

# ICD-10: The Implications for Physicians

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# Faculty Disclosure Information

- Member Anthem-Wellpoint Physician Advisory Council

# Objectives: to understand

- The background of ICD
- The differences between ICD-9-CM and ICD-10-CM
- Why we need to change
- Benefits of ICD-10-CM for the physician



# What is ICD?

- International Classification of Diseases (ICD) is an official copyrighted publication of the World Health Organization (WHO)
  - Part of the WHO Family of International Classifications
    - International Classification of Functioning, Disability and Health
    - International Classification of Health Interventions
    - International Classification of Diseases for Oncology
- Primary purpose is for vital statistics and epidemiological tracking of illness and injury
- It is the HIPAA standard for morbidity and mortality reporting
  - does not affect CPT and HCPCS codes which are used for physician work and outpatient services

# ICD

- 1893: International List of Causes of Death adopted by the International Statistical Congress
  - the first "ICD"
- 1900: First of decennial revisions to International List of Causes of Death
  - cycle interrupted by WW II
- 1946: WHO takes over ICD
- 1948: ICD-6 combines morbidity and mortality lists together
- 1968: Public Health Service published ICD-8
  - first version modified specifically for US use

# ICD

- 1975: WHO releases ICD-9
- 1979: US clinical modification (ICD-9-CM) is published and becomes the primary reference for morbidity and mortality statistics
  - a public-private collaboration (cooperating parties)
    - National Center for Health Statistics/CDC (NCHS)
    - Centers for Medicare and Medicaid Services (CMS)
    - American Hospital Association
    - American Health Information Management Association

# ICD-10

- 1994: Released by WHO
- 1999: January 1, adopted for reporting US mortality data
  - Input was taken from various specialty societies as early as 1994 on what they wanted in their area of the code set
    - e.g. there are 16 orthopedic identifiers to show everything from type of fracture (closed vs. type of open) to healing status (e.g. normal, delayed, malunion)
  - Principal reason for diagnosis code expansion from ~14,000 in ICD-9-CM to ~68,000 in ICD-10-CM
- 2009: January 16, CMS published the Final Rule for US clinical modification (ICD-10-CM)
- 2014: October 1, effective for all encounters for diagnoses and inpatient resources reporting



# 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"

# ICD-10-CM Benefits

- Improved specificity makes it easier to
  - measure health care services
  - quality metrics measurement
  - identifying fraud and abuse
- Supports improved public health surveillance and epidemiological research
- Allows easier comparison of mortality and morbidity diagnosis data

How does the increased specificity help?



# 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)



# 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)



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

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- 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)

# Structural Differences: ICD-9-CM

- Codes have 3 to 5 placeholders
  - all placeholders are numeric except for V and E supplemental codes
- 17 Chapters
  - supplemental chapters for factors influencing health or services and external causes of injury
  - more post-coordination
    - 462 Acute pharyngitis
    - 780.60 Fever, unspecified
    - V20.2 Routine infant or child health check
    - E914 Foreign body accidentally entering eye and adnexa





# Structural Differences: ICD-10-CM

- Codes may be 3, 4, 5, 6 or 7 characters
  - combination of alpha and numeric placeholders
- 21 Chapters
  - 2 new chapters
    - Diseases of the Eye and Adnexa
    - Diseases of the Ear and Mastoid Process
  - no supplemental chapters
  - more pre-coordination
    - J02 Acute pharyngitis
    - R50.9 Fever, unspecified
    - Z00.129 Encounter for routine child health examination without abnormal findings
    - T15.90A Foreign body on external eye, part unspecified, unspecified eye, initial encounter

# What is the difference between pre- and post-coordination?

- Pre-coordinated codes contain more than one diagnosis or concept identifying all of the elements in a single code:
  - D57.211 Sickle-cell/Hb-C disease with acute chest syndrome
- Post-coordinated: the condition is identified by more than one code
  - 282.64 Sickle-cell/HB-C disease with crisis
  - 517.3 Acute chest syndrome

# ICD-9-CM ⇒ ICD-10-CM

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

ICD-9-CM	to	ICD-10-CM
003.21 Salmonella meningitis	=	A02.21 Salmonella meningitis
745.2 Tetralogy of Fallot	=	Q21.3 Tetralogy of Fallot

