ICD-10: Ready or Not Here It Comes

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AHIMA Approved ICD-10 CM/PCS
Trainer/Ambassador
Are You ready to take the leap?

ICD-10
October 1, 2015

153 Days left...
Understanding The System

The MS-DRG system
Medicare Severity-Adjusted Diagnosis Related Groups
Documentation & Coding Rules:

- Part B – Physician Documentation for E&M Coding
  - ICD9 (diagnosis) codes must be specific
  - Coders may not code probable, likely, suspect, etc.

- Part A – Physician Documentation of Inpatient Care
  - Physicians should document presumptive diagnoses driving resource utilization such as “probable, likely, suspect, presumptive, etc.”
  - Coders may assign DRG based on presumptive diagnoses

- Who Can Identify Diagnoses?
  - Only physicians (and those working under their supervision such as PAs, NPs, residents)
MS DRG’s: What Are They

- Medicare Severity Diagnosis Related Groups (MS-DRGs)
  - The Principle Diagnosis or Procedure; plus
  - Severity (Acuity) - CC or MCCs
- DRG Assignment
  - DRGs are groups of diagnoses determined by Medicare to be related clinically and have similar resource consumption
  - Many different diagnoses exist within one DRG
  - One DRG per hospitalization, assigned at discharge
- Each DRG is assigned a “Relative Weight” (RW)
  - Average of 1.00
  - Originally designed for hospital payment
  - The RW has become the proxy for severity of illness
DRG vs MS-DRG’s
Better Severity Adjustment: Three levels vs. Two

- Traditional DRGs
  - 538 DRGs
  - Severity Adjustment
    - without CC
    - with CC

- MS-DRGs (October 2007)
  - 745 MS-DRGs
  - Severity Adjustment
    - without CC
    - with minor CC
    - with Major CC (MCC)
Principal Diagnosis:

- A principal diagnosis (PDx) is the condition present on admission, requiring admission and treatment (may be more than one)
- Explain etiology where possible (non-healing foot ulcer due to diabetic peripheral vascular disease)
- Avoid symptoms as a final diagnosis (abdominal pain vs. abdominal pain due to possible cholelithiasis)
Secondary Diagnosis

- Include *all* diagnoses present on admission which are in any way treated and/or monitored (re-exam, testing, meds, etc.)
  - This may be the only way to accurately reflect the patient’s true severity of illness
- Explain why the patient is at higher risk for surgery
- Utilize medical consults where appropriate to improve specificity of diagnoses, but document all diagnoses on your note as well
Co-Morbidities Drive Severity

- Typical Minor Comorbidities
  - Most Infections
  - Hypoglycemia
  - Transient Visual Loss
  - Chronic Kidney Disease
  - Chronic Heart Failure
  - Unstable Angina

  Typically add complexity to the care of the patient but not high degree of severity

- Typical Major Comorbidities
  - Septicemia
  - Meningitis
  - DKA
  - Acute Heart Failure
  - Acute Kidney Failure
  - Acute MI

  Typically add significant complexity to the care and add significant severity and Risk of Mortality. Can be a main driver of care with Principle Dx.
General Diagnosis that are no longer “codeable”

- CHF
- COPD
- Renal Insufficiency
  - Since 2007 they must be defined to end up as either a minor or major CC. If they are not clarified they can not be used and you do not get credit for the complexity……..

- Don’t stop using them because they will prompt someone to ask so you can get credit.
Conditions Arising During Hospitalization

– Clearly describe your “clinical impression” as to whether the condition is expected/anticipated (e.g. due to an underlying illness and/or commonly occurring and therefore *not* a complication) or a complication of care (e.g. unanticipated and/or outside of the expected post-op clinical course)
  – “Acute Blood Loss Anemia, expected, secondary to underlying (condition) and/or procedure”
  – Acute blood loss anemia is a CC

– Consider documenting a diagnosis any time you do something procedurally to a patient (straight cath – *acute urinary retention*; CVC – hypovolemic shock)
Post Operative Pitfalls…

- Beware of describing conditions in the post-op period as “post-op;” post-op hypertension, for example, codes as a complication – explain the etiology (e.g. exacerbation of essential hypertension) underlying the condition
- Link any medication or nursing order to a diagnosis in the day’s progress note
- Describe Your “Clinical Impression” of diagnosis/etiology
  - Diagnoses are not always “certain”
  - You can use words like probable, presumptive, suspect, etc.
X-Ray Reports

– If an x-ray report (routine chest film for example) demonstrates a clinical diagnosis, coders can’t code from an “interpreting physician’s report”
– Document the condition in the progress notes
  – e.g., Severe Interstitial Pulmonary Fibrosis
  – COPD
  – Atelectasis
The Quality Perspective

The Effect of Documentation on Outcome performance
Severity of Illness (SOI) = CMI

- The Common Denominator for clinical outcomes measures is *Case Mix Index* (CMI) (avg. of *all* MS-DRG RW’s).

