PATHWAY HEALTH
Insight | Expertise | Knowledge

Transitioning from ICD 9 to 10

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OBJECTIVES

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- Know what ICD-10 is & why coding is changing
- Know differences between ICD-9 and ICD-10
- Identify regulatory requirements of ICD-10
- Understand the benefits of ICD-10
- Learn the structure of ICD-10
- Be able to understand the expanded coding system
- Increase knowledge of implementation planning for ICD-10
- Be able to create an implementation team
- Be prepared for reimbursement changes under ICD-10

DEFINITIONS

- ICD-9-CM – International Classification of Diseases, 9th Revision, Clinical Modification, over 30 year old coding system, 17,000 codes
- ICD-10-CM – International Classification of Diseases, 10th Revision, Clinical Modification, only a handful of countries have not adopted yet (US and Italy are two), 68,000 codes
- http://www.cms.hhs.gov/ICD10/02m_2012_ICD_10_CM.asp

DEFINITIONS

- CMS – Centers for Medicare and Medicaid Services
- AAPC – International Standard Diagnostic classification for all general epidemiological, health, management purposes and clinical use
- NCHS – National Center for Health Statistics – www.cdc.gove/nchs/icd.htm

DEFINITIONS

- AHIMA – American Health Information Management Association – www.ahima.org/infocenter/guidelines/ltcs/
- HIPAA – Health Insurance Portability Accountability Act
- WHO – World Health Organization

TERMINOLOGY

- What is ICD-10-CM?
  - The International Classification of Diseases, 10th Edition, Clinical Modification
  - For use in all health care settings
- What is ICD-10-PCS?
  - The International Classification of Diseases, 10th Edition, Procedure Coding
  - Used in inpatient hospital settings
  - For procedure coding
- Codes for diseases, aftercare, symptoms, external causes, and procedures
- We will not use PCS in long term care

WHY IS IT CHANGING?

- Because ICD-9 produces limited data about a patient's medical condition and inpatient hospital procedures
- ICD-9 is 30 years old
- ICD-9 has outdated terms
- ICD-9 is inconsistent with current medical practices
- It limits the number of new codes that can be created as many ICD-9 categories are full

WHO NEEDS TO COMPLY?

- Everyone covered by HIPAA (Health Insurance Portability and Accountability Act)
- Does not affect CPT coding for outpatient procedures

TIMELINES FOR ICD-10

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- 9/30/14 – All records & bills must have ICD-9 codes
- 10/1/2014 – All records must have ICD-10 codes
- 10/2014 – All end of month bills must have ICD-10 codes
- 2/2014 – Ensure all appropriate staff are trained
- 10/2013 – Begin transition planning

REGULATORY REQUIREMENTS

- Anyone who is covered under HIPAA must comply with all changes from ICD-9 to ICD-10
- It is expected that providers will experience a delay in payment and claims submission
- It is expected that this conversion could have a significant financial impact on your organization

DIFFERENCES

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DIFFERENCES BETWEEN 9 & 10

- Differences in the number of codes in the different categories
- Diabetes – 59 to 200+
- Pressure Ulcers – 9 to 125
- Pathologic Fractures – 8 to 150
- TOTALS – 14,000 to 68,000

DIFFERENCES BETWEEN 9 & 10

- More flexibility in incorporating advances in medicine & technology
- Uses more current & up to date med terms
- Codes are no longer just numeric (except “u”)
- All codes begin with a letter
- Expanded code length 3-7 vs. 3-5
- Increased precision with diagnoses
- Full diagnostic titles for each code

DIFFERENCES BETWEEN 9 & 10

- Laterality Added (left and right, both)
- Code extensions for injuries & external causes
- Combo codes for diagnoses & symptoms

Example:

- ICD-9: 401.0 – Essential HTN, malignant, 401.1 – Essential HTN, benign, 401.9 – Essential HTN, unspecified
- ICD-10: I10 – Essential primary HTN

EXAMPLES OF DIFFERENCES

- Asthma with acute exacerbation

ICD-9

- 493.92 – Asthma unspecified with acute exacerbation

ICD-10

- J45.21 – Mild intermittent asthma with acute exacerbation < 2 weeks, J45.31 - > 2 weeks, J45.41 Daily

EXAMPLES OF DIFFERENCES

- Mechanical complications, grafts, devices

ICD-9

- 996.1 – Mechanical complication of other vascular device, implant, or graft

ICD-10

- T82.591A – Complication (mechanical) surgically created arterio-venous shunt – initial encounter

