ICD-10 UPDATE

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Disclosures

• none

LEARNING OBJECTIVES

• Recognize the new rules for assigning diagnosis codes in the ICD-10 system
• Develop a plan to improve data collection for compliance
• Document findings appropriately to facilitate coding
What’s all the fuss about?

In the news: Silly codes

Struck by a deer?

“Yeah, we’ve got a code for that.”

W55.32XA
What is ICD-10?

- ICD-10 is the most recent iteration of the International Classification of Diseases.
- The ICD system started in 1893 as a statistical way to track diseases. It has been updated about every 10-15 years ever since.
- The U.S. has been using ICD-9 since 1979.
- Most other countries have been using ICD-10 since 1994.

First, some good news...

- The start date for use of ICD-10 has been pushed back to October 2015, so you still have time to get ready.
- You don’t need to memorize codes.
- The providers’ duty is simply to document well the things we already do.
- About 60% of us are already documenting well enough to use the new codes.

Why should I do this???

- It proves level of care.
- If it isn’t documented, it didn’t happen.
- If it didn’t happen, it doesn’t get paid.
- Better documentation equals
  - Fewer inquiries from coders and payers
  - Fewer claims rejections and payment delays
  - Improved data exchange and disease tracking
  - Improved patient outcomes & better algorithms
Comparison of ICD-9 and ICD-10

ICD-10-CM and ICD-10-PCS Code Structures

Table 1: ICD-9-CM vs. ICD-10-CM Code Format

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnostic Codes</th>
<th>ICD-10-CM Diagnostic</th>
</tr>
</thead>
<tbody>
<tr>
<td>First digit in alpha (E or V) numeric</td>
<td>First digit in alpha; 2 and 3 are numeric: Digits</td>
</tr>
<tr>
<td>Digits 2-5 are numeric</td>
<td>4-7 are alpha numeric:</td>
</tr>
<tr>
<td>3-5 characters in length</td>
<td>5-7 characters in length</td>
</tr>
<tr>
<td>Male/female</td>
<td>Male/female (right vs. left)</td>
</tr>
<tr>
<td>Number of chapters = 17</td>
<td>Number of chapters = 21</td>
</tr>
<tr>
<td>Many codes for specific body sites</td>
<td>Many codes for specific body sites</td>
</tr>
<tr>
<td>Does not support interoperability — it is no longer used by other countries</td>
<td>Supports interoperability and the exchange of health data between other countries and the U.S.</td>
</tr>
</tbody>
</table>

Biggest worry: so many more codes!

The biggest change is in fracture codes.
What components need to be documented?

- It depends on the problem, to some extent.
- All the requirements are common sense: back to our training of **Who, What, When, Where, Why, and How.**
- For ENT, there is a larger emphasis on **LATERALITY** and on **TOBACCO HISTORY.**

<table>
<thead>
<tr>
<th>Mapping Categories</th>
<th>ICD-9 to ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Match</td>
<td>3.0%</td>
</tr>
<tr>
<td>1 to 1 Exact Match</td>
<td>24.2%</td>
</tr>
<tr>
<td>1 to 1 Approximate Match with 1 Choice</td>
<td>49.1%</td>
</tr>
<tr>
<td>1 to 1 Approximate Match with Multiple Choices</td>
<td>18.7%</td>
</tr>
<tr>
<td>1 to Many Match with 1 Scenario</td>
<td>2.1%</td>
</tr>
<tr>
<td>1 to Many Match with Multiple Scenarios</td>
<td>2.9%</td>
</tr>
</tbody>
</table>
What to keep in mind when you document an illness or injury:

- **WHO**: new or recheck; acute/chronic/postop
- **WHAT**: injury/infection/mass/illness/severity / co-morbidities/signs & symptoms/ complications/ sequelae/ history of...
- **WHEN**: timing/ stages of healing/ remission status/ episode
- **WHERE**: anatomic location/ laterality/ localization
- **WHY**: cause/ associated conditions/ contributing factors (tobacco, ETOH, HPV, etc.)
- **HOW**: agent (toxin, infectious agent), circumstances (AA, GSW, congenital, hereditary)