- Based *entirely* on physician documentation and MS-DRG assignment.

- CMS is now calculating CMI for *physicians*, as well as *hospitals*.

- ICD-10, with it’s possible use of *non-specific codes*, may have an adverse impact on both hospital and physician CMI reporting if non-specific codes are used.
What’s so important about my CMI?

<table>
<thead>
<tr>
<th></th>
<th>Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Hughes</td>
<td>4.7%</td>
</tr>
<tr>
<td>Dr Jones</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

Who has the better mortality index?  
Who profiles as the “better” physician??
We are shifting the landscape of payment in health care from Fee-for Service to **Fee-for VALUE** (quality + cost).

ICD-10 Will Dramatically Impact the Capture of Data Used for These Purposes
The Statistical FACTS About Physician Ratings...

– HALF the Physicians in America---
– Will be rated as “BELOW Average”…!

So you’re rated “BELOW Average” in the US---
WHAT is there to be worried about…?

WHO really needs to be worried…?
The federal government announced that Medicare will now allow use of its extensive medical claims database by employers, insurance companies and consumer groups to produce report cards on local doctors and hospitals.

…By analyzing masses of billing records, experts can glean such critical information as how often a doctor has performed a particular procedure and get a general sense of any major problems such as preventable complications…

Announced by Marilyn Tavenner – Acting Administrator of CMS
ICD-10 Has the Potential (if Non-Specific Codes Are Used) to Impact Your Measured Quality !!!

– Does Your Clinical Documentation Adequately Document Medical Necessity and Severity?

– ....And Why You Should Care

What Really Matters is Your Measured Quality
Now It’s Physician’s Turn to Be Under The Microscope
There are 58 Healthcare Professionals related to "Cardiovascular Disease (Cardiology)" within 5 miles of ZIP Code 33613.
MCOs ALSO measure MD Performance...

A Guide To the Aexcel® Network

The blue star ★ on the results page identifies Aexcel specialists.

These are doctors who meet our high standards for both clinical performance and efficiency.

Going to an Aexcel specialist can lower your cost$...
United Physician Locator Website...

UnitedHealth Premium® Designation Program

Not all health care is equal, and that can affect the care you receive. According to a study in The New England Journal of Medicine, "adults receive the recommended medical treatment only 55 percent of the time."¹ That's why UnitedHealthcare developed the UnitedHealth Premium® designation program, which recognizes physicians that meet guidelines for providing quality and cost efficient care.

The program uses national industry standards to evaluate for quality and local market benchmarks for cost efficiency across 25 specialties,² including family practice, internal medicine, pediatrics, cardiology and orthopaedics.

No two doctors are alike, and you probably think about many factors when choosing a physician. We offer tools and information to help you make more confident health care decisions. When you’re looking for a doctor, you can consider his or her Premium designation when making your choice.
United Physician Locator Website...

Physician designation results are displayed publicly on myuhc.com® and in UnitedHealthcare’s physician directories. Doctors who have met the criteria for quality and/or cost efficiency could have one of these four UnitedHealth Premium designations:

- Quality & Cost Efficiency
- Cost Efficiency & Not Enough Data to Assess Quality
- Quality & Not Enough Data to Assess Cost Efficiency
- Quality & Did NOT Meet Cost Efficiency
- Did NOT Meet Quality & Cost Efficiency

Members in health plans that offer tiered benefits may pay lower copays and coinsurance amounts for services provided by UnitedHealth Premium® Tier 1 physicians.

UnitedHealth Premium® Tier 1 physicians have received the Premium designation for Quality & Cost Efficiency…
How many of you think that being dropped from a managed care plan MAY BE in YOUR future...?

UnitedHealthcare drops 10–15 percent of its doctors in Medicare advantage plans

“...We believe our networks will continue to exceed accessibility standards--- right down to the county level,” McElrath-Jones said.

