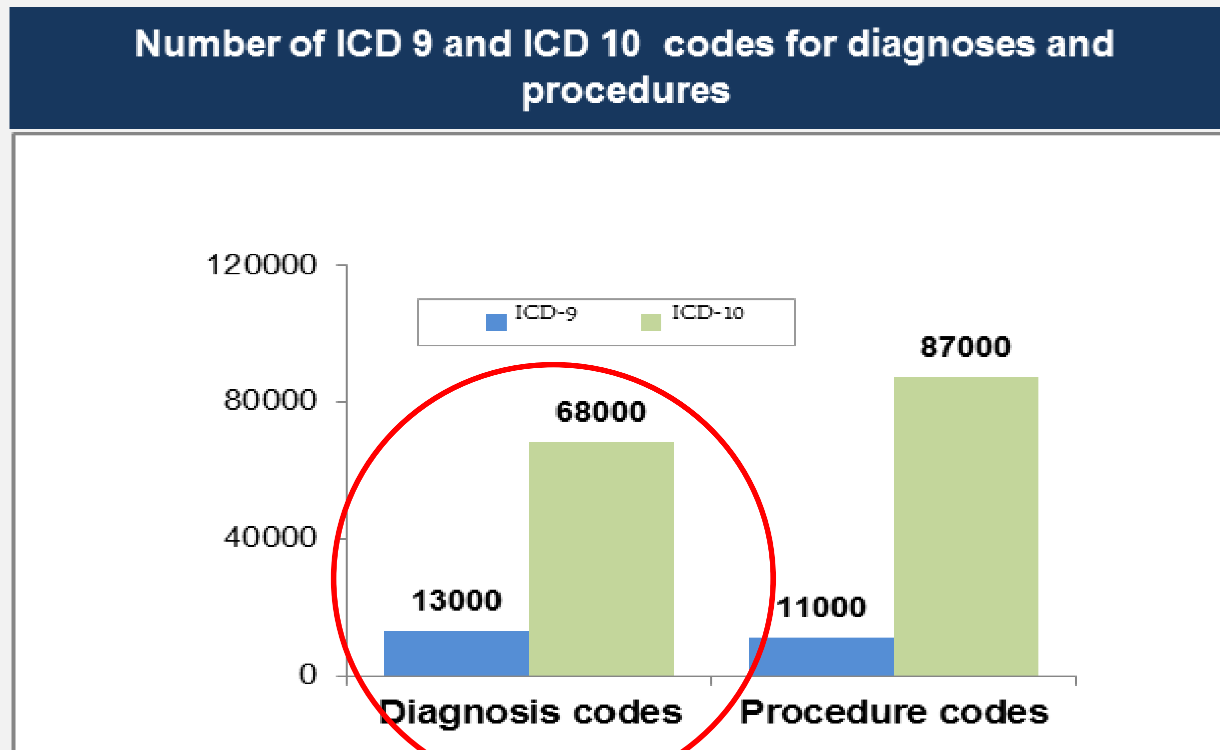
Increased Number of Codes



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

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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

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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

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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

Acuity

ICD-10-CM further enforces acuity in the diagnosis classification system. Many providers already document acuity in the medical record. For example:

Sialoadenitis

ICD-9
- 527.2

ICD-10
- K11.20 Sialoadenitis unspecified
- K11.21 Acute sialoadenitis
- K11.22 Acute recurrent sialoadenitis
- K11.23 Chronic sialoadenitis

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Cleft Lip and Palate

In ICD-9-CM, the codes for cleft lip, cleft palate, and cleft palate with cleft lip are divided into:

- Unilateral complete
- Unilateral incomplete
- Bilateral complete
- Bilateral incomplete

The ICD-10-CM codes are ***more specific about where the anomaly is located.*** For example, for a cleft palate, you will choose from these codes:

- Q35.1, cleft hard palate
- Q35.3, cleft soft palate
- Q35.5, cleft hard palate with cleft soft palate
- Q35.7, cleft uvula
- Q35.9, cleft palate, unspecified

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Cleft Lip and Palate

In ICD-10 for a cleft lip, you have these three choices:
- Q36.0, cleft lip, bilateral
- Q36.1, cleft lip, median
- Q36.9, cleft lip, unilateral

The codes for cleft palate with cleft lip provide a lot of detail about the patient's particular problem.
- Q37.0, cleft hard palate with bilateral cleft lip
- Q37.1, cleft hard palate with unilateral cleft lip
- Q37.2, cleft soft palate with bilateral cleft lip
- Q37.3, cleft soft palate with unilateral cleft lip
- Q37.4, cleft hard and soft palate with bilateral cleft lip
- Q37.5, cleft hard and soft palate with unilateral cleft lip
- Q37.8, unspecified cleft palate with bilateral cleft lip
- Q37.9, unspecified cleft palate with unilateral cleft lip

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Dental Caries

ICD-10-CM coding requires the more specific mention of whether the caries is limited to the enamel, dentin, or pulp. For example:

ICD-9-CM
- 521.06 – Dental caries pit and fissure

ICD-10-CM
- K02.51 – Dental caries on pit and fissure surface limited to enamel
- K02.52 – Dental caries on pit and fissure surface penetrating into dentin
- K02.53 – Dental caries on pit and fissure surface penetrating into pulp

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Gingivitis and Perodontal Diseases

Many of the ICD-10-CM categories have added a note for a necessary additional code to further specify the diagnosis. An example of a dentoalveolar code with an additional code needed would be:

- **K05 (523.00) Gingivitis and Periodontal Diseases**
  - ***Use additional code to identify:***
    Alcohol abuse and dependence (F10-)
    Exposure to environmental tobacco smoke (Z77.22)
    Exposure to tobacco smoke in the prenatal period (P96.81)
    History of tobacco use (Z87.891)
    Occupational exposure to environmental tobacco smoke (Z57.31)
    Tobacco dependence (F17-)
    Tobacco use (Z72.0)

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Edentulism

ICD-10 requires the more specific mention of the patient's class of edentulism pertaining to a specific cause.

For example:

- loss of teeth due to unspecified cause, class I-IV
- loss of teeth due to trauma, class I-IV
- loss of teeth due periodontal disease, class I-IV
- loss of teeth due to caries, class I-IV
- loss of teeth due to other specified cause, class I-IV

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Edentulism Classifications

- Class I – Ideal or minimally compromised
- Class II – Moderately compromised
- Class III– Substantially compromised
- Class IV – Severely compromised

ICD-10-CM

- K08.111 – Complete loss of teeth due to trauma, class I

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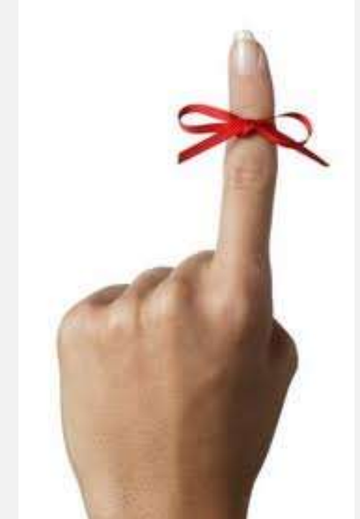
Infections Resistant to Antibiotics

- Many bacterial infections are resistant to current antibiotics. ***It is necessary to identify all infections documented as antibiotic resistant.*** The infection must also be identified.

- Code Category Z16 – Resistance to antimicrobial drugs



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Documentation of Causal Relationship

As with all postprocedural complications, code assignment is based on the ***provider's documentation of the relationship between the complication and the procedure.***

- H91.840, Postprocedural hemorrhage and hematoma of a ***digestive system organ or structure following a digestive system procedure***
- H91.841, Postprocedural hemorrhage and hematoma of a ***digestive system organ or structure following other procedure***

Codes specify not only **where the hemorrhage occurred,** but also **what kind of procedure the bleed complicated.**

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MSSA and MRSA Colonization

- The condition or state of being colonized or carrying MSSA or MRSA is called colonization or carriage, while an individual person is described as being colonized or being a carrier.
- A positive MRSA colonization test might be documented by the provider as ***"MRSA screen positive" or "MRSA nasal swab positive."***
  - Z22.322, Carrier or suspected carrier of Methicillin resistant Staphylococcus aureus
  - Z22.321, Carrier or suspected carrier of Methicillin susceptible Staphylococcus aureus

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Episodes of Care

- **ICD-10-CM relies more heavily on categorizing the episodes of care** for injuries and illnesses.
  - **A**: Initial encounter – when the patient is receiving active treatment/first visit by that physician
  - **D**: Subsequent encounter – after the active phase of treatment and when the patient is receiving repeat or routine care for the injury.
  - **S**: Sequela is assigned for complication or condition that arises as a direct result of an injury (takes priority for code- if no sequelae, code initial or subsequent).

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Episodes of Care

ICD-10-CM will require the use of a seventh character in coding instances such as entoalveolar fractures. For example:

ICD-9-CM

- 802.39 – Open fracture of multiple sites of mandible

ICD-10-CM

- S02.600**A** – Fracture of unspecified part of body of mandible, initial encounter

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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

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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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Underdosing

These codes also require a 7th character to identify whether this is:

- **A**: Initial encounter – when the patient is receiving active treatment/first visit by that physician
- **D**: Subsequent encounter – after the active phase of treatment and when the patient is receiving repeat or routine care for the injury.
- **S**: Sequela is assigned for complication or condition that arises as a direct result of an injury (takes priority for code- if no sequelae, code initial or subsequent)

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Procedure Documentation Examples

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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***

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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**

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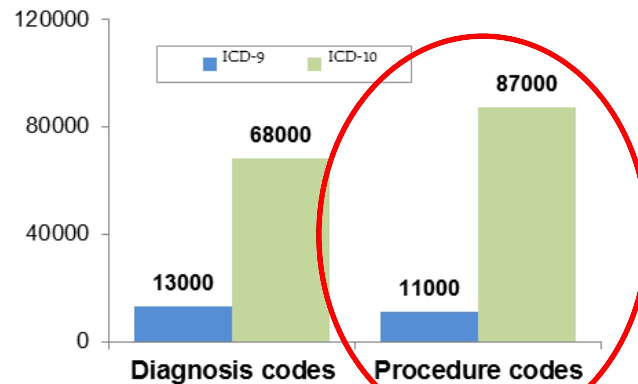
ICD-10-PCS



(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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ICD-10-PCS ORIF Mandible Fracture

Patient presents for ORIF of right mandible fracture.

