The ICD-10: What is it and How Can I Survive?

2014 Internal Medicine Update
SC ACP Chapter Scientific Meeting
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Objectives
- Explain what happened in April and how the landscape looks for ICD-10
- Provide a brief overview of ICD-10 to allay fears and realize where the concerns really lie
- Talk about how clinically correct coding will play in our future as it relates to ICD-9 and ICD-10

Terminology
- HIPAA – Health Insurance Portability and Accountability Act of 1996
- ICD-9-CM – International Classification of Diseases, 9th Revision, Clinical Modification
- ICD-10-CM – International Classification of Diseases, 10th Revision, Clinical Modification – diagnosis code set
- ICD-10-PCS – International Classification of Diseases, 10th Revision, Procedure Coding System – procedure code set
- HCPCS – Healthcare Common Procedure Coding System
- WHO – World Health Organization
- NCHS – National Center for Health Statistics, Center for Disease Control and Prevention
- CMS – Centers for Medicare & Medicaid Services
History Of International Classification of Diseases (ICD)

1620-1674

History of ICD-10: “ICD-1”

- Bertillon Classification of Causes of Death
  - Created by Jacques Bertillon, MD (1851-1922), Chief of Statistical Services of the City of Paris
  - An abridged classification of 44 titles
  - Realized a correlation between suicide rates and divorces
  - Felt both were associated with “social disequilibrium”
- The International List of Causes of Death (1893)… the first
- Followed by… ICD-2, ICD-3, ICD-4, ICD-5, ICD-6, ICD-7, ICD-8, ICD-9….

History Of International Classification of Diseases (ICD)

- The International Statistical Institute managed ICD until ICD-6 (1948)
- The World Health Organization took over ICD 1948
- 10 international centers helped modify ICD
- Use as tool so that medical terms reported by Physicians, Medical Examiners, and Coroners on death certificates can be grouped together for statistical purposes
International Classification of Diseases (ICD)

- Since 1900, the ICD has been modified about once every 10 years, except for the 20-year interval between the last two revisions, ICD-9 and ICD-10.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Years In Effect</th>
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<tbody>
<tr>
<td>ICD-1</td>
<td>1890-1909</td>
</tr>
<tr>
<td>ICD-2</td>
<td>1900-1920</td>
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<tr>
<td>ICD-3</td>
<td>1921-1930</td>
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<td>ICD-4</td>
<td>1931-1948</td>
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<td>ICD-5</td>
<td>1949-1959</td>
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<td>ICD-6</td>
<td>1960-1969</td>
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<tr>
<td>ICD-7</td>
<td>1970-1978</td>
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<tr>
<td>ICD-8 (adopted*)</td>
<td>1979-1988</td>
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<tr>
<td>ICD-9</td>
<td>1980-1998</td>
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<tr>
<td>ICD-10</td>
<td>1999-2015</td>
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</tbody>
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Other Countries are ahead of US

- United Kingdom 1995
- France 1997
- Australia 1998
- Belgium 1999
- Germany 2000
- Canada 2001
- United States 2013...2014...2015

No longer morbidity and mortality

- The international standard classification for
  - General epidemiological info
  - Health management purposes
  - Clinical uses
  - Population health management
  - Disease prevalence
  - Quality metrics
  - Reimbursement/resource allocation
- Documentation of the encounter is how we translate the clinical picture into code sets
- Translation is difficult with ICD-9 at times
What is ICD-9-CM Used For?
- Calculate payment – Medicare Severity Diagnosis Related Groups (MS-DRGs)
- Adjudicate coverage – diagnosis codes for all settings
- Compile statistics
- Assess quality

ICD-9-CM Basics
- ICD-9-CM has 3 – 5 digits
- Chapters 1 – 17: all characters are numeric
- Supplemental chapters: first digit is alpha (E or V), remainder are numeric
- Examples:
  - 496 Chronic airway obstruction not elsewhere classified (NEC)
  - S11.9 Unspecified pleural effusion
  - V02.61 Hepatitis B carrier

ICD-9…Do You Know?
- Code for benign essential hypertension?
- Code for unspecified essential hypertension?
- …for malignant essential hypertension?
- …from a pheochromocytoma?
- What about CHF?
- …benign hypertensive heart disease w CHF?
- What about chest pain?
- …chest wall pain?
- …chest pain with breathing?
ICD-9-CM is Outdated