WHAT REMAINS THE SAME

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WHAT REMAINS THE SAME

- Use of Coding Books or E-Encoder
- Tabular List (Chapters similar to ICD-9) with same exceptions
- Main Terms – Indented Sub-terms
- Alphabetical Index of external causes
- Table of Neoplasms
- Table of Drugs & Chemicals

WHAT REMAINS THE SAME

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- Conventions, Abbreviations, Punctuation
- Symbols, Code First, Use additional code
- Includes & Excludes
- Code to highest level of specificity
- Adherence to HIPAA & Official Guidelines
- Non-specific codes still available
- Inconsistent, missing, or conflicting documentation must be resolved by provider

BENEFITS OF ICD-10

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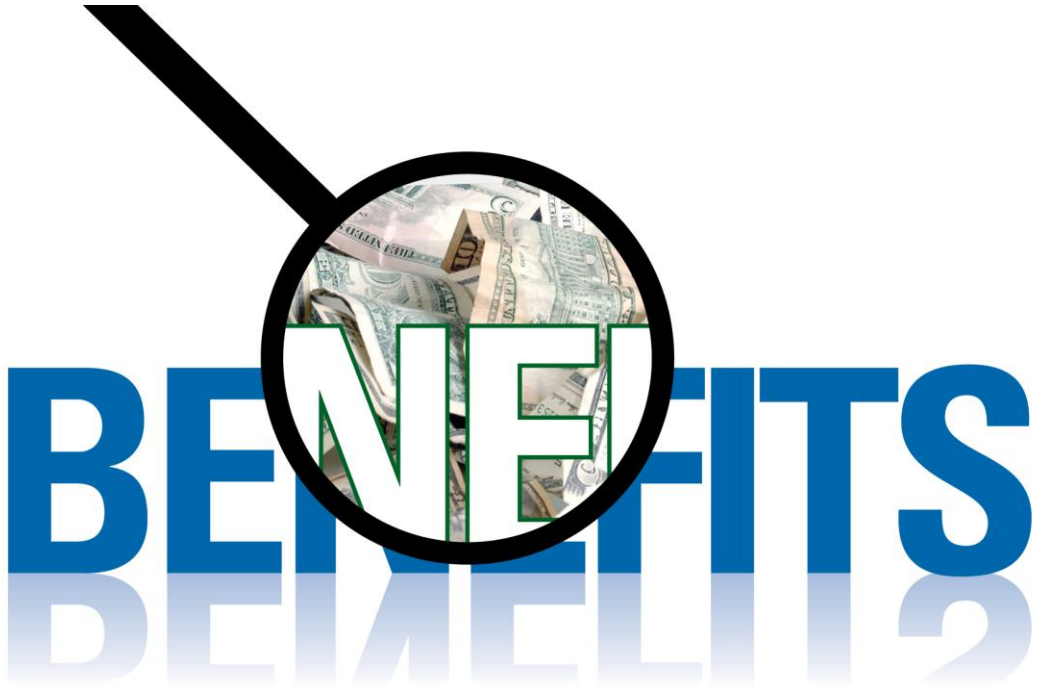

BENEFITS OF ICD-10

- Reduces the need for attachments
- Monitor resource utilization
- Set health policy
- Improve clinical, financial, & administrative performance
- Prevent and detect fraud and abuse

BENEFITS OF ICD-10

- Track public health and risks
- Measures quality, safety, & efficacy
- Used for research, studies and clinical trials

STRUCTURE OF ICD-10

- 3-7 Characters
- Alphanumeric
- All letters but “U” used
- Letters and numbers are mixed
- Decimal (.) after the third character
- www.cms.gov/ICD10/02c