ICD-10-PCS

0NST04Z

- Reposition Right Mandible with Internal Fixation Device, Open Approach

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ICD-10-PCS Table

Section	0	Medical and Surgical
Body System	N	Head and Facial Bones
Operation	S	Reposition: Moving to its normal location, or other suitable location, all or a portion of a body part

Body Part	Approach	Device	Qualifier
0 Skull **R** Maxilla, Right **S** Maxilla, Left **T** Mandible, Right **V** Mandible, Left	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**4** Internal Fixation Device **5** External Fixation Device **Z** No Device	**Z** No Qualifier
0 Skull **R** Maxilla, Right **S** Maxilla, Left **T** Mandible, Right **V** Mandible, Left	**X** External	**Z** No Device	**Z** No Qualifier
1 Frontal Bone, Right **2** Frontal Bone, Left **3** Parietal Bone, Right **4** Parietal Bone, Left **5** Temporal Bone, Right **6** Temporal Bone, Left **7** Occipital Bone, Right **8** Occipital Bone, Left **B** Nasal Bone **C** Sphenoid Bone, Right **D** Sphenoid Bone, Left **F** Ethmoid Bone, Right **G** Ethmoid Bone, Left **H** Lacrimal Bone, Right **J** Lacrimal Bone, Left **K** Palatine Bone, Right **L** Palatine Bone, Left **M** Zygomatic Bone, Right **N** Zygomatic Bone, Left **P** Orbit, Right **Q** Orbit, Left **X** Hyoid Bone	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**4** Internal Fixation Device **Z** No Device	**Z** No Qualifier

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ICD-10-PCS ORIF Mandible Fracture

1st	2nd	3rd	4th	5th	6th	7th
Section 0	Body System N	Root Operation S	Body Part T	Approach 0	Device 4	Qualifier Z

The ICD-10-PCS code structure tells a story

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ICD-10-PCS Tooth Extraction

Patient presents for extraction of right upper incisor and left upper molar

ICD-10-PCS

0CDWXZ1

- Extraction of Upper Tooth, Multiple, External Approach

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ICD-10-PCS Table

Section	0	Medical and Surgical	
Body System	C	Mouth and Throat	
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
T Vocal Cord, Right **V** Vocal Cord, Left	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic **7** Via Natural or Artificial Opening **8** Via Natural or Artificial Opening Endoscopic	**Z** No Device	**Z** No Qualifier
W Upper Tooth **X** Lower Tooth	**X** External	**Z** No Device	**0** Single **1** Multiple **2** All

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ICD-10-PCS Tooth Extraction

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

The ICD-10-PCS code structure tells a story

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ICD-10-PCS Excisional Biopsy

Patient presents for excisional biopsy of the left maxilla

ICD-10-PCS

0NBS0ZX

- Excision of Left Maxilla, Open Approach, Diagnostic

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ICD-10-PCS Table

Section	0	Medical and Surgical	
Body System	N	Head and Facial Bones	
Operation	B	Excision: Cutting out or off, without replacement, a portion of a body part	
Body Part	**Approach**	**Device**	**Qualifier**
0 Skull **1** Frontal Bone, Right **2** Frontal Bone, Left **3** Parietal Bone, Right **4** Parietal Bone, Left **5** Temporal Bone, Right **6** Temporal Bone, Left **7** Occipital Bone, Right **8** Occipital Bone, Left **B** Nasal Bone **C** Sphenoid Bone, Right **D** Sphenoid Bone, Left **F** Ethmoid Bone, Right **G** Ethmoid Bone, Left **H** Lacrimal Bone, Right **J** Lacrimal Bone, Left **K** Palatine Bone, Right **L** Palatine Bone, Left **M** Zygomatic Bone, Right **N** Zygomatic Bone, Left **P** Orbit, Right **Q** Orbit, Left **R** Maxilla, Right **S** Maxilla, Left **T** Mandible, Right **V** Mandible, Left **X** Hyoid Bone	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**Z** No Device	**X** Diagnostic **Z** No Qualifier

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ICD-10-PCS Tooth Extraction

1st	2nd	3rd	4th	5th	6th	7th
Section 0	Body System N	Root Operation B	Body Part S	Approach 0	Device Z	Qualifier X

The ICD-10-PCS code structure tells a story

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Physician Queries

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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

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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

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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

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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***

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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***.

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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!

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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.***

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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

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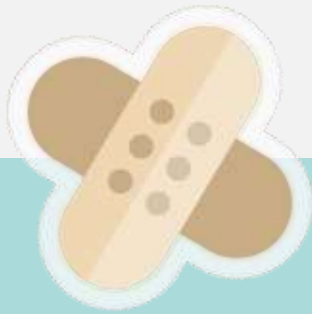

Questions?

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