- 30+ years old—technology has changed
- Many categories full
- Not descriptive enough
- Research limitations
- Payment limitations
- Unable to compare across countries

ICD-9 and ICD-10 Differences

<table>
<thead>
<tr>
<th></th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
<td>13,000</td>
<td>68,000</td>
</tr>
<tr>
<td>Procedure</td>
<td>3,800</td>
<td>72,000</td>
</tr>
<tr>
<td>Codes</td>
<td>3-5 characters in length, mostly numbers</td>
<td>3-7 characters in length, numbers and letters</td>
</tr>
<tr>
<td>Flexibility</td>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Specificity</td>
<td>Lacks detail</td>
<td>Very specific</td>
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</tbody>
</table>

The WHO ICD-10 non-CM....?

- “Rest of the world”: WHO ICD-10
  - 16,000 codes (!!) (this is c/w the Canadian version)
- BUT.....physicians DON’T USE these for coding and billing in Canada
- INSTEAD the coding and billing in Canada comes from a code set of 600 three-digit codes
- The US ICD version is a “-CM” or “Clinical Modification” that causes all of the diversity and expanse of the code set
ICD-9 and ICD-10 Differences

- ICD-10 CM codes are alpha-numeric, as opposed to primarily numeric in ICD-9
  - Malignant neoplasm, upper third esophagus: C15.3
  - Malignant neoplasm, upper third esophagus: 150.3
- Essential (primary) hypertension: I10
- Unspecified essential hypertension: 401.9
- Acute tonsillitis: J03
- Acute tonsillitis: 463

ICD-9 and ICD-10 Differences

- ICD-10 CM codes contain up to a maximum of 7 characters, as opposed to the 5 characters seen in ICD-9
- Late effects are handled differently
  - Late effects (ICD-9) are referred to as sequela (ICD-10) and these events are noted with the addition of an additional digit to address the condition that caused the sequela

ICD-9 and ICD-10 Differences

- ICD-9 has 17 chapters, ICD-10 has 21
  - ICD-10 has separate chapters for eye/adnexa and ear/mastoid
  - There is an ICD-10 chapter 22, but it is not used for international data comparison and therefore this chapter is not included in the ICD-10 CM for the US
  - The “External Cause” codes (V and E codes) for ICD-9 are not “supplemental” in ICD-10 as they have their own chapters (20, 21)
- ICD-10 codes are organized differently than in ICD-9
  - Sense organs have been separated from nervous system disorders
  - Post-operative complications have been moved to procedure-specific body system chapter
  - Injuries are grouped by anatomical site, not by injury category
Injury Changes

- ICD-9-CM
  - Fractures (800-829)
  - Dislocations (830-839)
  - Sprains and strains (840-848)

- ICD-10-CM
  - Injuries to the head (S00-S09)
  - Injuries to the neck (S10-S19)
  - Injuries to the thorax (S20-S29)

Example:

- Fracture of wrist:
  - Patient fractures left wrist
  - A month later, fractures right wrist
  - ICD-9-CM does not identify left versus right – requires additional documentation
  - ICD-10-CM describes left versus right
  - Initial encounter, subsequent encounter
  - Routine healing, delayed healing, nonunion, or malunion

ICD-10-CM Diagnosis Codes

- Characters 1-3 – Category
- Characters 4-6 – Etiology, anatomic site, severity, or other clinical detail
- Characters 7 – Extension (initial visit, subsequent, etc.)

Example:

- S52 Fracture of forearm
- S52.5 Fracture of lower end of radius
- S52.52 Torus fracture of lower end of radius
- S52.521 Torus fracture of lower end of right radius
- S52.521A Torus fracture of lower end of right radius, initial encounter for closed fracture
The 7th Character

- 7th character used in certain chapters (e.g., Obstetrics, Injury, Musculoskeletal, and External Cause chapters)
- Different meaning depending on section where it is being used
- Must always be used in the 7th character position
- When 7th character applies, codes missing 7th character are invalid

7th Character Defined

- **Initial encounter:** As long as patient is receiving active treatment for the condition.
  - Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.
- **Subsequent encounter:** After patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
  - Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow-up visits following treatment of the injury or condition.
- **Sequela:** Complications or conditions that arise as a direct result of a condition (e.g., scar formation after a burn).

Note: For aftercare of injury, assign acute injury code with 7th character for subsequent encounter.

