ICD-10-CM: Impact to the Code Assignment Process

As we continue to move closer to ICD-10-CM implementation, providers are trying to determine how this change may impact their internal process of assigning a code. Most assume it will be more difficult, and at least at first, this might very well be the case, because of the magnitude of the changes involved. But, looking closer, there are advantages to the new system as well.

Currently, most physicians pick their codes using one of several methods:

1. Reliance on memory
2. From the patient’s problem list
3. From the fee ticket or cheat sheet
4. From an EHR Custom List

While all these methods work, their accuracy is subject to limitations. If the patient has chronic obstructive asthma, but the cheat sheet/fee ticket just lists the code for “asthma, unspecified,” it’s more efficient, but not entirely accurate, to pick the known code rather than search for the more accurate one.

The purpose of ICD-10-CM is greater specificity. In support of this, the method of choosing specific codes may adapt as well.

To address this, first review the basic differences between ICD-9-CM and ICD-10-CM:

1. The code structure is different between the two systems. Whereas ICD-9-CM is primarily numeric, ICD-10-CM is alpha-numeric. This means that all code numbers will change. For example, in ICD-9-CM, the code for “cough” is 786.2. In ICD-10-CM, the code will be R05.

   This may be a challenge for physicians, especially those who might have memorized many of the diagnosis codes used on a daily basis.

   For these number-savvy providers, mapping books, like Ingenix’s ICD-10-CM Mapping, may be helpful, especially during the training and early implementation phases. These books show the ICD-9-CM code and equivalent crosswalks to ICD-10-CM.

2. ICD-10-CM is more specific. For some codes, there may be a direct crosswalk to a single ICD-10-CM code. For others, there may be multiple code choices that do not currently exist in ICD-9-CM. For example, the ICD-9-CM code for “abnormal bowel sounds” is 787.5, but in ICD-10-CM, there are three codes; two describe different types of abnormalities and a third code is for “other abnormal bowel sounds.”

ICD-10 Workshops and Webinars Coming in October

The OMA is offering crucial educational programs to help physicians and their staff understand the magnitude of ICD-10-CM and how it will impact medical practices. These interactive workshops and webinars will help you prepare for the transition to ICD-10:

ICD-10-CM Introduction and Planning Workshop
• October 4

ICD-10-CM Planning and Preparation Webinar Series
• Part 1 - October 7
• Part 2 - October 14
• Part 3 - October 20
• Part 4 - October 28

Anatomy and Physiology for ICD-10 Workshop
• October 12

Learn more about these programs and register now at www.theOMA.org/ICD-10.

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Make your plans now to attend the 2011 OMA Fall Forum and earn CME credit! Each October, the OMA invites all members to gather for top-quality education and networking. Weekend highlights include:

• Plenary session on Practice Transformation with an ACO/CCO panel discussion
• Break-out sessions regarding Generation Change in Health Care; Disruptive Physicians; Medical Staff Issues; and Childhood Obesit
• Health IT educational program on Friday: Quality Improvement - Part of OMA's Passport to Health IT Series

Learn more about the Fall Forum and register now at www.theOMA.org/FallForum.

Visit www.theOMA.org/Workshops for a complete lineup of upcoming OMA workshops and webinars, or see the OMA's Fall 2011 Educational Programs Brochure.
For some conditions that may be site specific, the ICD-10-CM codes may also be specific to site and laterality (right, left, bilateral), status (acute versus chronic), and timing (first encounter for the condition versus subsequent encounter).

Physicians may find that choosing the most appropriate code means searching a greater number of code options.

Custom lists for most frequently used codes can certainly be developed, but are likely to be longer than they have been in the past.

3. Specificity also impacts the “length” of the code. For example, in ICD-9-CM, all codes include a minimum of three digits, but may require up to five digits (i.e., 250.00). In ICD-10-CM, codes may have up to seven digits. As with ICD-9-CM, coding to the highest degree of specificity is required.

As specificity increases, so do documentation requirements. In order to assign the most specific codes, the documentation must be descriptive enough to identify the optimal code choice.

With the advent of electronic medical records and accreditation standards, most physicians have been required to develop problem lists. Once an ICD-9-CM code is established on a problem list, the physician often references the list and use the same code in future encounters where the same problem is addressed.

In ICD-10-CM, this methodology may not be quite so intuitive. For some of the codes in ICD-10-CM, the final digit may be transitional rather than static. One code may be correct for a specific encounter, but a different final digit may be required for accuracy at a different encounter. So when choosing a diagnosis code, in some cases, referencing a code from the problem list may not be as feasible as it currently is using ICD-9-CM.

Example:

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Description</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V20.00</td>
<td>Supervision Normal 1st Pregnancy</td>
<td>Z34.00</td>
<td>Supervision Normal 1st Pregnancy, unspecified trimester</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Z34.01</td>
<td>Supervision Normal 1st Pregnancy, first trimester</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Z34.02</td>
<td>Supervision Normal 1st Pregnancy, second trimester</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Z34.03</td>
<td>Supervision Normal 1st Pregnancy, third trimester</td>
</tr>
<tr>
<td>845.00</td>
<td>Unspecified site of ankle sprain/strain</td>
<td>S93.401A</td>
<td>Sprain, unspecified ligament, right ankle, initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S93.401D</td>
<td>Sprain, unspecified ligament, right ankle, subsequent encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S93.401S</td>
<td>Sprain, unspecified ligament, right ankle, sequela</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S93.402A</td>
<td>Sprain, unspecified ligament, left ankle, initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S93.402D</td>
<td>Sprain, unspecified ligament, left ankle, subsequent encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S93.402S</td>
<td>Sprain, unspecified ligament, left ankle, sequela</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S93.409A</td>
<td>Sprain, unspecified ligament, unspecified ankle, initial encounter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S93.409D</td>
<td>Sprain, unspecified ligament, unspecified ankle, subsequent encounter</td>
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</tr>
</tbody>
</table>

The key here may be for the provider to be familiar with the types of codes most frequently used in the practice where the final digit of the code is more likely to be changeable.