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Laterality

- RIGHT
- LEFT
- BILATERAL
- UNILATERAL
- UNSPECIFIED

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LATERALITY ≠ LOCALIZATION

<table>
<thead>
<tr>
<th>LATERALITY</th>
<th>LOCALIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>Medial</td>
</tr>
<tr>
<td>Left</td>
<td>Lateral</td>
</tr>
<tr>
<td>Bilateral</td>
<td>Proximal</td>
</tr>
<tr>
<td>Unilateral</td>
<td>Distal</td>
</tr>
<tr>
<td>Unspecified</td>
<td>Central</td>
</tr>
<tr>
<td></td>
<td>Peripheral</td>
</tr>
</tbody>
</table>
TOBACCO

• Current tobacco use
• History of tobacco use
• Tobacco dependence
• Environmental exposure (i.e., child in smoking household)
• Occupational exposure (i.e., nonsmoking bartender in bar that allows smoking)

New coding format is up to 7 places

First 3 spaces: Related Conditions

• There are 21 different chapters of related conditions (eye, ear, skin, respiratory, etc.)
  - They are called “CATEGORIES”

• First space ALWAYS ALPHA
• Next two are either alpha or numeric
Next 3 spaces

- site, etiology, manifestation, stage
- location
- laterality

- If enough descriptors are not applicable, but a 7th number is needed, the coder uses X as space holders.

The 7th space
Use to document **episode of care**: use A, D, or S.

- **A** = **Acute** or Initial encounter. This describes the entire period in which a patient is receiving active treatment for the injury, poisoning, or other consequences of an external cause. So, you can use “A” as the seventh character on more than just the first claim. In fact, you can use it on multiple claims.
- **D** = **Subsequent** encounter. This describes any encounter after the active phase of treatment, when the patient is receiving routine care for the injury during the period of healing or recovery.
- **S** = **Sequela**. The seventh character extension “S” indicates a complication or condition that arises as a direct result of an injury. An example: hearing loss after temporal bone fracture.

Combination Codes

- Some related problems from different categories are combined into one code.

  Example: Diabetes
  + Retinopathy
  + macular edema

  ONE code, not three
GENERAL GUIDELINES

1. LEVEL of DETAIL:
   Be as specific as possible.

   Example: right chronic serous otitis media with environmental tobacco exposure
   not “middle ear effusion”

2. PRINCIPAL DIAGNOSIS:
   This is the reason for the visit.
   Other conditions also under care get coded additionally.

   Complication after surgery MUST be coded 1st.

3. SIGNS & SYMPTOMS:
   Use signs/symptoms only if no confirmed diagnosis when coded.

   Example: c/o sore throat, cough, fever
   -Code as J06.9 (acute URI, unspecified)
GENERAL GUIDELINES

4. ACUTE, SUBACUTE & CHRONIC:
   If both exist, code both, with acute 1st, Do NOT use a combination code.
   Example: J01.01 acute recurrent maxillary sinusitis
   and J32.0 chronic maxillary sinusitis

GENERAL GUIDELINES

5. SEQUELA:
   Late effects, no time limits
   Use 2 codes: 1st is condition, 2nd is sequel
   Example: Bil. SNHL, 6 weeks post meningitis
   H90.3 bilateral sensorineural hearing loss
   G09 sequelae of inflammatory disease CNS

GENERAL GUIDELINES

6. RESOLVED CONDITIONS:
   status post-procedures or previous visits
   Only report if there is a bearing on current treatment.
   Example: AOM this visit. Do not code resolved PTA months ago.
GENERAL GUIDELINES

7. ABNORMAL TEST RESULTS:

- not coded unless clinically significant
- Ok to code signs/symptoms if test result not yet available
- Ok to code if it’s the reason to order another test.

GENERAL GUIDELINES

8. BMI

- can be calculated by ancillary staff, provider, or obtained from another provider (PCP)

GENERAL GUIDELINES

9. “BORDERLINE” CONDITIONS

- use a confirmed diagnosis unless there is a specified “borderline” code.
  Example: borderline diabetes, code diabetes
GENERAL GUIDELINES

10. IMPENDING/THREATENING:

Use symptoms or condition unless there is a separate subterm.

