On Your Marks, Get Set, Go: Preparing for ICD-10

Julio Vasquez, MD
Cara Harris, MSN, RN, CCDS
Objectives

At the end of the presentation, you’ll be able to:

• State the implementation dates for 5010 & ICD-10
• Identify the benefits of ICD-10-CM/PCS
• State the major similarities & differences between ICD-10 CM/PCS & ICD-9-CM
• Understand the impact on reimbursement & operations
What is the Clinical Documentation Program?

A daily scavenger hunt
Documentation is the key factor, not the quality of care or service.

We know that we deliver exceptional health care services to the people of our region!

Many times the documentation doesn’t support the true severity of illness of our patients.
Medicare 101 – Coding Basics

- How are MS-DRG’s (Medical Severity Diagnosis Related Groups) used:
  - Calculating Hospital reimbursement
  - Evaluate quality of care
  - Evaluate utilization of resources
    - Each DRG represents the average resources utilized to care for a patient within the grouping
    - Every DRG has a relative weight (RW) assigned to it
    - The RW is used in the calculation of the Hospitals and Physicians Case Mix Index
Medicare 101 – Coding Basics

Each DRG can also include:

- MCC (Major complication/comorbidity)
- CC (complication/comorbidity)
- Non CC
Benefits of Clinical Documentation

- More accurate documentation is more reflective of true acuity and services provided
- More accurate profiling data for both Hospital and medical staff
- More accurate E/M physician billing
- More appropriate case mix and reimbursement
- Reduced compliance risk
- Potential reduction in denials
- More appropriate patient severity, mortality, outcomes and resource consumption data
- Increased cooperation between physicians and hospital
ICD-10: What’s all the buzz about?

- ICD-10 is the biggest change to healthcare since the creation of Medicare in 1965
- Implementing ICD-10 will impact every system, process and transaction that contains or uses a diagnosis or procedure code
- The devotion of time and resources is beyond what was required for Y2K or MS-DRG preparation
Total Cost of Conversion

Per the RAND study:
   Projected one-time conversion cost: $425 million to $1.5 billion
   Projected annual cost in lost productivity: $5 million to $40 million

Per the Department of Health & Human Services:
   Projected transition costs for all parties: $1.8 billion
   Projected benefits: $4.5 billion over 15 years

Per Nolan Corp. study:
   Projected transition cost of $1.6 to $13.5 billion
How does this impact me?

Physicians will not be required to learn ICD-10-CM coding for the hospital setting, but you do need to know how the transition will impact your documentation.

Physician documentation is directly responsible for complete & accurate coding of your patient charts.

Documentation requirements for ICD-10 are greater than they were for ICD-9.
<table>
<thead>
<tr>
<th>Date</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 31, 2010</td>
<td>Internal testing of Version 5010 must be complete to achieve Level I Version 5010 compliance</td>
</tr>
<tr>
<td>January 1, 2011</td>
<td>Payers and providers should begin external testing of Version 5010 for electronic claims. CMS begins accepting Version 5010 claims. Version 4010 claims continue to be accepted.</td>
</tr>
<tr>
<td>December 31, 2011</td>
<td>External testing of Version 5010 must be complete to achieve Level II compliance</td>
</tr>
<tr>
<td>January 1, 2012</td>
<td>All electronic claims must use Version 5010. Version 4010 claims are no longer accepted.</td>
</tr>
<tr>
<td>October 1, 2013</td>
<td>Claims for services provided on or after this date must use ICD-10 codes for medical diagnoses and inpatient procedures.</td>
</tr>
</tbody>
</table>
No Impact on Use of CPT® and HCPCS Level II Codes

- CPT® and HCPCS Level II will continue to be used for:
  - Reporting physician and other professional services
  - Procedures performed in hospital outpatient departments and other outpatient facilities
## Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD.9.CM</th>
<th>ICD.10.CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>14,025</td>
<td>68,069</td>
</tr>
</tbody>
</table>
ICD 10 CM Structure

ICD 10 CM

- 3–7 characters
- Character 1 is alpha (all letters except U are used)
- Character 2 is numeric
- Characters 3–7 are alpha or numeric
- Use of decimal after 3 characters
- Use of dummy placeholder “x”
- Alpha characters are not case-sensitive