# ICD-9-CM ⇒ ICD-10-CM

- Some codes won't match because of changes in definitions in I-10

ICD-9-CM	to	ICD-10-CM
764.09 "Light-for-dates" without mention of fetal malnutrition birthweight 2,500 grams and over	≠	No diagnosis for infant with this birthweight ○ code set is for weights <2500 grams

# ICD-9-CM ⇒ ICD-10-CM

- In some cases ICD-9-CM may have had certain specificities that are not being translated to I-10

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



# 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

<b>ICD-9-CM Source</b>	<b>to</b>	<b>ICD-10-CM Target</b>
V70.3 Exam for administrative purposes	≈	Z02.0 School physical
V70.3 Exam for administrative purposes	≈	Z02.5 Sports physical

How can you more effectively use  
diagnosis coding?



# 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





# Trimming the hedge...

- Indeterminate terms such as "rule out", "possible" or "probable" are not allowed in outpatient diagnosis coding
  - unless listed in the tabular or index sections
    - use these terms in your assessment
- When used for inpatient coding a patient with a diagnosis of "rule out" is given the diagnosis even if the condition was not present
- Phrases such as "consistent with" or "most likely due to" cannot be "translated" in to a diagnosis code in either setting



# Just a bit...

- 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



# "Inherent" conditions

- Vomiting and diarrhea are inherent in acute gastroenteritis (AGE) and wouldn't be listed as separate diagnoses
- Hypoxia is not considered inherent in asthma (acute exacerbation or status) so it may listed as a contributing diagnosis

# Is that a diagnosis?

- Not all medical problems listed on the medical record should be coded as part of the discharge diagnoses
- List only those diagnoses that are
  - relevant to the encounter
  - active and/or contributing to the visit
    - include issues from past medical history if they are clinically relevant to the visit/care
  - explain any work-up (labs, x-ray, referrals)
- Code for any abnormal lab tests that you (the provider) feel are significant or contributory to the patient's condition
  - just because the lab value comes back flagged from the lab doesn't mean it has clinical significance



# Coding complaints & symptoms

- Symptom and complaint based diagnosis is permissible
- Not limited to a single outcome finding



# Coding complaints & symptoms

- Child present 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)



# This goes here...

- The primary diagnosis is the one that carries the greatest risk of morbidity or mortality or is the principal reason for the visit
  - For hospitals: Principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care
- List all contributing (secondary) diagnoses that help show the medical necessity for the encounter
- Be aware of "code first" rules for specific diagnosis





# Primary diagnosis

- Mother brings her child to the office because he has a cold and it's causing his asthma to flare up
- While the "presenting" problem was a cold the "principal" problem is the asthma exacerbation
- "Asthma exacerbation" would be listed as the primary diagnosis and URI as contributing (secondary)



# Terminology matters

- 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



# Terminology matters

- *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



# Terminology matters

*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

# Terminology matters

*You write this*

- Acute gastroenteritis

*The reported diagnosis*

- ICD-9-CM
- Other and unspecified noninfectious gastroenteritis and colitis (558.9)
  - ICD-10-CM
- K52.89 Other specified noninfective gastroenteritis and colitis or K52.9 Noninfective gastroenteritis and colitis, unspecified





# Terminology matters

*You write this*

- Diarrhea
- Vomiting

*The reported diagnosis*

- *ICD-9-CM*
- Diarrhea, not otherwise stated (787.91)
  - *ICD-10-CM*
- R19.7 Diarrhea, unspecified
  - *ICD-9-CM*
- Vomiting alone (787.03)
  - *ICD-10-CM*
- R11.11 Vomiting without nausea or R11.10 Vomiting, unspecified



# Terminology matters

- Infectious gastroenteritis
  - ICD-9-CM: 009.0
  - ICD-10-CM: A09
- Infectious diarrhea
  - ICD-9-CM: 009.2
  - ICD-10-CM: A09
- Rotavirus enteritis
  - ICD-9-CM: 008.61
  - ICD-10-CM: A08.0
- Gastroenteritis due to unspecified virus
  - ICD-9-CM: 008.8
  - ICD-10-CM: A08.4