Given the specificity of ICD-10-CM, many physicians view the changes to be a disadvantage, primarily because they are unaccustomed to the nomenclature and more codes translates to more time spent searching for a code.

However, as physicians study the coding structure of ICD-10-CM, they are also discovering advantages toward the process of assigning codes.

In some code categories, the definitions change as well, and physicians are finding more intuitively descriptive categories. For example, in ICD-9-CM, the basic codes for “asthma” break down as “extrinsic” and “intrinsic.” In ICD-10-CM, the asthma codes are categorized as “mild intermittent,” “mild persistent,” “moderate persistent,” and “severe persistent.” These categories are far more consistent with physician logic than “intrinsic” and “extrinsic.” So while there may be more code choices, the most accurate code may be easier for the physician to identify.
ICD-10-CM also contains some additional categories not found in ICD-9-CM, so this may also aid in more specific coding.

For some code categories, ICD-10-CM may make coding manifestations easier. For example, the diabetic complication codes identify the type of complication (e.g., 250.5x = diabetes with ophthalmic complications) but requires the use of an additional code to document the actual manifestation (e.g., 366.41 = diabetic cataract). In ICD-10-CM, many of the manifestation codes are built into the category code and there is no need to identify a second code (e.g., E11.36 = Type II diabetes mellitus with diabetic cataract).

There are also consistencies between the two systems. The general guidelines and principles for choosing a code have not changed. For example, the process for identifying the principal and first listed remain the same. The direction to code signs/symptoms rather than possible, probable, or rule-out diagnoses is unchanged as well. A physician is still expected to report only those diagnoses that were addressed or assessed at that specific encounter.

The conventions are another component that remains the same. There are still codes with “NEC” and “NOS” in the description and the punctuation and abbreviations have not changed.

There is no doubt that the implementation of ICD-10-CM will bring change. The degree to which the transition will impact a practice is variable. Key factors include:

- understanding how highly utilized codes will be altered
- maintaining a solid plan for pre-implementation training provided
- development of supportive tools that are utilized within the practice

The solution to managing the code choice process in ICD-10-CM includes understanding how that code choice is currently conducted in the practice, and to plan how best to support that strategy moving forward.

**ICD-10-CM CODING QUICK TIP**

Implementation of ICD-10-CM is still two years away. But for computer technology upgrades, two years feels like a milli-second. Start identifying a list of all the technical applications in your office that use, connect, or intersect with diagnosis codes. Contact your vendors to make sure they are on track for testing and implementation of ICD-10-CM upgrades by the target date of October 1, 2013.

**HANDS-ON CODING EXERCISE**

**Answer the following 5 questions:**

1. The code S90.411 is for an abrasion of the great right toe. The code requires a 7th digit. What are the 7th digit coding options?
2. The ICD-9-CM code for routine GYN exam is V72.31. What are the ICD-10-CM counterpart codes?
3. The ICD-9-CM code 462 is for acute pharyngitis. Based on coding crosswalks, how many options are there for this code in ICD-10-CM?
4. In ICD-9-CM, there is a code for essential hypertension malignant (401.0), a code for benign essential hypertension (401.1), and a code for unspecified essential hypertension (401.9). How many crosswalks are there for those three codes in ICD-10-CM?
5. In ICD-9-CM, the code 305.1 is reported for tobacco dependence. How many coding options are there for this circumstance in ICD-10-CM?

**Answers:**

1. A, D, S
2. Z01.411 & Z01.419
3. Two
4. One - I10
5. Eight. The code depends on the product type and whether or not the patient is in remission
### Chief Complaint:
Knife Injury

### Subjective:
Injured left knee yesterday with utility knife. Cutting vinyl, pulled blade towards self and stabbed knee with sharp knife. Blade was new. Cleaned at home with alcohol pad. Did not see any foreign material. No further bleeding. Knee is painful to bend, but not too bad.

Presents for tetanus shot because he thinks last tetanus shot was about 10 years ago.

### Past History:
no medications

### Allergies:
NKDA

### Objective:
<table>
<thead>
<tr>
<th>BP</th>
<th>HR</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>120/80</td>
<td>60</td>
<td>175</td>
</tr>
</tbody>
</table>

NAD

Left knee w 7mm laceration over upper outer patella w/o erythema or foreign material. Moderately tender to palpation. +3 tenderness with knee flexion to 90 degrees. Guards against further knee flexion, but is able to flex to 100 degrees. Walks with limp.

Wound cleaned with water, covered with polysporin, steri-strip placed.

### Assessment/Plan:
Open wound - knee
Tetanus Booster
Keflex x5 days to cover any infection
Pain meds declined
Warning signs/symptoms discussed
RTO if not improved

### ICD-9-CM code: 891.0  Open wound, knee, uncomplicated
E920.3  Accident caused by knife
V03.7  Need for vaccination/inoculation: tetanus toxoid

### ICD-10-CM code:
S81.012A  Laceration w/o foreign body, left knee, initial encounter
W27.0xxA  Contact with workbench tool, initial encounter
Z23  Encounter for immunization

* There is an actual ICD-10-CM code for Crushed by a crocodile: W58.13. Bitten by a crocodile is W58.12 and Struck by a crocodile is W58.11.