ICD 9 CM

- 3–5 characters
- First character is numeric or alpha (E or V)
- Characters 2–5 are numeric
- Always at least 3 characters
- Use of decimal after 3 characters
Comparison of ICD.9.CM to ICD.10.CM Nontraumatic Intracerebral Hemorrhage

<table>
<thead>
<tr>
<th>ICD.9.CM</th>
<th>ICD.10.CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>431</td>
<td>Intracerebral</td>
</tr>
<tr>
<td>431 is the only code available to capture any location of bleeding in the brain</td>
<td>I61.0</td>
</tr>
<tr>
<td></td>
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</tr>
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<td></td>
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</tbody>
</table>
## Comparison of ICD.9.CM to ICD.10.CM

<table>
<thead>
<tr>
<th>ICD.9.CM</th>
<th>ICD.10.CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>434.91</td>
<td>Cerebral artery occlusion with infarct</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD.9.CM</th>
<th>ICD.10.CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>I63.50</td>
<td>Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery</td>
</tr>
<tr>
<td>I63.59</td>
<td>Of other cerebral artery</td>
</tr>
<tr>
<td>I63.511</td>
<td>Of right middle cerebral artery</td>
</tr>
<tr>
<td>I63.512</td>
<td>Of left middle cerebral artery</td>
</tr>
<tr>
<td>I63.519</td>
<td>Of unspecified middle cerebral artery</td>
</tr>
<tr>
<td>I63.521</td>
<td>Of right anterior cerebral artery</td>
</tr>
<tr>
<td>I63.522</td>
<td>Of left anterior cerebral artery</td>
</tr>
<tr>
<td>I63.529</td>
<td>Of unspecified anterior cerebral artery</td>
</tr>
<tr>
<td>I63.531</td>
<td>Of left posterior cerebral artery</td>
</tr>
<tr>
<td>I63.532</td>
<td>Of right posterior cerebral artery</td>
</tr>
<tr>
<td>I63.539</td>
<td>Of unspecified posterior cerebral artery</td>
</tr>
<tr>
<td>I63.541</td>
<td>Of left cerebellar artery</td>
</tr>
<tr>
<td>I63.542</td>
<td>Of right cerebellar artery</td>
</tr>
<tr>
<td>I63.549</td>
<td>Of unspecified cerebellar artery</td>
</tr>
</tbody>
</table>
# CAD of Native Coronary Artery

<table>
<thead>
<tr>
<th>ICD.9.CM</th>
<th>ICD.10.CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>414.01</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I25.10</th>
<th>without angina pectoris</th>
</tr>
</thead>
<tbody>
<tr>
<td>I25.110</td>
<td>with unstable angina pectoris</td>
</tr>
<tr>
<td>I25.111</td>
<td>with angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I25.118</td>
<td>with other form of angina pectoris</td>
</tr>
<tr>
<td>I25.119</td>
<td>with unspecified angina pectoris</td>
</tr>
</tbody>
</table>
### CAD of Coronary Artery Bypass Graft(s)

<table>
<thead>
<tr>
<th>ICD.9.CM</th>
<th>ICD.10.CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>414.05</td>
<td>unspecified type of bypass graft</td>
</tr>
<tr>
<td>I25.700</td>
<td>unspecified, with unstable angina pectoris</td>
</tr>
<tr>
<td>I25.701</td>
<td>unspecified, with angina pectoris with documented spasm</td>
</tr>
<tr>
<td>I25.708</td>
<td>unspecified, with other forms of angina pectoris</td>
</tr>
<tr>
<td>I25.709</td>
<td>unspecified, with unspecified angina pectoris</td>
</tr>
</tbody>
</table>
Myocardial Infarction

ICD-9-CM
Acute Myocardial Infarction
10 codes (410.01-410.91)

ICD-10-CM
Myocardial Infarction
9 codes for initial (I21) and 5 codes for subsequent (I22)