“...We have conducted outreach to area providers that will remain in network to confirm their capacity to take on additional patients.”
The Risk to Providers

• The only way your clinical performance is adjudicated by those outside of your medical staff is through BILLING DATA!!! ICD-10 Has the Potential to Impact the Accurateness of Reported Data.

• If you do not get the billing data correct then your performance will be adjudicated incorrectly…

• This will be vital in the changing healthcare environment
  • It would be a shame for your career to be affected just because you didn’t understand the Documentation, Regulatory, and Compliance environment we live in today.
SGR Repeal Creates Two Tracks for Providers
Providers Must Choose Enhanced FFS\(^1\) or Accountable Care Options

### Merit-Based Incentive Payment System

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015:H2 – 2019</td>
<td>0.5% annual update</td>
</tr>
<tr>
<td>2018</td>
<td>Last year of separate MU, PQRS, and VBM penalties</td>
</tr>
<tr>
<td>2019</td>
<td>Combine PQRS, MU, &amp; VBM programs: -4% to +12%(^1) at risk</td>
</tr>
<tr>
<td>2020</td>
<td>-5% to +15%(^1) at risk</td>
</tr>
<tr>
<td>2021</td>
<td>-7% to +21%(^1) at risk</td>
</tr>
<tr>
<td>2022 and on</td>
<td>-9% to +27%(^1) at risk</td>
</tr>
</tbody>
</table>

### Advanced Alternative Payment Models\(^2\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>2015:H2 – 2019</td>
<td>0.5% annual update</td>
</tr>
<tr>
<td>2019</td>
<td>5% participation bonus</td>
</tr>
<tr>
<td>2019 - 2024</td>
<td>5% participation bonus</td>
</tr>
<tr>
<td>2019 - 2020</td>
<td>25% Medicare revenue requirement</td>
</tr>
<tr>
<td>2021 and on</td>
<td>Ramped up Medicare or all-payer revenue requirements</td>
</tr>
</tbody>
</table>

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1. Fee for service.
2. Positive adjustments for professionals with scores above the benchmark may be scaled by a factor of up to 3 times the negative adjustment limit to ensure budget neutrality. In addition, top performers may earn additional adjustments of up to 10 percent.
3. APM participants who are close to but fall short of APM bonus requirements will not qualify for bonus but can report MIPS measures and receive incentives or can decline to participate in MIPS.

Source: The Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board analysis.
New Law Strengthens Move To P4P Incentives

Builds on Trend of Increasing Provider Accountability Even Within FFS

Merit-Based Incentive Payment System (MIPS) Summary

- Sunsets current Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System (PQRS) penalties at the end of 2018, rolling requirements into a single program
- Adjusts Medicare payments based on performance on a single budget-neutral payment beginning in 2019
- Applies to physicians, NPs, clinical nurse specialists, physician assistants, and certified RN anesthetists

Includes improvement incentives for quality and resource use categories

MIPS Performance Category Weights

- EHR Use
  - Meaningful Use measures
  - 25%
- Quality
  - PQRS measures
  - 30%
- Clinical Improvement
  - Care coordination, patient satisfaction, access measures
  - 15%
- Resource Use
  - Cost measures
  - 30%

Source: The Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board analysis.
The Overall Context of ICD-10

- ICD-10 Implementation is Not an Isolated Event
- ACO’s, Accepting Risk, Bundled Payment
  - Proposed payment mechanisms (CMS-HCC system) require accurate clinical documentation of relevant diagnoses with high specificity.
  - The evolving integration of healthcare and transitions to quality-based payment provide opportunities, if we have the systems in place to capture severity
- Key Success Factors
  - Accurate population metrics – based on accurate, compliant documentation
  - Clinical documentation processes that improve physician workflow and efficiency
  - Advanced CDI programs
  - ICD-10 intelligence
ICD-10

Currently slated to begin October 1, 2015

- ICD-10-CM (Diagnosis) codes will be required for claims submitted for all DOS after 10-1-2015.
  - Specificity of documentation will be necessary to correctly code in ICD-10.
  - Clinical thought process very familiar to providers – however, you must translate clinical specificity into the documented record.

- E&M, procedure codes will continue to be reported using CPT.

- Provider offices should begin now with staff training & education and outline plans for gap analysis of documentation deficiencies.

- CMS “Road to 10” excellent resource for small—midsize practices to prepare and plan for transition (http://www.roadto10.org/
Why the switch?