•when occurring with the same illness vomiting and diarrhea are considered "inherent" to gastroenteritis and should not be listed as separate diagnoses

# 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



# Helps to explain 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)



# School problems

- Not part of the behavior chapter
  - Illiteracy and low-level literacy (Z55.0)
  - Schooling unavailable and unattainable (Z55.1)
  - Failed school examinations (Z55.2)
  - Underachievement in school (Z55.3)
  - Educational maladjustment and discord with teachers and classmates (Z55.4)



# Everyday issues

- Inadequate parental supervision and control Z62.0
- Parental overprotection Z62.1
- Upbringing away from parents Z62.2
- Hostility towards and scapegoating of child Z62.3
- Inappropriate (excessive) parental pressure Z62.6
- Type A behavior pattern Z73.1



And then of course...

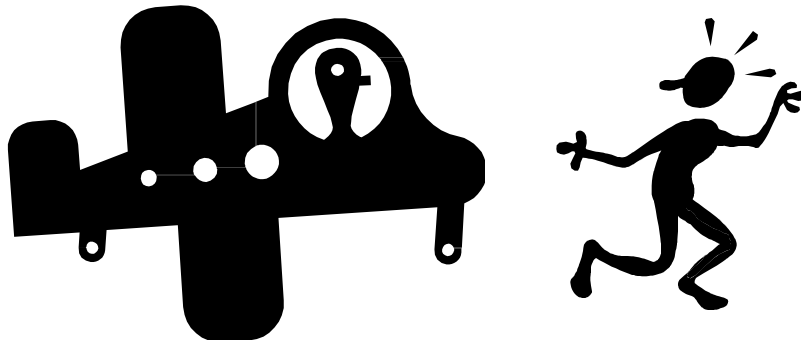




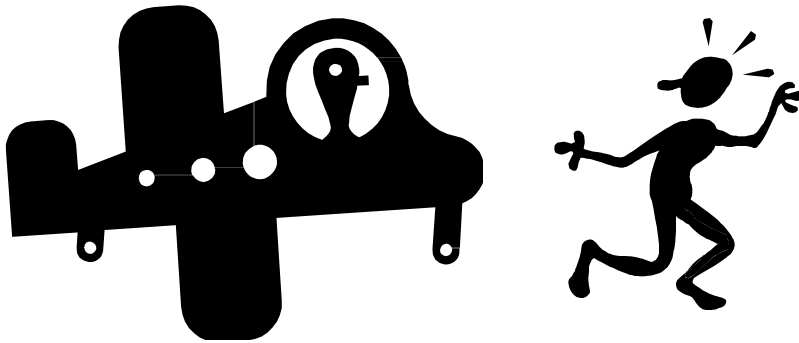
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- Person on ground injured by being sucked into jet engine (V97.33)

# Transition to ICD-10-CM

- Encounters that take place on or after October 1, 2014 are reported with ICD-10-CM codes
  - ICD-10-PCS for inpatient hospital resource utilization
  - transition is required for all Health Insurance Portability Accountability Act (HIPAA) covered entities
- Encounters that take place before October 1, 2014 will continue to be reported with ICD-9-CM codes
- Will require systems for simultaneous reporting of ICD-9 and ICD-10 until claims for services before October 1, 2014 have cleared
- The change to ICD-10-CM does not affect CPT or HCPCS coding for outpatient procedures and physician services.



# Transition

- Encounters that take place on or after October 1, 2014 are reported with ICD-10-CM codes
- Encounters that take place before October 1, 2014 are reported with ICD-9-CM codes
- You will have to run simultaneous systems of ICD-9 and ICD-10 until all your claims from before October 1, 2014 have cleared



# Transition: What you can do now?

- Look at the current resources that exist
- Review your EMR/HER programs to verify they are ICD-10-CM ready and what steps you have to take to update
- If you don't have an EMR or billing program look in to one that supports ICD-10-CM
  - capability to run both codes a bonus
- Look at costs of the change-over and start planning for that now



# Transition: What you can do now?

- Encourage your physicians to document and use more specific codes
  - especially those who tend to use unspecified codes or whose documentation leads to an "unspecified" code
- Work with those physicians on their documentation and in areas where you know more documentation is needed (e.g. Otitis Media)
- Remember that all HIPAA covered entities are required to adhere to the transition to ICD-10-CM
  - so do you!

