June 2015

ICD-10 for Psychiatry

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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ICD-10 Resources: USA.GOV
ICD-10 Resources: CMS.GOV

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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.

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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.

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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.

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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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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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Consequences of Inadequate Documentation

Inappropriate Payment for Submitted Claims

Claim Denials

Increased Risk of Government Audit, Repayment and Fines

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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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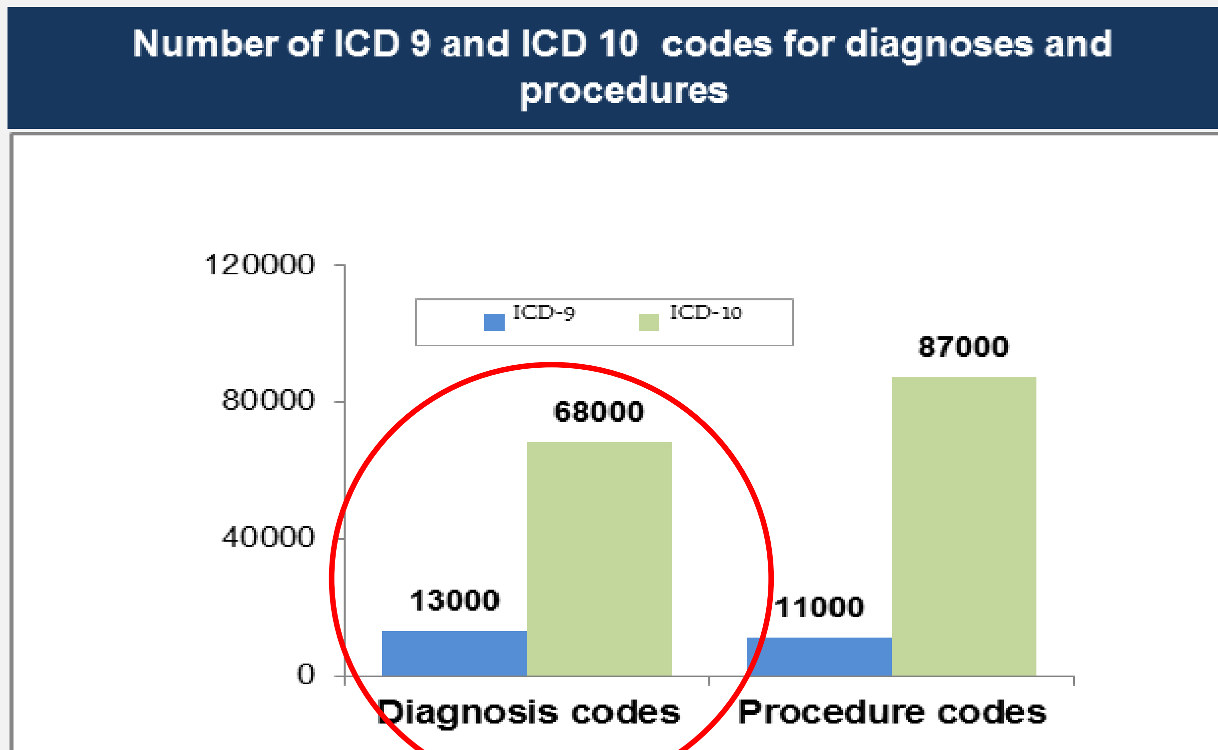
Increased Number of Codes



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

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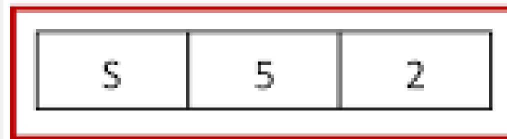
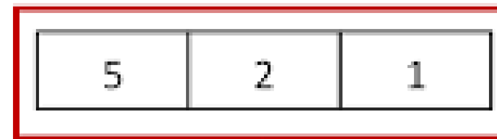
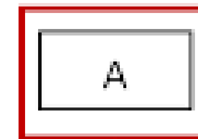
Structure of ICD-10 codes







Analogous to Problem List diagnoses, some with more specificity regarding etiology:

"Stroke"
Cerebral infarction =I63

"Head Injury"
Intracranial injury = S06

Adds detail as clinical picture becomes clearer.

Cerebral infarction due to embolism of right middle cerebral artery = I63.411

Diffuse traumatic brain injury with loss of consciousness for greater than 24 hours without return to pre-existing level with patient surviving = S06.2X6

For Injuries and Fractures:
- Initial, Subsequent, Sequela
- Open, Closed, Nonunion, etc. for fractures
- Only other use is in OB

Initial encounter = S06.2X6A

Also must describe how injury occurred.