Including:
I21.01 STEMI myocardial infarction involving the anterior wall with left main coronary artery involvement
I21.02 STEMI myocardial infarction involving the anterior wall with left anterior descending coronary artery involvement
I21.09 STEMI myocardial infarction involving other coronary artery of anterior wall

I22.0 Subsequent STEMI of anterior wall (within 4 weeks of initial MI)

- Myocardial infarction documentation and coding will need to include:
  - Type of infarction
    - STEMI
    - NSTEMI
  - Age of infarction
    - If within 4 weeks coded as initial
    - If older than 4 weeks coded as “old”
  - Specific site of myocardium involved
    - Anterior wall
    - Inferior wall
  - Coronary artery involved
  - Information regarding initial or subsequent MI within 4 weeks
### ST Elevation (STEMI) Myocardial Infarction of Inferior Wall

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>410.21 Inferolateral wall</td>
<td>I21.11 Involving right coronary artery</td>
</tr>
<tr>
<td>410.31 Inferoposterior wall</td>
<td>I21.19 Involving other coronary artery of inferior wall</td>
</tr>
<tr>
<td>410.41 Inferior wall</td>
<td></td>
</tr>
</tbody>
</table>
## ST Elevation (STEMI) Myocardial Infarction of other site

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>410.51 Lateral wall</td>
<td>I21.21 Involving left circumflex coronary artery</td>
</tr>
<tr>
<td>410.61 Posterior wall</td>
<td>- Oblique marginal coronary artery</td>
</tr>
<tr>
<td></td>
<td>I21.29 Involving other sites</td>
</tr>
<tr>
<td></td>
<td>- Lateral</td>
</tr>
<tr>
<td></td>
<td>- Posterior</td>
</tr>
<tr>
<td></td>
<td>- Septal</td>
</tr>
</tbody>
</table>
Angioplasty

ICD-9-CM angioplasty – 39.50

ICD-10-PCS – angioplasty codes – 854 choices

- Examples: Right femoral angioplasty
  - 047K04Z - Dilation of right femoral artery, open, with drug-eluting intraluminal device
  - 047K0DZ - Dilation of right femoral artery, open, with intraluminal device
  - 047K34Z - Dilation of right femoral artery, percutaneous, with drug-eluting intraluminal device
  - 047K3DZ - Dilation of right femoral artery, percutaneous, with intraluminal device

- Angioplasty documentation will need to include:
  - Body part
  - Approach
  - Device (and if drug eluting)
Asthma

- Mild intermittent
- Mild persistent
- Moderate persistent
- Severe persistent
Diabetes Mellitus

- Diabetes documentation and coding will need to include:
  - Type or cause of diabetes
    - Type I
    - Type 2
    - Due to drugs or chemicals
    - Due to other cause
  - Body system complications related to diabetes
    - Nephropathy
    - Neuropathy
  - Specific complication, such as:
    - Chronic kidney disease
    - Proliferative diabetic retinopathy with macular edema
    - Foot ulcer
    - Hypoglycemia without coma

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>59 codes</strong></td>
<td>(249-250)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>200+ codes</strong></td>
<td>(E08-E13)</td>
</tr>
</tbody>
</table>

Including:
- E1121 Type 2 diabetes with diabetic nephropathy
- E1122 Type 2 diabetes with chronic kidney disease
- E1129 Type 2 diabetes with other kidney complications
- E11321 Type 2 diabetes with mild nonproliferative retinopathy with macular edema
- E11621 Type 2 diabetes with foot ulcer
- E11649 Type 2 diabetes with hypoglycemia without coma
Laterality (Right / Left)

- Cancers
- Cerebral Infarction
- Pressure Ulcers
- Extremity Atherosclerosis
- Arthritis
- Fractures
- Sprains
- Injury
- Joint Pain
- Joint Effusion
- Tears, Meniscus, Cruciate Ligament
- Dislocations
Fractures

- **Musculoskeletal system:**
  - Fracture codes require documentation of displaced or non-displaced
  - Seventh character required to identify:
    - Initial; subsequent; sequela
    - With further sub-classification such as routine healing, delayed healing, nonunion, or malunion
  - Further classification of open fractures using the Gustilo-Anderson classification system (This classification is used to identify the extent of soft tissue injury, arterial injury, as well as contamination)
Gout:

Acute or Chronic

- Drug induced
- Idiopathic
- Due to renal impairment
- Lead induced
- Primary
- Secondary

Due to

Site Specific

- Ankle
- Elbow
- Foot joint
- Hand joint
- Hip
- Knee
- Multiple site
- Shoulder
- Specific joint NEC
- Wrist

Code to highest level of specificity

Left
Right
Infection

- Identify all infections by organism
- Document as antibiotic resistant if applicable
Documentation Guidelines — *Pneumonia*

- Document type of pneumonia, if known (e.g., aspiration pneumonia, MRSA pneumonia, pneumonia due to *Klebsiella*, viral pneumonia).

- Documentation of CAP, HAP, and HCAP can be further specified with the possible/probable causative organism, if known.

- It is the physician’s responsibility, when cultures reveal the responsible pathogen, to document the relationship between the causative organism and the pneumonia (e.g., *Klebsiella* pneumonia, pneumonia due to *Klebsiella*).

- Document “probable,” “suspected,” or “clinical” pneumonia if treating pneumonia as if present but cannot be confirmed.
Respiratory/Ventilators

- Respiratory/ventilators
  - Specificity related to:
    - Ventilators
      - Less than 24 consecutive hours
      - 24–96 consecutive hours
      - Greater than 96 consecutive hours
    - Pneumonia – Ventilator-associated pneumonia; requires additional reporting of type of pneumonia
    - Respiratory insufficiency – just a symptom
Ulcers

- Cause
- Site
- Laterality
- Severity (Stage 1 – Stage 4)
Debridement for Pressure Ulcer

ICD-9-CM – pressure ulcer codes

9 location codes (707.00–707.09)
Show broad location, but not depth (stage)

ICD-10-CM – pressure ulcer codes

125 codes
Show more specific location as well as depth

- L89.131 Pressure ulcer of right lower back, stage I
- L89.132 Pressure ulcer of right lower back, stage II
- L89.143 Pressure ulcer of left lower back, stage III
- L89.149 Pressure ulcer of left lower back, unspecified stage
- L89.152 Pressure ulcer of sacral region, stage II

ICD-10-PCS – per draft

- Debridement (excisional) is indexed “See Excision”
- Debridement (non-excisional) is indexed “See Extraction”
- Excision is defined as “Cutting out or off, without replacement, a portion of a body part”
- Extraction is defined as “Pulling or stripping out or off all or a portion of a body part by the use of force”

- Documentation of these procedures will require more precise language to differentiate between excisional and non-excisional
Pregnancy

Pregnancy

Specificity related to:

- Trimester – Pregnancy codes have a final character indicating the trimester for the current encounter

  - 1st Trimester – less than 14 weeks, 0 days
  - 2nd Trimester – 14 weeks 0 days to less than 28 weeks 0 days
  - 3rd Trimester – 28 weeks 9 days until delivery

- Gestational diabetes – documentation of diet controlled or insulin controlled is required to appropriately classify this condition

  - If both diet and insulin controlled, only insulin controlled will be used in the coding process
  - Only present in the second or third trimester

- Puerperal sepsis

  - Causal organism should be documented
  - Documentation of severe sepsis and organ dysfunction is required (if present)
Urosepsis

Urosepsis is a nonspecific term and requires clarification from the provider. There is no default code.