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- Compliance training for medical staff
  - documentation
  - ICD-10-CM





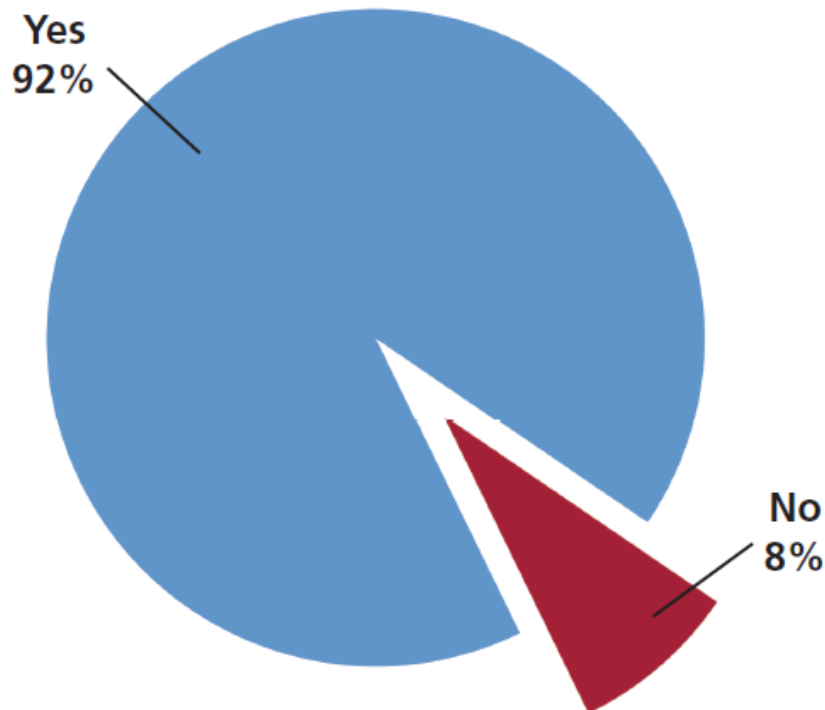
# How Can Hospitals Work with Physicians to Prepare for ICD-10?

**Nelly Leon-Chisen, RHIA**  
**Director Coding and Classification**  
**American Hospital Association**

# Hospitals Actively Working with Physicians to Implement ICD-10

92% of hospitals are proactively working with physicians to implement ICD-10.

Is your hospital engaging with staff physicians in ICD-10 implementation?



Source: AHA Survey, July, 2013

## A Few Strategies

- What's in it for the physicians?
  - It's not only about getting a code number on the claim for the hospital
- Leverage existing medical staff relationships
  - Physicians are members of medical staffs in our hospitals
  - Members of medical group practices
  - Private community practice relations
  - Some with academic practices
  - Members of professional organizations



# Opportunity for Hospitals to Collaborate With Physicians On Improving Documentation

- Collaboration is key
  - Training
  - Documentation changes
  - ICD-10 requires more detailed documentation to specify aspects of diagnoses and procedures required for more detailed codes
- Partnering (already happening on several fronts)
  - Help them understand the impact
  - Include their office staff in training
  - Assist them to convert their “super bills”



# Documentation

- The importance of consistent, complete documentation in the medical record cannot be overemphasized.
- Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not.
- Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider.
- “Documentation of causal relationship: As with all postprocedural complications, code assignment is based on the provider’s documentation of the relationship between the infection and the procedure.”

-- *Official Guidelines for Coding and Reporting*

# Leverage Existing Documentation Improvement Programs

- Work with your medical staff
- Audit: what is the quality of your documentation today?
- Are chronic conditions described in sufficient detail to determine if there is an acute exacerbation?
- Are all significant secondary diagnoses properly documented?
- Is there a physician champion that can help?
- Will need support from administration
- Will need to redesign physician queries
- Start thinking about the greater specificity available in ICD-10-CM and ICD-10-PCS
- How will that granularity affect your payments, quality reports? Other areas?