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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

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ICD-9 Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior

- ICD-9-CM **296.33**
- Short description: Recur depr psych-severe.
- ICD-9-CM 296.33 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.

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ICD-10 Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior

- Convert to ICD-10-CM: 296.33 converts directly to:2015 ICD-10-CM F33.2 Major depressive disorder, recurrent severe without psychotic features.
- F33.2 is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.

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ICD-10 Major depressive affective disorder, recurrent episode, severe, without mention of psychotic behavior

- **Documentation Improvement**
- 2015 ICD-10-CM F33.2
- Etiology of diagnosis, Link must be established between manifestations and underlying diseases, degree of severity.

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ICD-9 Posttraumatic stress disorder

- ICD-9-CM Diagnosis Code **309.81**
- Short description: Posttraumatic stress dis.
- ICD-9-CM 309.81 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.

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ICD-10 Posttraumatic stress disorder

- ICD-9-CM 309.81 converts approximately to:
- 2015 ICD-10-CM F43.10 Post-traumatic stress disorder, unspecified or:
- 2015 ICD-10-CM F43.12 Post-traumatic stress disorder, chronic.
- F43.10 is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.
- F43.12 is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.

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ICD-10 Posttraumatic stress disorder

- **Documentation Improvement**
- Etiology of diagnosis, Link must be established between manifestations and underlying diseases, degree of severity, Injury details.

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ICD-9 Alzheimer's disease

- ICD-9-CM Diagnosis Code **331.0**
- ICD-9-CM 331.0 is a billable medical code that can be used to specify a diagnosis on a reimbursement claim.

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ICD-10 Alzheimer's disease

- ICD-9-CM 331.0 converts approximately to:
- 2015 ICD-10-CM G30.9 Alzheimer's disease, unspecified.
- G30.9 is a billable ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.

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ICD-10 Alzheimer's disease

- **Documentation Improvement**
- Etiology of diagnosis, Link must be established between manifestations and underlying diseases, degree of severity.

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ICD-9 Schizoaffective Disorder

- 2015 ICD-9-CM 295.7: Schizoaffective disorder
- **Clinical Information:**
- A disorder in which the individual suffers from both symptoms that qualify as schizophrenia and symptoms that qualify as a mood disorder (e.g., depression or bipolar disorder) for a substantial portion (but not all) of the active period of the illness; for the remainder of the active period of the illness, the individual suffers from delusions or hallucinations in the absence of prominent mood symptoms

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ICD-10 Schizoaffective Disorder

- F25.0 Schizoaffective disorder, bipolar type
  - Cyclic schizophrenia
  - Schizoaffective disorder, manic type Schizoaffective disorder, mixed type Schizoaffective
  - psychosis, bipolar type
  - Schizophreniform psychosis, manic type
- F25.1 Schizoaffective disorder, depressive type
  - Schizoaffective psychosis, depressive type
  - Schizophreniform psychosis, depressive type
- F25.8 Other schizoaffective disorders
- F25.9 Schizoaffective disorder, unspecified
- Schizoaffective psychosis NOS

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ICD-10 Schizoaffective Disorder

- 2015 ICD-9-CM 295.7: Schizoaffective disorder
- **Documentation Improvement**
- Etiology of diagnosis, Link must be established between manifestations and underlying diseases, degree of severity.

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ICD-10 Autistic Disorder

- F84.0 Autistic disorder includes:
    - Infantile autism
    - Infantile psychosis
    - Kanner's syndrome

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ICD-10 Autistic Disorder

- **Documentation Improvement**
- Etiology of diagnosis, Link must be established between manifestations and underlying disease and degree of severity.

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ICD-10 Attention-deficit hyperactivity disorders

- F90.0: Attention-deficit hyperactivity disorder, predominantly inattentive type
- F90.1: Attention-deficit hyperactivity disorder, predominantly hyperactive type
- F90.2: Attention-deficit hyperactivity disorder, combined type
- F90.8: Attention-deficit hyperactivity disorder, other type
- F90.9:Attention-deficit hyperactivity disorder, unspecified type
- Attention-deficit hyperactivity disorder of childhood or adolescence NOS
- Attention-deficit hyperactivity disorder NOS

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ICD-10 Emotional Disorder

- F93.0 Separation anxiety disorder of childhood
- F93.8 Other childhood emotional disorders
  - Identity disorder
- F93.9 Childhood emotional disorder, unspecified

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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

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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

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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

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Depression ICD-9

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

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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

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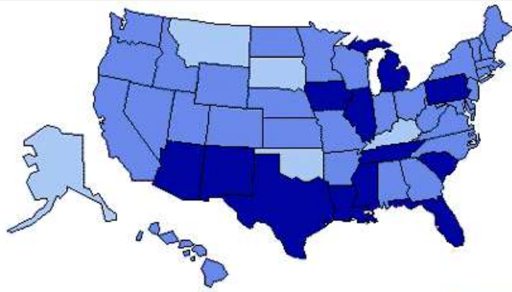