7th character in fractures

- **A** Initial encounter for closed fracture
- **B** Initial encounter for open fracture
- **D** Subsequent encounter for fracture with routine healing
- **G** Subsequent encounter for fracture with delayed healing
- **K** Subsequent encounter for fracture with nonunion
- **P** Subsequent encounter for fracture with malunion
- **S** Sequela
"X" Marks the Spot

- Addition of dummy placeholder "X" (or "x") is used in certain codes to:
  - Allow for future expansion
  - Fill out empty characters when a code contains fewer than 6 characters and a 7th character applies

When placeholder character applies, it must be used in order for the code to be valid

"X" is not case-sensitive

- T46.1X5A or T46.1X5A are both OK to use
  - Adverse effect of calcium-channel blockers, initial encounter
- T15.02xD or T15.02xD
  - Foreign body in cornea, left eye, subsequent encounter

Make Note: Underdosing

- Underdosing is a new code in ICD-10
- It identifies situations in which a patient has taken less of a medication than prescribed by the physician
  - Non-compliance codes available
  - Complication of care
- May be a way for physicians to show a difficult to treat population
  - "T" code set (T136-T150) and is specific to the medication
Make Note: Unspecified

- If documentation doesn't support more specific codes, coders may code "unspecified"
- Severity and risk scores
- Reimbursement

Medical Necessity issues can arise
- Non/Un-specified disease code doesn't merit as frequent of follow-up
- Diabetes Mellitus

Combination Codes

- ICD-10's greater specificity also allows comorbid conditions to be combined
- I25.110 Arteriosclerotic heart disease of native coronary artery with unstable angina pectoris
- K50.013 Crohn's disease of small intestine with fistula
- K71.51 Toxic liver disease with chronic active hepatitis with ascites

Complication Coding

- Limited in ICD-9
- For "complications of foreign body accidently left in body cavity following a procedure" ICD-10 has 50 different codes
- ICD-9 has one
- T81.530 Perforation due to foreign body accidently left in body following surgical operation
67 year old seen for atrial fibrillation. Bursts of paroxysmal a-fib have been noted on recent holter. He is symptomatic. Several medication adjustments have been made and you have seen the patient 4 times this month.

Atrial fibrillation 427.31
- Paroxysmal atrial fibrillation I48.0
- Persistent atrial fibrillation I48.1
- Chronic atrial fibrillation I48.2
- Unspecified atrial fibrillation I48.91

Atrial flutter 427.32
- Typical atrial flutter I48.3
- Atypical atrial flutter I48.4
- Unspecified atrial flutter I48.92

Maps should not be used to assign codes to report on claims. GEMs and Reimbursement Mappings are not a substitute for learning how to use ICD-10-CM/PCS. Mapping ≠ Coding. Mapping links concepts in 2 code sets without consideration of context or medical record documentation. Coding involves assignment of most appropriate codes based on medical record documentation and applicable coding rules/guidelines – GEM is not a substitute for correct coding. GEM: [www.cdc.gov/nchs/icd/icd10cm.htm](http://www.cdc.gov/nchs/icd/icd10cm.htm)
My favorite: [ICD10data.com](http://ICD10data.com)
GEM may not be answer

- Healthcare intelligence software
- Data mines claims and produces DRG options and looks at ICD-9 → ICD-10 permutations and transitions
- Groups together to get best DRG option possible
- Some ICD-9 codes will translate into multiple ICD-10
- Some ICD-9 codes will not be found in ICD-10
- Some ICD-9 will be found in combination codes

Physician impact

- More queries as Clinical Documentation Improvement staff will catch fall-out.
- More frustration with trying to enter codes in the outpatient world of office settings
- Staff frustration with new codes, increased denials
  - Trickle down effect
  - Financial downward pressure (vicious cycle)

ICD-10 implementation

- Areas of cost concern
  1. Education of physicians and staff
  2. Process analysis for needed flow change
  3. Modification of code sets to paper tracking/superbills
  4. IT upgrades
    - 29 different applications at SRHS that must be enhanced
  5. Increased documentation issues
  6. Cash flow slow-down due to slowness of system to pay and appeals/denials
Since Washington Ruined My Talk... What About 1-9 Coding Opportunities?

- Need to pay attention to the detail of documentation
- Translates into dollars **now** for Hospitals
- ...............into dollars later for physicians

The record reflects severity, intensity and medical necessity through the documentation of diagnoses and procedures.