- Currently, in ICD-9-CM it defaults to 599.0 (UTI-CC condition)
- ICD-10 Alpha Index entry
  - Urosepsis – code to condition
- Documentation must identify whether it was a UTI or sepsis due to a urinary origin
| **Clinical Statement**  
* (Documentation needs clarification) | **Diagnostic Statement**  
* (Accurate ICD-10-CM code can be assigned) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home medications include Digoxin, Lasix, Imdur, HCTZ, etc.</td>
<td>Chronic systolic/diastolic heart failure, CAD, atrial fib, angina, HTN</td>
</tr>
<tr>
<td>LUL infiltrate</td>
<td>Pneumonia, please specify type, if known, (e.g., <em>Klebsiella</em> pneumonia, aspiration pneumonia, etc.)</td>
</tr>
<tr>
<td>Hgb 5.2, will transfuse</td>
<td>Acute or chronic blood loss anemia</td>
</tr>
<tr>
<td>Emaciated; total protein/albumin low, nutrition supplements started</td>
<td>Malnutrition (Please specify type: mild, moderate, severe)</td>
</tr>
<tr>
<td>pH = 7.25, pO2 = 58, pCO2 = 52, will treat accordingly</td>
<td>Acute respiratory failure; acidosis</td>
</tr>
<tr>
<td>Will rehydrate patient</td>
<td>Dehydration</td>
</tr>
<tr>
<td>BP 70/40, on Dopamine for support</td>
<td>Shock (specify type, i.e. cardiogenic, septic, hypovolemic)</td>
</tr>
<tr>
<td>Cardiac enzymes elevated, EKG positive</td>
<td>Acute MI, please specify site</td>
</tr>
<tr>
<td>CHF</td>
<td>Please specify type e.g., acute/chronic systolic and/or diastolic heart failure</td>
</tr>
<tr>
<td>Unable to void, cathed for 600 cc</td>
<td>Urinary retention</td>
</tr>
</tbody>
</table>
## General Surgery

<table>
<thead>
<tr>
<th>Clinical Statement (Documentation needs clarification)</th>
<th>Diagnostic Statement (Accurate ICD-10-CM code can be assigned)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdomen distended; NPO, NG placed</td>
<td>Ileus</td>
</tr>
<tr>
<td>R calf swollen, reddened and tender</td>
<td>Phlebitis; thrombophlebitis; DVT</td>
</tr>
<tr>
<td>Fever to 102 S/P appendectomy; patient pancultured, IV antibiotics given</td>
<td>Sepsis; acute peritonitis</td>
</tr>
<tr>
<td>Dysuria, urine culture positive, will treat with antibiotics</td>
<td>UTI</td>
</tr>
<tr>
<td>H&amp;H ↓, will transfuse</td>
<td>Acute or chronic blood loss anemia; expected acute blood loss anemia</td>
</tr>
<tr>
<td>Wound red and indurated, IV antibiotics given</td>
<td>Cellulitis</td>
</tr>
<tr>
<td>Debrided wound</td>
<td>Excisional vs. non-excisional debridement and provide a thorough description of procedure performed</td>
</tr>
<tr>
<td>Continue home meds, Digoxin, Lasix, Imdur, HCTZ, Dilantin</td>
<td>Document corresponding medical diagnosis, e.g., CAD, atrial fib, angina, hypertension, seizure disorder, chronic systolic heart failure</td>
</tr>
<tr>
<td>Unable to void, will insert Foley</td>
<td>Urinary retention; specify cause if known (urinary retention due to adverse effects of pain meds, etc.)</td>
</tr>
<tr>
<td>Urine output ↓, will bolus with IV fluids</td>
<td>Volume depletion; dehydration</td>
</tr>
<tr>
<td>↑ temp, ↓ breath sounds, ↑ ambulation, CXR, will begin incentive spirometry</td>
<td>Atelectasis</td>
</tr>
</tbody>
</table>

Diagnoses documented solely on diagnostic reports are not “codeable.” The physician must clinically correlate diagnoses in the body of the medical record with abnormal findings.
To reflect your patient’s true severity of illness, document all conditions you are treating, evaluating, or monitoring.
Summary

- Transitioning to ICD-10 specificity will be challenging and will require more complete and accurate documentation by the physician.

- The benefits will include a more complete capture of patient data, which will lend support to medical necessity, more accurately reflect severity of illness and expected mortality, and facilitate appropriate reimbursement.
Portneuf Medical Center
Clinical Documentation Specialists

- Tonya Hunt, RN – Medical Floor, ICU
  - Ext. 1476
  - Ascom 239-2855

- Cara Harris, RN – Surgical Floor, CV Floor
  - Ext. 1475
  - Ascom 239-2854

- Medical Records Ext. 1100
Questions
References

- www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/08_ISOCD10.asp
- www.ahima.org/icd10/faq.asp
- www.3Mhis.com
- www.icd-10-ready.com (3M site)