STRUCTURE OF CODES

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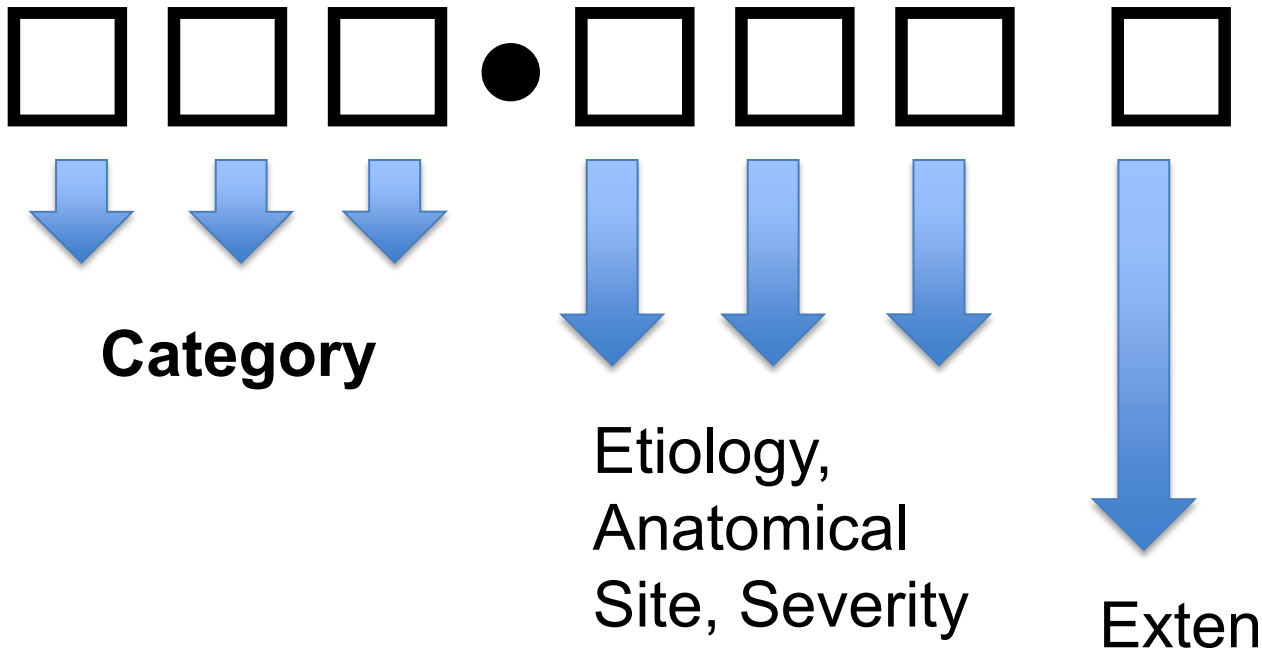


EXAMPLES OF STRUCTURE

- SF2 – Fx of Forearm
- SF2.5 – Fx lower end of radius
- SF2.52 – Torus Fx of lower end of radius
- SF2.521 – Torus Fx of lower end of R radius
- SF2.521A – Torus Fx of lower end of R radius, initial encounter

BASIC CODING PRINCIPLES

- Analyze clinical documentation from discharge summaries and history & physicals
- Locate main term in alpha index
- Identify all of component elements of the diagnostic statement
- Follow cross reference instructions as directed
- Use sub-terms and modifiers to assist in obtaining correct code

BASIC CODING PRINCIPLES

- Verify the code obtained from the alpha index in the Tabular List
- Assign code numbers at their highest level of specificity using the maximum number of digits available
- Follow all instructional information within a code category (inclusion and exclusion notes, use of additional codes as necessary)

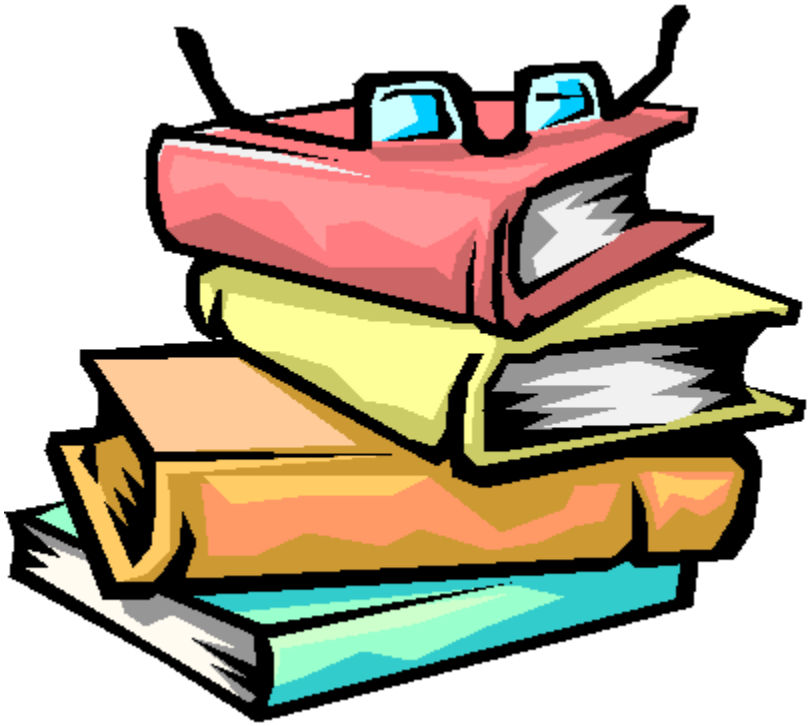
BASIC CODING PRINCIPLES

- Interpret "and" in a code as "and/or"
- Terms "with" "with mention of" and "associated with" in a title mean that both parts of the title must be present in the diagnostic statement in order for the code to be assigned
- Use "residual" codes (final digits of 8 and 9) only if no more specific code assignment can be made