• ICD-9-CM is no longer robust enough to meet current and future health care needs
• Some of content is no longer clinically accurate (a lot has changed in 30 years)
• Structure limits the ability to expand to meet new demands for codes
• Makes comparison of State, National and International morbidity and mortality data difficult
ICD-10-CM Benefits

Reflects advances in medicine and medical technology uses current medical terminology and classification of diseases
more specificity
  • laterality and episode of care
Can help support in making clinical decisions
  • Flexible
Can quickly incorporate emerging diagnoses
  • More room for expansion
Drug and Chemical Table has new category "Under-dosing"
## Comparing Code Options

<table>
<thead>
<tr>
<th></th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses</td>
<td>14,567</td>
<td>69,833</td>
</tr>
<tr>
<td></td>
<td>(including V and E codes)</td>
<td></td>
</tr>
<tr>
<td>Procedures (TOTAL)</td>
<td>(19,331)</td>
<td>(142,423)</td>
</tr>
<tr>
<td></td>
<td>4,764</td>
<td>72,590</td>
</tr>
</tbody>
</table>
ICD-10 Is Really Two Different Code Sets

ICD-10-CM
• International Classification of Diseases, 10th Revision, Clinical Modification

ICD-10-PCS
• International Classification of Diseases, 10th Revision, Procedure Coding System

There is no relationship between the two code sets – they have completely different structures and uses.
Understanding the differences

- ICD-10-CM is not an update of ICD-9-CM. The structure of ICD-10-CM was first developed with the input of a select group of physicians and then further refined by physician specialty groups.
- Specialty groups requested additional detail for many codes to help capture diagnostic details that physicians use to determine and deliver the most appropriate patient care.
Practice benefit

- CMS breaks the benefits of ICD-10-CM implementation into four categories: clinical, operational, professional, and financial.
Operational benefits include:

– Ability to match professional resources with patient needs due to more precise definitions of patient conditions found in ICD-10-CM codes,
– Better communication between healthcare providers because ICD-10-CM codes capture more specific information about patient conditions, and
– Data captured with ICD-10-CM codes enhances providers’ ability to determine staffing and medical technology needs
Professional benefits include:

- ICD-10-CM code specificity provides objective data to support credentialing and privilege requirements,
- ICD-10-CM codes provide more specificity for development and reporting of quality measures, and
- ICD-10-CM codes provide better data to support public health initiatives
Financial benefits include:

– ICD-10-CM codes require better documentation of clinical conditions, which in turn helps to support the medical necessity and level of care for the services provided, and

– Use of the codes may reduce audit risks due to the greater specificity of ICD-10-CM codes
The Good News

– To begin with, 78% of ICD-9 codes map “one-to-one” with an ICD-10 code, either exactly or approximately, according to the American Health Information Management Association (AHIMA). This means that they require no more documentation than physicians enter now for those codes.
Still Not So Bad….

– Of the ICD-10 codes that do not have ICD-9 counterparts, about half are related to laterality (left, right and bilateral indications), AHIMA says. Another big chunk of ICD-10 codes consists of “external cause reporting” codes, such as what caused a particular injury. While these have been widely mocked by ICD-10 opponents, the Center for Medicare & Medicaid Services does not require providers to use these codes. (Some states mandate certain ones, however.)
How Does the Increased Specificity Help?

Demonstrate severity of disease
– Acute suppurative otitis media of right ear, recurrent (H66.004)
– Seizure disorder, poorly controlled with break-through seizures, without status epilepticus (G40.919)

– Better quality metrics
  – Mild persistent asthma, uncomplicated (J45.30)
  – Intentional under-dosing of medication due to financial hardship (Z91.120)
How Does The Increased Specificity Help?

Differentiate specific primary care services
– Routine child health examination with abnormal findings (Z00.121)
– Sports physicals (Z02.5)

– Demonstrate health risks
  – Exposure to second hand tobacco smoke (Z77.22)
  – Severe obesity due to excess calories (E66.01)
ICD-9-CM vs. ICD-10-CM
Code Structural Changes

- ICD-9-CM (Diagnoses)

  Category

  3-5 characters
  • All numeric
  • Decimal point after 3rd digit

  etiology, site, manifestation

- ICD-10-CM (Diagnoses)

