Electronic Health Records Next
Chapter: Best Practices, Checklists, and Guidelines
ICD-10 and Small Practices
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“Making our communities healthy”

Topics

- Implications of Section 212 – ICD-10-CM delay
- MHDC - Provider Education & Communications
  Subgroup
- Planning for ICD-10-CM
- Documentation Readiness for ICD-10-CM
- Similarities & Differences: ICD-9-CM to ICD-10-CM
- Documentation & Coding
Implications of Section 212 – Did you hear that we have a delay?

On Tuesday, April 1, 2014, the President signed into law H.R. 4302, the “Protecting Access to Medicare Act of 2014” which included a provision to delay the transition to ICD-10-CM for minimally 1 year.

What does this mean for the Provider community?

- If you started your transition planning, GOOD JOB! NOW KEEP GOING!
- If you lagged behind in your planning efforts, then this is an opportunity to take a thoughtful, mindful approach to ICD10-CM transition efforts.
- This is an opportunity for providers to “catch-up”.

MHDC – PROVIDER EDUCATION & COMMUNICATION SUBGROUP
MHDC - Who are they & How can they help?

The Massachusetts Health Data Consortium, founded in 1978, is a not-for-profit organization that has served as a trusted, neutral convener of the Massachusetts healthcare community for 35 years.

- In 2013, the MHDC rolled out the ICD-10 Project. More than 70 organizations - including the Massachusetts Medical Society - and more than 200 technology, finance, coding and administrative staff, managers and executives are collaborating on a number of efforts including provider education.
- Members of the Provider Education & Communications Subgroup are seeking your input into future education efforts and messaging.

*Help us help you!* What ICD-10-CM resources, tools and venues would create value for the provider community? What are your needs?

ICD-10-CM

PLANNING FOR ICD-10-CM
Planning for ICD-10-CM

- ICD-10-CM codes will replace all ICD-9-CM codes for all healthcare services.

- To make sure you are ready to use the new code set, you will want to review how and where you currently use ICD-9-CM codes.

- Wherever you see ICD-9-CM codes today, you will need to transition to ICD-10-CM.

Planning for ICD-10-CM

**Develop Your ICD-9-CM List**

- Ask your clinical and administrative staff to develop a list of places where they encounter ICD-9-CM codes in their work.

- This will acquaint your practice with how the switch to ICD-10-CM will affect your daily work.

**Review Your List**

- Once you have a master list of where your office uses ICD-9-CM codes, you can assess how and where you will need to make changes to be ready for the transition to ICD-10-CM.
Planning for ICD-10-CM

As you review your list, make sure you have accounted for the use of ICD-9-CM codes in:

- Authorizations/pre-certifications
- Physician orders
- Medical records
- Superbills/Encounter forms
- Practice management and billing systems
- Coding manuals
- Public health reporting

Your practice and the clearinghouses, payers, and billing companies that you work with will need to use ICD-10 CM codes.

References

- AAPC ICD-9-CM-Volumes 1 and 2, 2014
- AAPC ICD-10-CM Clinical Modification Code Set and PCS 2014
- Centers for Medicare and Medicaid retrieved from [www.cms.gov/ICD10](http://www.cms.gov/ICD10)
- MMS has a series of videos focused on the impact of ICD-10 CM available on their website. MMS has also videotaped this session: [http://link.videoplatform.limelight.com/media/?channelId=4e1db9e67af74edf9ea93af05d99627&width=960&height=360&playerForm=PlayerHorizontalPlaylist&deepLink=true](http://link.videoplatform.limelight.com/media/?channelId=4e1db9e67af74edf9ea93af05d99627&width=960&height=360&playerForm=PlayerHorizontalPlaylist&deepLink=true)
Documentation Readiness for ICD-10-CM

- Take a look at the documentation for the most often used codes in your practice, and work with your coding staff to determine if the documentation would be specific and detailed enough to select the best ICD-10-CM code.

- For example, since laterality is expanded in ICD-10-CM, clinical documentation for diagnoses should include information on which side of the body is affected (i.e. right, left, bilateral).
Documentation Readiness for ICD-10-CM

Examples of the specific information needed to accurately code the following common diagnoses:

- **Diabetes Mellitus:**
  - Type of diabetes
  - Body system affected
  - Complication or manifestation
  - If type 2 diabetes, long-term use of insulin

- **Fractures:**
  - Site
  - Laterality
  - Type
  - Location

Documentation Readiness for ICD-10-CM

Additional examples of the specific information needed to accurately code the following common diagnoses:

- **External Cause:**
  - Provide the cause of the injury; when meeting with patients, ask and document “how” the injury happened.

- **Place of Occurrence:**
  - Document where the patient was when the injury occurred; for example, include if the patient was at home, at work, in the car etc.

- **Activity Code:**
  - Describe what the patient was doing at the time of the injury; for example was he or she playing a sport or using a tool?

- **External Cause Status**
  - Indicate if the injury was related to military, work, or other.
Assessments of documentation and coding is a process:

- Changing your documentation to align with ICD-10-CM is a process…

- You may want to begin with assessing the “top 10” diagnoses of your practice and compare documentation and coding currently used for ICD-9-CM to what is needed for converting to ICD-CM-10.