CPT codes are **not** used.

**MS-DRG Structure-Medical**

- **Simple Pneumonia**
  - DRG 195 w/o CC/MCC $4,541
  - DRG 194 with CC $5,414
  - DRG 193 with MCC $5,536
    - Difference $1,873

- **Complex Pneumonia**
  - DRG 179 w/o CC/MCC $4,287
  - DRG 178 with CC $5,242
  - DRG 177 with MCC $5,116
    - Difference $1,746

- **CHF**
  - DRG 293 w/o CC/MCC $4,332
  - DRG 292 with CC $5,438
  - DRG 291 with MCC $5,734
    - Difference $2,106

*Principal Dx* + *Secondary Dx* + *Procedures* → *DRG (Diagnostic-Related Group)*

#
Severity of Illness (SOI) defined

The extent of physiologic decomposition, organ system loss of function, and/or mortality.

Refers to:
- How sick is the patient?
- How difficult is the patient to manage?
- What types of interventions are required?
- What is the intensity of resources utilized?

Risk of Mortality

Secondary Diagnosis - Cardiac Dysrhythmias
1. Minor
   - Premature Beats
2. Moderate
   - Sinus Tachycardia
3. Major
   - Paroxysmal Ventricular Tachycardia
4. Extreme
   - Ventricular Fibrillation

Severity of Illness

Secondary Diagnosis - Diabetes Mellitus
1. Minor
   - Uncomplicated Diabetes
2. Moderate
   - Diabetes with Renal Manifestation
3. Major
   - Diabetes with Ketoacidosis
4. Extreme
   - Diabetes with Hyperosmolar Coma

How are Severity and Risk of Mortality Measured?
By documenting secondary diagnoses!
What is a Hierarchial Condition Category (HCC)?
- CMS launched in 2004
- Used to help establish a payment model for Medicare insurers (MA Plans)
- These are grouped clinical diagnoses
  - Coronary Artery Disease
- Subcategories of conditions under CAD: AMI → CAD
  - Descending order of severity and cost expectations

What is a Hierarchial Condition Category (HCC)?
- Info comes from IP hospital, OP hospital, physician or NPP medical record
- Collected once a year and reported to CMS
- MAP paid based on severity, quality
- Better capture of “highly weighted HCCs” means more $$ paid to the MAP

MAP (or insurer) and HCC
- Better HCC capture → more revenue
- Watch useless spending → higher profit
- “Shared Savings”
  - Profits are “shared” with the provider (doctor or healthcare system)
  - Physicians who are poor coders may get deselected from plans as the HCC capture is such a large component to insuring sustainability of insurer
Example of Clinically Correct Coding (Diabetes)

- 67 yo with longstanding DM (x14 yr), on oral med, well controlled (A1c 6.9). She has stable findings on exam: numbness to light touch mid feet distally bilaterally. Has a h/o Glaucoma that started 8 yrs after DM diagnosed.
- How do you code...?

Physician Compensation/CMS

- Future will be to pay for quality achievement and cost containment
- Severity of illness/risk will be a part of calculation
  - "my patient’s are sicker"
  - ...SRHS’ latest numbers
- Learn how to code correctly

ICD-10 Timeline

- "Don’t teach too soon"
- You should have started...don’t “go cold”
- Billing “end to end testing” with TPA and Clearinghouses
- Inpatient strategy
  - Documentation Improvement Teams
  - Flyers, emails, “pop-ups” at dictation stations
  - Web-based learning
- IP doctors MAY BE OK...but CDI team/coders may have issues in “searching for info to code”
- Outpatient strategy
  - Much different due to lack of front line support
  - Specialty specific “cross-walks” to insure “top 100” primary care, “top 10 money makers” in surgery
  - Ease of use, make sure staff aware – TEAM EFFORT here for sure!!
ICD-10 will allow us to correctly define conditions

- Each specialty needs to create CHEAT SHEETS: “Long lists” and “Short lists” of the most commonly used codes
- cms.gov has free programs with GEMS (general equivalence mappings)
- ICD10data.com
- AAPC has specialty specific crosswalks, others...
- Must use I-10 correctly to capture the severity and specificity of the condition
- Much more granularity with I-10

Closing.....

- Embrace the change that is coming
- Use it to your advantage
- Don’t consider being suited for the ICD-10 code:
  - F63.3
Connect with me...

- Thank you!!
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