  Category

  3-7 characters
  • 1st is alpha (all letters except U)
  • 2nd is always #
  • 3-7 can be either alpha or #
    • α characters not case sensitive
  • Decimal point after 3rd character

  etiology, site, manifestation

  extension
## Major Difference Between ICD-9 and ICD-10: Granularity

<table>
<thead>
<tr>
<th>Today: ICD-9</th>
<th>Tomorrow: ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM (Diagnosis)</td>
<td>ICD-10-CM (Diagnosis)</td>
</tr>
<tr>
<td>5 Digits</td>
<td>6 alphanumeric with qualifier</td>
</tr>
<tr>
<td>(821.01 – closed fracture of shaft of femur)</td>
<td>(S72.344 - Displaced spiral fracture of shaft of right femur)</td>
</tr>
<tr>
<td>14,000 codes</td>
<td>68,000 codes</td>
</tr>
<tr>
<td>ICD-9-CM (Procedure)</td>
<td>ICD-10-PCS (Procedure)</td>
</tr>
<tr>
<td>3-5 digits</td>
<td>7 alphanumeric</td>
</tr>
<tr>
<td>(47.01 – laparoscopic appendectomy)</td>
<td>(ODTJ4ZZ – Laparoscopic appendectomy)</td>
</tr>
<tr>
<td>3,000 codes</td>
<td>Of the 72,081 codes in ICD-10-PCS, 62,022 are in the first section,</td>
</tr>
<tr>
<td></td>
<td>&quot;medical and surgical&quot;</td>
</tr>
</tbody>
</table>
ICD-9-CM $\Rightarrow$ ICD-10-CM

- Some codes will have the same wording between the 2 codes sets and basically "crosswalk" over

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>to</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>003.21 Salmonella meningitis</td>
<td>=</td>
<td>A02.21 Salmonella meningitis</td>
</tr>
<tr>
<td>745.2 Tetralogy of Fallot</td>
<td>=</td>
<td>Q21.3 Tetralogy of Fallot</td>
</tr>
</tbody>
</table>
ICD-9-CM ⇔ ICD-10-CM

Multiple ICD-9 Codes Can map to a Single ICD-10 Diagnosis

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>010.90 Primary tuberculosis infection, unspecified examination</td>
<td>A15.7 Primary respiratory tuberculosis</td>
</tr>
<tr>
<td>010.91 Primary tuberculosis infection, bacteriological/histological exam not done</td>
<td></td>
</tr>
<tr>
<td>010.92 Primary tuberculosis infection, bacteriological/histological exam unknown (at present)</td>
<td></td>
</tr>
<tr>
<td>010.93 Primary tuberculosis infection, tubercle bacilli found by microscopy</td>
<td></td>
</tr>
<tr>
<td>010.94 Primary tuberculosis infection, tubercle bacilli found by bacterial culture</td>
<td></td>
</tr>
<tr>
<td>010.95 Primary tuberculosis infection, tubercle bacilli confirmed histologically</td>
<td></td>
</tr>
<tr>
<td>010.96 Primary tuberculosis infection, tubercle bacilli confirmed by other methods</td>
<td></td>
</tr>
</tbody>
</table>
ICD-9-CM ⇔ ICD-10-CM

- When there is more specificity in I-10, there may be multiple codes to describe the condition, disease or reason for encounter. More specific physician documentation will be helpful.

<table>
<thead>
<tr>
<th>ICD-9-CM Source</th>
<th>to</th>
<th>ICD-10-CM Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>V70.3 Exam for administrative purposes</td>
<td>≈</td>
<td>Z02.0 School physical</td>
</tr>
<tr>
<td>V70.3 Exam for administrative purposes</td>
<td>≈</td>
<td>Z02.5 Sports physical</td>
</tr>
</tbody>
</table>
Diagnosis Codes

• Use the code that best explains the reason or significant finding for the encounter
  – list contributing (secondary) codes
• Code to the highest level of clinical certainty
  – use clinical judgment even in absence of lab or x-ray confirmation
  – if condition is unclear then code for symptoms and/or complaint
• do not need a "final" diagnosis
• Unlike SNOMED, ICD does not contain diagnosis definitions
Modifiers such as "mild", "slight" or "moderate" are included with certain conditions in ICD-10-CM
“Inherent” Conditions

Do not separately code for presenting problems or findings that are inherent to a condition

Do code for conditions that explain the reason for tests especially if not justified by the final diagnoses
Coding complaints & symptoms

• Symptom and complaint based diagnosis is permissible
• Not limited to a single outcome finding
Coding complaints & symptoms

Patient presents with cough, fever and vomiting
  • While it appears the symptoms and complaints are due to a viral process, no one condition is used to explain the encounter

• Code for the symptoms and complaints
  – fever (R50.9)
  – cough (R05)
  – vomiting (R11.10)
Be Specific

With ICD-10-CM payers will be more likely to question some "unspecified" diagnosis codes.