BASIC CODING PRINCIPLES

- Query the physician or physician extender as needed to clarify diagnoses
- Assign appropriate codes. Follow Official Coding Guidelines
- Practice, Practice, Practice
- Try WHO's coding teacher on-line
- http://apps.who.int/classifications/apps/icd/icd10training/ICD-10%20training/Start/index.html

CHAPTERS OF ICD-10



A00-B99

- Certain Infections and parasitic diseases
- A41.9 UnspecifiedSepsis
- B95.62 Methicillin resistant Staphylococcus aureus infection (MRSA)

C00-D49

- Neoplasms
- C80.1 Cancer, unspecified
- Chemotherapy would have a Z Code for aftercare Z51…
- Personal History of neoplasm would have Z Code

D50-D89

- Diseases of blood, blood forming organs, immune disorders
- *Reserved for future guideline expansion*

E00-E89

- Endocrine, Nutrition, & metabolic diseases
- Diabetes not specified in the medical record is E11.-, Type 2 Diabetes Mellitis
- Z79.4 – Long term use of insulin

F01-F99

- Mental, behavioral, and neurodevelopmental disorders
- F45.41 – pain exclusively related to psych disorders
- F10-19 are used for remission and are at the providers discretion

G00-G99

- Diseases of the Nervous System
- G89 – Pain not elsewhere classified
- Can be principle if the main reason for admission is pain control

H00-H59

- Diseases of the Eye and Adnexa
- H40 – Glaucoma
- Code type, stage, which eye or both
- 7th character "4" is used when stage is indeterminable

H60-H95

- Diseases of the Ear and Mastoid Process
- *Reserved for future guide expansion*

I00-I99

- Diseases of the circulatory system
- I15 – Hypertension
- I13 – Combination codes that include hypertension, heart disease, and chronic kidney disease
- I10-I15 codes assigned for controlled hypertension

J00-J99

- Diseases of the Respiratory System
- J44 & J45 distinguish between COPD that is uncomplicated and those in acute exacerbation
- J96.0 Acute respiratory failure
- J09 - Influenza

K00-K95

- Diseases of the Digestive System
- *Reserved for future guideline expansion*

L00-L99

- Diseases of the Skin and Subcutaneous Tissue
- L89 – Designates Pressure Ulcer site and stage
- Healed requires no code upon admission
- Query MD if necessary

M00-M99

- Diseases of Musculoskeletal system & Connective Tissue
- Site and laterality
- Site represents bone, joint or muscle
- Acute vs chronic
- Pathologic fx coded with 7th character "A"
- M81 - Osteoporosis

N00-N99

- Diseases of Genitourinary System
- CKD – Mild N18.2
- ESRD – N18.6
- Kidney disease with transplant status requires a Z Code

O00-O9A

- Pregnancy, Childbirth, and the Puerperium
- Z33.1 used if encounter is unrelated but the patient is pregnant
- O Codes are used only on the maternal records, never on the newborn record
- 7th character used for fetus identification

P00-P96

- Certain conditions originating in the perinatal period
- Never used on the maternal record
- Z Code used for principle dx according to place of birth and type of delivery
- P07 – Low birth weight or prematurity

CHAPTERS Q & R

Q00-Q99

- Congenital malformations, deformations, & chromosomal abnormalities
- If no unique code assignment, use additional codes for manifestations
- May be used throughout the life of the patient
- Z Codes may be used if the malformation is corrected

R00-R99

- Symptoms, signs, abnormal clinical or lab findings
- Used when a related definitive dx has not been established
- Not used if combination code includes symptoms
- R29.6 Repeated falls, reason being investigated
- Z91.81 Hx of Falling

S00-T88

- Injury, poisoning, & other certain consequences of external causes
- Most codes here require 7th character
- A-active tx initial encounter
- D-routine care subsequent
- S-Sequela or late effects