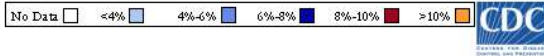

Diabetes Mellitus

- **New in ICD-10-CM**
- The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system.
- When documenting diabetes, include the following:
  – **Type:** e.g. Type 1 or Type 2 disease, drug or chemical induced, due to underlying condition, gestational
  – **Control:** out of control, inadequately controlled and controlled are no longer used in ICD-10-CM
  – **Complications:** What (if any) other body systems are affected by the diabetes condition? e.g. Foot ulcer related to diabetes mellitus
  – **Treatment:** Is the patient on insulin?

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Hypertension

- There is only **<u>one code</u>** 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**

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Hypertension

- Documentation has been simplified to Essential (Primary) Hypertension
  - No longer use malignant, systolic, accelerated, etc.
  - As with diabetes, document associated heart or kidney disease
- Examples:
  - I10 Essential hypertension
  - I12 Hypertensive heart disease
  - I12 Hypertensive chronic kidney disease
  - I13 Hypertensive heart and kidney disease

  Additional specificity by indicating with or without heart failure and stage of kidney disease

- If Secondary Hypertension, document cause

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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

- 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

Intentional	Unintentional
- Financial hardship	- Age-related debility
- Other reasons	- Other reasons

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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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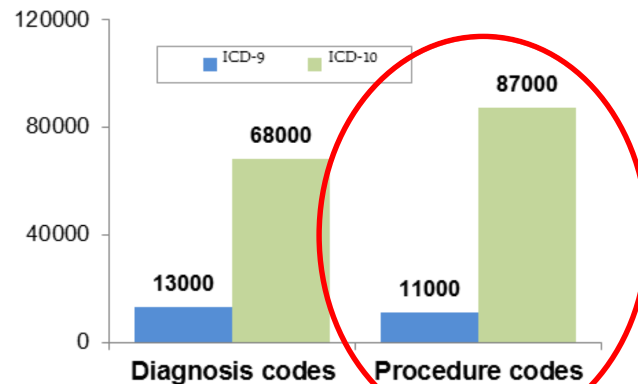
ICD-10-PCS



(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 Removal Neurostimulator lead

Patient presents for removal of Neurostimulator lead from Cranial nerve

ICD-10-PCS

OOPE3MZ

- Removal of Neurostimulator lead from Cranial nerve, percutaneous approach

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ICD-10-PCS Table

Section	0	Medical and Surgical
Body System	0	Central Nervous System
Operation	P	Removal: Taking out or off a device from a body part

Body Part	Approach	Device	Qualifier
0 Brain **V** Spinal Cord	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Drainage Device **2** Monitoring Device **3** Infusion Device **7** Autologous Tissue Substitute **J** Synthetic Substitute **K** Nonautologous Tissue Substitute **M** Neurostimulator Lead	**Z** No Qualifier
0 Brain **V** Spinal Cord	**X** External	**0** Drainage Device **2** Monitoring Device **3** Infusion Device **M** Neurostimulator Lead	**Z** No Qualifier
6 Cerebral Ventricle **U** Spinal Canal	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Drainage Device **2** Monitoring Device **3** Infusion Device **J** Synthetic Substitute **M** Neurostimulator Lead	**Z** No Qualifier
6 Cerebral Ventricle **U** Spinal Canal	**X** External	**0** Drainage Device **2** Monitoring Device **3** Infusion Device **M** Neurostimulator Lead	**Z** No Qualifier
E Cranial Nerve	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**0** Drainage Device **2** Monitoring Device **3** Infusion Device **7** Autologous Tissue Substitute **M** Neurostimulator Lead	**Z** No Qualifier
E Cranial Nerve	**X** External	**0** Drainage Device **2** Monitoring Device **3** Infusion Device **M** Neurostimulator Lead	**Z** No Qualifier

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Removal Neurostimulator lead

1st	2nd	3rd	4th	5th	6th	7th
Section 0	Body System P	Root Operation P	Body Part E	Approach 3	Device M	Qualifier Z

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"

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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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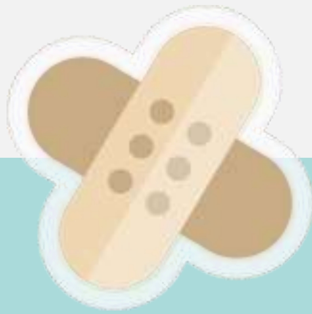

Questions?

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