Non-specific diagnostic terminology could result in delays in prior approval for
   – laboratory and radiograph tests
   – referrals
   – elective surgeries

Using unspecified codes could lead to more claim rejections and appeals.

Potential Erosion on Performance Based Measures
• You write this
  • ROM
  • Acute OME

• OME

• The reported diagnosis
  – ICD-9-CM
    • 382.9 Unspecified otitis media
  – ICD-10-CM
    • H66.90 Otitis media, unspecified, unspecified ear
  – ICD-9-CM
    • 381.4 Nonsuppurative otitis media, not specified as acute or chronic
  – ICD-10-CM
    • H65.90 Unspecified nonsuppurative otitis media, unspecified ear
Terminology matters

• Acute suppurative otitis media
  – ICD-9-CM: 382.00
  – ICD-10-CM:
    • H66.001 right ear
    • H66.002 left ear
    • H66.003 bilateral
    • H66.004 recurrent, right ear
    • H66.005 recurrent, left ear
    • H66.006 recurrent, bilateral
    • H66.007 recurrent, unspecified ear
    • H66.009 unspecified ear

• Acute serous otitis media
  – ICD-9-CM: 381.01
  – ICD-10-CM:
    • H65.01 right ear
    • H65.02 left ear
    • H65.03 bilateral
    • H65.04 recurrent, right ear
    • H65.05 recurrent, left ear
    • H65.06 recurrent, bilateral
    • H65.07 recurrent, unspecified ear
– You write this
– •Reactive airway disease
– •Respiratory distress

– The reported diagnosis
– •ICD-9-CM
– •Asthma (493.xx)
– •ICD-10-CM
– •J45.909 Unspecified asthma, uncomplicated or J45.998 Other asthma
– •ICD-9-CM
– •Other dyspnea and respiratory abnormalities (786.09)
– •ICD-10-CM
– •R06.09 Other forms of dyspnea or R06.89 Other abnormalities of breathing or R06.00 Dyspnea unspecified
Terminology Matters

- Acute bronchospasm
  - ICD-9-CM: 519.11
  - ICD-10-CM: J98.01
- Acute respiratory distress
  - ICD-9-CM: 518.82
  - ICD-10-CM: J80
- Asthma
  - ICD9-CM
    - 493.81 Exercise induced bronchospasm
    - 493.82 Cough variant asthma
    - 493.90 Asthma unspecified
    - 493.91 Asthma with status
    - 493.92 Asthma exacerbation
Asthma

• ICD-10-CM will be able to show the severity of asthma based on the NHLBI Guidelines

• J45.20 Mild intermittent, uncomplicated
• J45.21 Mild intermittent with (acute) exacerbation
• J45.22 Mild intermittent with status asthmaticus
• J45.30 Mild persistent, uncomplicated
• J45.31 Mild persistent with (acute) exacerbation
• J45.32 Mild persistent with status asthmaticus
• J45.40 Moderate persistent, uncomplicated
• J45.41 Moderate persistent with (acute) exacerbation
• J45.42 Moderate persistent with status asthmaticus

• J45.50 Severe persistent, uncomplicated
• J45.51 Severe persistent with (acute) exacerbation
• J45.52 Severe persistent with status asthmaticus
• J45.901 Unspecified asthma with (acute) exacerbation
• J45.902 Unspecified asthma with status asthmaticus
• J45.909 Unspecified asthma, uncomplicated
• J45.990 Exercise induced bronchospasm
• J45.991 Cough variant asthma
Z Codes

• Unlike V-codes they are considered part of the main code set, not supplemental
• May be used as primary diagnosis
• Can help support medical necessity of encounter
More clarity as to why you're seeing the patient

Specific codes for
– routine child health examination with abnormal findings (Z00.121)
– school exams (Z02.0)
– driving license physicals (Z02.4)
– sports physicals (Z02.5)
– adoption services (Z02.82)
– summer camp (Z02.89)
– receiving immunizations (Z23)

alone or as part of a routine visit
Better Explains Concerns

More detail for non-compliance with medical treatment
• ICD-9-CM
  – noncompliance with medical treatment (V15.81)
• ICD-10-CM
  – with dietary regimen (Z91.11)
  – intentional under-dosing of medication regimen due to financial hardship (Z91.120)
  – with other medical treatment and regimen (Z91.19)
CLINICAL DOCUMENTATION IMPROVEMENT AND ICD-10
Diagnosis Documentation Requirements