Consider doing a documentation gap analysis. Medical record sampling may include:

- Random sampling
- Clinical specialty sampling
- High volume diagnosis
- Diagnosis known to represent documentation and coding challenges today
### ICD-9-CM & ICD-10-CM

#### SIMILARITIES & DIFFERENCES

- **Code Structure Comparison**

<table>
<thead>
<tr>
<th>ICD-9 CM</th>
<th>ICD-10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 Characters</td>
<td>3-7 Characters</td>
</tr>
<tr>
<td>First character is numeric or alpha (E or V)</td>
<td>First character is alpha (all letters except U are used.)</td>
</tr>
<tr>
<td>Characters 2-5 are numeric Always at least 3 characters</td>
<td>Characters 3-7 are alpha and numeric</td>
</tr>
<tr>
<td>Use of decimal after 3 characters</td>
<td>Use of decimal after 3 characters</td>
</tr>
<tr>
<td></td>
<td>Alpha characters are not case-sensitive (e.g., Right ankle sprain, initial encounter: S93.401A, S93.401a, s93.401a, s93.401A)</td>
</tr>
</tbody>
</table>
As we transition from ICD-9 CM to ICD-10 CM there are a number of features that will remain the same. If you struggle currently with these points then we would encourage you to resolve discrepancies during the delay.

- Many conventions have the same meaning, abbreviations, punctuation, symbols, notes such as “code first” and “use additional code”.
- Nonspecific codes (“unspecified” or “not otherwise specified”) are available to use when detailed documentation to support more specific code is not available.
- Codes are looked up the same way.
  - Look up diagnostic terms in Alphabetic Index
  - Verify the code number in Tabular list.

Codes are invalid if they are missing an applicable character.

Adherence to the official coding guidelines in all healthcare settings is required under the Health Insurance Portability and Accountability Act (HIPPA).

Similarities to ICD-9 CM

**Index (alphabetical list of terms and their corresponding codes)**

- Indented sub-terms appear under main terms
  - Same structure as ICD-9 CM Alphabetic Index of Diseases and Injuries
  - Alphabetic Index of External Causes
  - Table of Neoplasms
  - Table of Drugs and Chemicals

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**Tabular (chronological list of codes divided into chapters based on body system or condition)**

- Same hierarchical structure
  - Chapters in the Tabular are structured similarly to ICD-9 CM, with minor exceptions.
  - A few chapters have been restructured.
  - Sense organs (eye and ear) separated from Nervous system chapter and moved to their own chapters.
Differences from ICD-9-CM

ICD-10-CM

- **Expanded detail and specificity**
- Laterality has been added to relevant codes
- Expanded use of combination codes for certain conditions and associated common symptoms or manifestations.
- Inclusive of poisonings and associated external cause
- Injuries are grouped by anatomical site rather than type of injury
- Codes reflect updated medical terminology

ICD-10-CM Specificity Example

**Increased Specificity**

- **169.351** Sequelae of cerebral infarction of cerebral infarction, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side

- **S72.044G** Nondisplaced fracture of base of neck of right femur, subsequent encounter for closed fracture with delayed healing
ICD-10-CM Laterality Example

Laterality

- **C50.511** Malignant neoplasm of lower-outer quadrant of right female breast
- **H01.111** Allergic dermatitis of right upper eyelid
- **L89.223** Pressure ulcer of left hip, stage 3

ICD-10-CM Combination Code Example

Combination Codes

- **125.110** Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
- **E11.311** Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
- **K71.51** Toxic liver disease with chronic active hepatitis with ascites
ICD-9-CM & ICD-10-CM

**DOCUMENTATION & CODING**

**Medical Record documentation is where the coding process begins – regardless of the International Classification of Diseases Model (ICD-9-CM or ICD-10-CM). It is the start of all billing and payment activity!**

- One way to help your practice prepare for ICD-10-CM is to work on Clinical Documentation Improvement – CDI.

- Clinical documentation must be complete and clearly address the clinical evaluation. Clinical documentation should have MEAT (Monitor, Evaluation, Assessment & Treatment).

- Without complete and appropriate provider documentation on the front end, coders’ ability to assign accurate ICD10 CM codes will be compromised.
Documentation & Coding

- Documentation and ICD codes are the same no matter what kind of insurance.

- Documenting and coding diagnoses to the highest level of specificity reveals the patient’s complete and accurate clinical picture at the time of the visit.

- Under-documentation of diagnoses and lack of specificity in medical record notes are key areas for providers to consider when preparing for ICD-10-CM.

Under-documentation

Avoid under-documentation:

- Often times a provider sees a patient and documents on the progress note, then chooses a code reflecting the diagnoses that the patient has; although this is often NOT what is documented in the medical record.

- From a coding perspective ICD-9-CM and ICD-10-CM do not allow for assumptions and rely solely on what is explicitly documented in the progress note.

- Provider documentation that supports ICD codes submitted on a claims form undergirds reimbursement for both providers and carriers.

*Coding is dependent upon physician documentation*
Specificity

Increase specificity:

- **For both ICD-9-CM and ICD-10-CM** it is important that providers document all necessary and known details of a diagnosis.

- ICD-10-CM requires providers to document with even more specificity to support the expanded and more detailed set of codes for example:
  - Laterality has been added to relevant codes
  - Expansion of combination codes for certain conditions and associated common symptoms or manifestations
  - Inclusive of poisonings and associated external cause

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