S00-T88

- S02-S92 Fractures
- If not indicated as closed or not, code as closed
- M80 – used for osteoporotic fractures
- Aftercare Z codes are not used for traumatic fx, use appropriate 7th character
- T20-25 - Burns

V01-Y99

- External Causes of Morbidity
- Intended to provide data for injury research & evaluation of injury prevention strategies
- How the injury happened
- Used with any code in range of A00-T88 and Z00-Z99
- Can never be principle dx

V01-Y99

- Y92 used to designate where patient was when injury occurred
- Y93 used to designate the activity of the patient when the injury occurred
- Some codes take priority such as terrorism, cataclysmic events, transport accidents, related to the most serious dx

Z00-Z99

- Factors influencing health status and contact with health services
- May be used as principle dx
- Z20 indicates contact with and suspected exposure to communicable disease
- Z23 is used for inoculations and vaccinations
- Status codes indicate carrier status or sequela

Z00-Z99

- Prosthetic
- Z94.1 Heart transplant status
- Z99.11 Ventilator dependent
- Z16 Antimicrobial drug resistance
- Z66 DNR Z68 BMI
- Z79 Long term drug use
- Z88 Drug Allergy
- Z89 Acquired absence of limb

EXTENSIONS

EXTENSIONS – NEW TO LTC

- D – Extension specifically related to fx
- S – Injuries related to specific body region
- T – Injuries to unspecified region, poisoning, external causes
- V & Y Codes – will have 7th character extension
  - A – Initial Encounter
  - D – Subsequent Encounter
  - S – Sequela (Late Effect)

EXTENSIONS – NEW TO LTC

- Subsequent – After the patient receives active treatment of injury and receiving routine care during healing or recovery period
- Sequela – complications or conditions that arise as a direct result of the injury (late effect)
- Extension "D" for subsequent episode of care

LATE EFFECTS / SEQUELA

- In ICD-9 we would code late effects for hemiplegia after a stroke using 438 codes if neuro deficits present or V Codes if no neuro deficits present
- In ICD-10 we code sequela for hemiplegia after a stroke using _____ if neuro deficits present and Z Codes if not neuro deficits present

EXAMPLES OF HISTORY CODES

- Z80 – Family hx of primary malignant neoplasm
- Z85 – Personal hx of malignant neoplasm
- Z91.5 – Personal hx of self harm
- Z43 – Attention to artificial opening
- Z47 – Orthopedic aftercare
- Z91.1 – Noncompliance with treatment

EXAMPLES OF ICD-10 CODES

- A78 – Fever
- A69.21 – Meningitis due to Lyme's Disease
- O9A.311 – Physical abuse complicating pregnancy, first trimester
- S52.131A – Displaced fracture of neck of right radius, initial encounter for closed fracture

EXAMPLES OF PLACEHOLDER "X"

- T42.3x2S – Poisoning by barbiturates intentional self harm, sequel
- Character "x" is used as 5th character placeholder
- For future additions or changes

GUIDELINES

WHO APPROVES CODING GUIDELINES

- **Cooperating Parties for the ICD-10-CM**
- AHA – American Hospital Association
- AHIMA – American Health Information Management Association
- CMS – Centers for Medicare & Medicaid Services
- NCHS – National Center for Health Statistics

TERMS USED IN GUIDELINES

- **Encounter**: used for all settings, including hospital admissions
- **Provider**: used throughout the guidelines to mean "physician" or any other health care practitioner who is legally accountable for establishing the patient's diagnoses

SECTIONS 1 - GUIDELINES

- Section 1: Structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classifications

SECTIONS 2 - GUIDELINES

- Section 2: Includes guidelines for selection of principle diagnosis for non-outpatient settings

SECTIONS 3 - GUIDELINES

- Section 3: Includes guidelines for reporting additional diagnoses in non-outpatient settings

SECTIONS 4 - GUIDELINES

- Section 4: For outpatient coding and reporting
- We must review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly

INCREASED PRECISION

- From 17,000 to 68,000 codes
- Far more specific
- Should make research and studies better because the information is more specific

ICD-10-CM VS. PCS

- ICD-10-CM is used for diagnosis coding in all settings
- ICD-10-PCS is used for procedure coding in inpatient settings
- CPT Coding will still be used as well

COMMUNICATION

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Physicians

Clinics

Hospitals

Lab & X-Ray

Podiatry & Dentist

Optometry

Vendors

VERSION 5010

- Electronic health transaction standards that will incorporate the use of ICD-10 codes and other updated fields
- Final Date for compliance: June 30, 2012