– Asthma

1) Document severity and type:
- Mild intermittent
- Mild persistent
- Moderate persistent
- or
- Severe persistent

2) Document status:
- Uncomplicated
- w/ acute exacerbation
- w/ status asthmaticus
Congestive Heart Failure

1) Document severity:
   - Acute
   - Chronic
   - Acute on chronic

2) Document type:
   - Systolic
   - Diastolic
   - Combined systolic and diastolic

3) Specify etiology, if known, such as
   - due to:
   - Dilated cardiomyopathy
Complications of Surgery

1) Document timeframe of when complication occurred:

- Intraoperatively
- Postoperatively
Chronic Obstructive Pulmonary Disease (COPD)

1) Document if with acute lower respiratory tract infection + causal organism when known, such as:
   - Pseudomonas pneumonia
2) Document if with:
   - Acute exacerbation
3) Document if with respiratory failure and severity:
   - Acute respiratory failure
   - Chronic respiratory failure
   or
   - Acute on chronic respiratory failure
Malnutrition

1) Document type such as:
- Protein calorie
- Protein energy

2) Document severity:
- Mild or 1st degree
- Moderate or 2nd degree
Neoplasms

1) Document site and laterality such as:
   - Main bronchus
   - Left lower lobe of lung

2) Differentiate between primary and secondary (metastatic) site

3) For secondary sites:
   - Document primary
ICD-10-PCS

The area that has coders most worried…
Physician Notes

- **ICD-10-PCS codes** are only used to code inpatient procedures

- You will continue to bill for your professional fees (at least for now) with **CPT codes**

- In order to submit a hospital bill, the hospital **must have all seven characters** of any ICD-10-PCS code – for inpatient procedures
ICD-9-CM vs. ICD-10-PCS

Structural Changes

- ICD-9-CM (Procedures)

3-4 characters
- All Numeric
- Decimal point after 2nd digit

7 characters
- All letters except “I” & “O”
- No decimal point
- Character Position matters
7 Steps to Building an ICD-10-PCS Code

- **Section** (“type” of service, 16—many are OP services)
- **Body system** (e.g., gastrointestinal system, nervous system)
- **Root operation** (31, based on the objective of the procedure)
- **Body part** (e.g., ascending colon, descending colon)
- **Approach** (9, e.g., natural orifice, endoscopic, percutaneous)
- **Device** (4 general types, e.g., drainage, monitoring, infusion)
- **Qualifier** (e.g., transplant type, fluid removed, bypass sites)

It will be very difficult for coders to recognize the “root operation” (principal intent) of the procedure—**unless clearly documented by the physician**...
ICD-10-PCS

Body System

- 0  Central nervous system
- 1  Peripheral nervous system
- 2  Heart and great vessels
- 3  Upper arteries
- 4  Lower arteries
- 5  Upper veins
- 6  Lower veins
- 7  Lymphatic and hemic system
- 8  Eye
- 9  Ear, nose and throat
- B  Respiratory system
- C  Mouth and throat
- D  Gastrointestinal system
- F  Hepatobiliary system
- G  Endocrine system
- H  Skin and breast
- J  Subcutaneous tissue and fascia
- K  Muscles
- L  Tendons
- M  Bursae and ligaments
- N  Head and facial bones
- P  Upper bones
- Q  Lower bones
- R  Upper joints
- S  Lower joints
- T  Urinary system
- U  Female Reproductive system
- V  Male reproductive system
- W  Anatomic region, general
- Y  Anatomic regions, upper extremities
- Z  Anatomic regions, lower extremities
### ICD-10-PCS