Example: threatening nasal hemorrhage, code epistaxis

INFECTIONS

• HIV is always coded first
• Must include manifestation AND cause unless there is a combination code including both

Example: otitis externa and MRSA - code both

Neoplasms

• Include location, laterality, morphology for each.
• Include metastatic, known primary
• Change code to “personal history of...” when resolved
ENT CLINICAL CONDITIONS: Capturing the Concepts

WAX IMPACTION
- Right/left/bilateral
- Include chief complaint as secondary code (example nosebleed, poor hearing, headache etc.)

ADENOIDITIS
- Type:
  - With tonsillitis
  - With hypertrophied adenoid
  - With hypertrophied tonsils
- Cause/ contributing factors
  - Tobacco exposure
TM PERFORATION
- Location, laterality
- Type: central, attic, marginal, multiple, total, unspecified
- Associated with: OM, trauma, tobacco, etc.

Example: Right total TM perf with drainage =
R acute mucoid OM + total perf + infection mastoid cavity. 3 codes.

Lesson learned: Don’t just call this “otorrhea.”

CA TONGUE
- Laterality, location (base, border, ventral, etc.)
- Caused by… (tobacco, ETOH)
- Code lesion type
- Code personal hx of radiation, chemo, etc.

NASAL FRACTURE
- Type: open or closed
- Episode
  - Initial (Active treatment phase)
  - Subsequent-routine healing/delayed/nonunion
  - Sequela
RHINITIS
- Type: allergic, seasonal, vasomotor, atrophic etc.
- Temporal: acute or chronic
- Caused by: pollen, food, animal dander
- Other factors: tobacco

TONSILLAR HYPERTROPHY
- With tonsillitis, adenoid hypertrophy
- Caused by...

CA LARYNX
- Location/ laterality
- Caused by...
NASAL OBSTRUCTION
- Type: abscess, cyst, deviated septum, turbinates, mucositis, other unspecified

SINUSITIS
- Laterality & Location
  - Maxillary
  - Ethmoid
  - Sphenoid
  - Frontal
  - Pansinusitis
- Temporal factors- acute, chronic, recurrent
- Contributing factors- tobacco

TONSILLITIS
- Type
  - Acute
  - Chronic
  - Streptococcal
  - Recurrent
  - Due to other specified organisms
  - Unspecified
- Associated with infectious agent
CHOLESTEATOMA

- Anatomic location
  - Attic
  - TM
  - Mastoid
  - diffuse
- Laterality – R, L, Bilateral, unspecified

OTITIS MEDIA

- Type-infectious, allergic, tubotympanic, atticoantral, other
- Manifestations – serous, mucoid, suppurative, nonsuppurative, with or without perforation
- Infectious agent- scarlet fever, flu, measles, other
- Temporal factors- acute, chronic, Subacute, recurrent
- Laterality

THYROID MASS

- Type
  - Nontoxic diffuse
  - Nontoxic single
  - Nontoxic multinodular
  - Other specific nontoxic
  - Unspecified
So, now what?

- Start thinking about how you are documenting your visits. If much of what we just talked about looks familiar, you probably won’t have much trouble documenting well enough.
- If you are the one who has to code, choose one of many products available to help you.
- Learn how your EMR will change.
- Make a “cheat sheet” for your office notes.

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**your ICD-10 timeline**

- **DEFINE & PLAN**
  - Review ICD-10 requirements & resources
  - Establish a steering committee
  - Develop a project plan
  - Perform practice impact assessment

- **TRAINING**
  - Participate in vendor & ICD-10 code training

- **TESTING**
  - Test that your office staff can competently work with the new code sets
  - Test each redesigned process
  - Test integration with vendor

- **IMPLEMENTATION & FOLLOW-UP**
  - Gauge the efficiency & effectiveness of your new workflows after the October 2014 compliance date
RESOURCES

• There are good (and free!) sources, like CMS website [www.cms.gov/ICD10/](http://www.cms.gov/ICD10/)
• AAO-HNSF has a superbill template with many common codes, and a 200-code “crosswalk” from currently used codes to the newer ICD-10 codes, as well as many other good tips and resources for your practice. Go to their coding page: http://entnet.org/practice/codingResources.cfm