FAQs ABOUT 5010

- ZIP Code: Must include complete 9 digit zip code for the billing provider and service location, ensure your system captures the full 9 digits
- Billing Provider Address: A physical address must be listed as the pay to address as 5010 does not allow for the use of PO Boxes
- NPI – Must use NPI number now, TAX ID and/or SSN will no longer be allowed

BUDGETING FOR ICD-10

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BUDGETING FOR ICD-10

- Hardware or software upgrades & maintenance fees
- Training
  - Anatomy / Physiology
  - Pathophysiology
  - Medical Terminology
  - ICD-10 Coding Classes
- Temporary staff to assist during transition period

BUDGETING FOR ICD-10

- Data Conversion – double coding
- Reports
- Policy and Procedure changes
- Forms Design
- Reprinted Paper Forms
- Face Sheets
- Physician Orders
- Diagnosis Listings

GEMs

- General Equivalent Mappings
- Translates/converts ICD-9 to ICD-10 codes
- Forward & backward mapping

GEMs

Two Ways to use GEMS

1. Translating lists of coded data or converting a system or application of certain ICD-9 codes
2. Creating a "one-to-one" applied mapping (aka crosswalk) between code sets that will be used ongoing to translate records or other coded data

http://www.cms.gov/Medicare/Coding/ICD10/2012-ICD-10-CM-and-GEMs.html

DO NOT USE GEMS IF:

A. Short list of ICD-9 codes with code description
B. You have access to the clinical record
C. You have access to other forms of clinical information such as text descriptions or clinical terms from surveys, research, or clinical software applications

ASSEMBLING A TEAM

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ASSEMBLING A PROJECT TEAM

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- Important to oversee your organization's shift to ICD-10 and for a successful transition
- Responsible for planning and implementation process
- Team members should be from key areas of your organization: Senior Management, HIM, Coding, Billing, Compliance, IS, Nursing

ASSEMBLING A PROJECT TEAM

- Appoint a Project Manager – responsible for establishing accountability across the ICD-10 implementation team, and making business, policy, and technical decisions

TEAM's INITIAL TASKS

- Establish regular check-in meetings
- Conduct ICD-10 impact assessment
- Plan a comprehensive & realistic budget
- Identify and involve internal & external stakeholders
- Develop and adhere to established timelines
- Keep up to date on ICD-10

TRANSITION PLANNING

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Step 1: Impact Analysis (3-6 months)

Step 2: Contact your Vendors (2-3 months)

Step 3: Contact your payers, Billing Services, and Clearinghouse (2-3 months)

Step 4: Installation of Vendor Upgrades (3-6 months)

Step 5: Internal Testing (2-3 months)

Step 6: Update Internal Processes (2-3 months)

TRANSITION PLANNING

Step 7: Conduct Staff Training (2-3 months)

Step 8: External Testing with Clearinghouses, Billing Service, and Payers (6-9 months)

Step 9: Make the switch to ICD-10 (October 1, 2014)

Step 10: Monitor the submission and receipt of transactions to ensure reimbursement is accurate and what you expect

SPECIAL INSTRUCTIONS FOR HIM

- Purchase new code books (or update pages) annually
- Check software to ensure codes are accurate, updated, and sequenced correctly
- Ask to be in the loop for information from Medicare, Medicaid, MACs and other payers
- Review job descriptions for HIM employees

AFTER OCTOBER 1, 2014

- Monitor the submission and receipt of transactions to ensure they are working properly. Issues on your end and at the end of the payer or clearinghouse could delay payment and cause cash flow issues.

- Use AMA's ICD-10 Project Plan Template

PARTIAL CODE SET FREEZE

- The last regular update to both ICD-9 and ICD-10 were scheduled for 10/1/11 (this changed with the delay in ICD-10)
- As of 10/1/2012 there will be limited code updates to ICD-9 and ID-10 to capture new technology and diseases
- There will be no updates to ICD-9 on 10/1/2014 as the system will no longer be a HIPAA standard

DOCUMENTATION CHANGES

- The documentation we receive from our acute care partners could look much different in the future as they will have to have far more specific documentation for DRG payments.
- We may see more specific diagnoses than HTN and anemia in the future
- We will need to have better med term knowledge

REFERENCES

- Dept of Health & Human Services
- CMS
- AHIMA
- CDC
- NCHS
- HIMSS
- AAPC
- WHO
- AHA

Thank you for your time today!

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