#### Root Operation

<table>
<thead>
<tr>
<th>Code</th>
<th>Operation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Excision</td>
<td>Take something away</td>
</tr>
<tr>
<td>T</td>
<td>Resection</td>
<td>Take something away</td>
</tr>
<tr>
<td>6</td>
<td>Detachment</td>
<td>Take out solids / fluids / gases</td>
</tr>
<tr>
<td>5</td>
<td>Destruction</td>
<td>Involve cutting or separation only</td>
</tr>
<tr>
<td>D</td>
<td>Extraction</td>
<td>Put in / put back or move some or all of body part</td>
</tr>
<tr>
<td>9</td>
<td>Drainage</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Extirpation</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Fragmentation</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Division</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>Release</td>
<td></td>
</tr>
<tr>
<td>Y</td>
<td>Transplantation</td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Reattachment</td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>Transfer</td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>Reposition</td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>Restriction</td>
<td>Alter the diameter / route of a tubular body part</td>
</tr>
<tr>
<td>L</td>
<td>Occlusion</td>
<td>Always involves a device</td>
</tr>
<tr>
<td>7</td>
<td>Dilation</td>
<td>Examination only</td>
</tr>
<tr>
<td>1</td>
<td>Bypass</td>
<td>“Other” repairs</td>
</tr>
<tr>
<td>H</td>
<td>Insertion</td>
<td>Other objectives</td>
</tr>
<tr>
<td>R</td>
<td>Replacement</td>
<td></td>
</tr>
<tr>
<td>U</td>
<td>Supplement</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Change</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Removal</td>
<td></td>
</tr>
<tr>
<td>W</td>
<td>Revision</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>Inspection</td>
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</tr>
<tr>
<td>K</td>
<td>Map</td>
<td></td>
</tr>
<tr>
<td>Q</td>
<td>Repair</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Control</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Fusion</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>Alteration</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Creation</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Alteration</td>
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<td>3</td>
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<tr>
<td>4</td>
<td>Creation</td>
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<tr>
<td>Code</td>
<td>Approach</td>
<td>Definition</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>0</td>
<td>Open</td>
<td>Cutting through skin or mucous membrane and other body layers to expose site of procedure</td>
</tr>
<tr>
<td>3</td>
<td>Percutaneous</td>
<td>Entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and/or any other body layers to reach site of procedure</td>
</tr>
<tr>
<td>4</td>
<td>Percutaneous endoscopic</td>
<td>Entry, by puncture or minor incision, of instrumentation through skin or mucous membrane and/or any other body layers to reach and visualize site of procedure</td>
</tr>
<tr>
<td>7</td>
<td>Via natural or artificial opening</td>
<td>Entry of instrumentation through a natural or artificial external opening to reach site of procedure</td>
</tr>
<tr>
<td>8</td>
<td>Via natural or artificial opening</td>
<td>Entry of instrumentation through a natural or artificial external opening to reach and visualize site of procedure</td>
</tr>
<tr>
<td>F</td>
<td>Via natural or artificial opening</td>
<td>Entry of instrumentation through a natural or artificial external opening and entry, by puncture or minor incision, or instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure</td>
</tr>
<tr>
<td>X</td>
<td>External</td>
<td>Procedures performed directly on the skin or mucous membrane and procedures performed indirectly by the application of external force through the skin or mucous membrane</td>
</tr>
</tbody>
</table>
ICD-10-PCS

Device

- 0  Drainage device
- 2  Monitoring device
- 3  Infusion device
- 7  Autologous tissue substitute
- C  Extraluminal device
- D  Intraluminal device
- J  Synthetic substitute
- K  Nonautologous tissue substitute
- L  Artificial sphincter
- M  Stimulator lead
- Y  Other device
- Z  No device

Interventional Cardiology

Dilation Devices (Stents)
- Drug-eluting
- Non-drug-eluting
- Radioactive

Insertion Devices
- Monitoring device, pressure sensor
- Monitoring Device
- Cardiac lead, pacemaker
- Cardiac lead, defibrillator
- Cardiac lead
- Pacemaker, single chamber
- Pacemaker, single chamber , rate respon
- Pacemaker, double chamber
Building an ICD-10 Procedural Code

Example:
Interventional Cardiology
This clinical example illustrates the key component of PTCA documentation... how many sites and the device used for each site

PTCA with 1 DES

027034Z

Medical and Surgical
Heart & Great Vessels
Dilation
Coronary Artery, One Site
Perc
Intraluminal Drug-eluting device
No Qualifier

PTCAs are always:
Section 0: Medical & Surgical
Body System 2: Heart & Great Vessels
Root Operation 7: Dilation

0: one site
1: (2) sites
2: (3) sites
3: (4+) sites

0: open
3: perc
d: non-elut
T: radioactive
Z: no device

6: bifurcating
Z: no qualifier

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Helpful web sites

- National Center for Health Statistics
  - http://www.cdc.gov/nchs/about/major/dvs/icd10des.htm

- CMS

- AHIMA
  - http://www.ahima.org/icd10

- MGMA
  - www.mgma.com

- AAPC
  - www.aapc.com
"I hear there's a new ICD-10 code for carpal tunnel syndrome caused by clicking too many times in an EMR system."