# Win-Win Situation

- For the physician
  - More accurate physician profiling for quality reporting, better reflecting actual practice
  - Better performance improvement and quality rating scores
  - More precise internal evaluation of healthcare competencies
  - Make sure ICD-10 is part of any new systems
- For administrators and regulators
  - Improved rating of providers
  - Reduced manual medical record review and manual claims

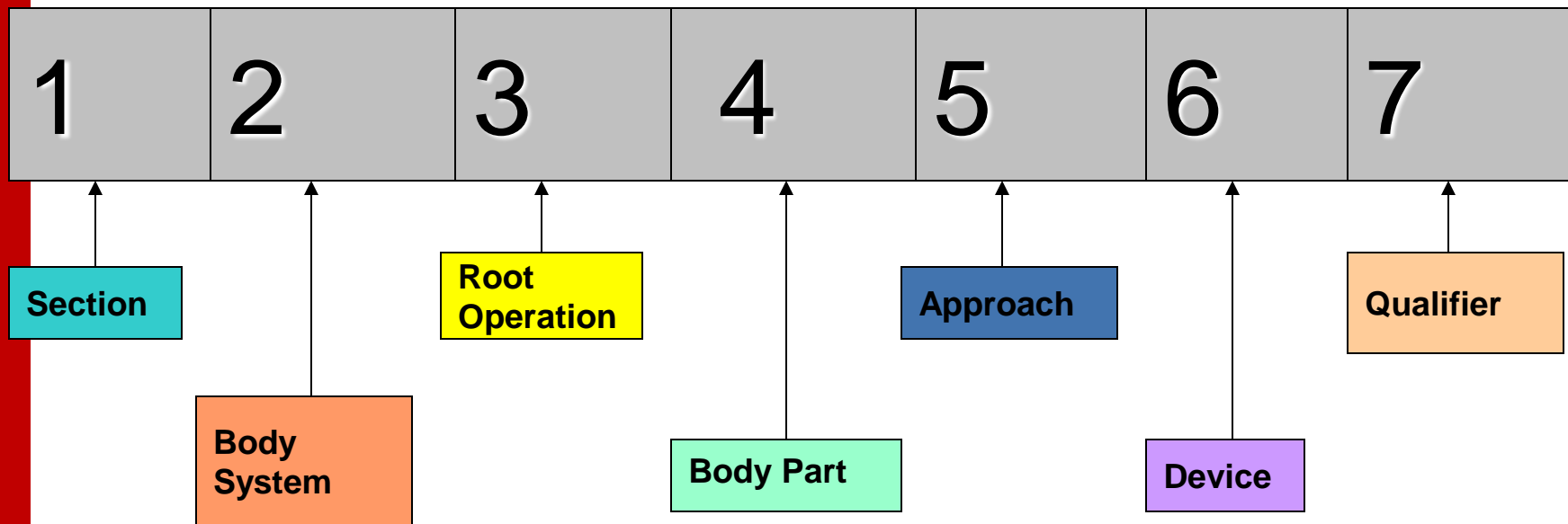
# It's Not Just About the Codes

- What strategies have you used previously to work with physicians and medical staffs?
  - Successful strategies (e.g., patient safety)
  - Unsuccessful strategies
  - Who were the physician champions?
- Physician specialties working on resources and tools
- CMS offers a number of free resources for physicians, and more to come
- Are there vendors who are stepping up to the plate?



# Just a Few Words About ICD-10-PCS . . .

**ONLY REQUIRED FOR HOSPITAL INPATIENT REPORTING  
and does not have any effect on CPT**



**All 7 characters of an ICD-10-PCS code are required to code. Are all of them documented today?**

# General Documentation Differences in ICD-10-PCS

- Crucial for coders to understand 31 root operations—but may need physician’s help to understand objective of the procedure
- Approach
  - No defaults for unspecified approach
- Specific body part
  - Laterality (e.g. right ovary, left ovary, or bilateral ovaries; no default for unspecified ovary; same for fallopian tubes)
  - Greater granularity (vessels, muscles, nerves)

# Questions?

