Diagnosis Documentation and Coding for Pediatrics

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for American Academy of Pediatrics – Alabama Chapter
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ICD-9-CM

- Maintained by the Cooperating Parties
  - American Hospital Association
  - American Health Information Management Association
  - National Center for Health Statistics
  - Centers for Medicare and Medicaid Services
- Updated yearly – October 1 – no grace period
- Official guidance published by AHA - Coding Clinic - even for physician billing

Agenda

- ICD-9-CM Background
- Getting Ready for ICD-10-CM
- Getting Better at ICD-9-CM
  - Guidelines
  - Problem Areas
- Comparisons Between ICD-9-CM and ICD-10-CM

Clinical Information vs. Coding Guidelines

Remember that the coder/biller cannot assume anything and that he/she does not have the clinical knowledge that the physician has.

The coder/biller can only assign a code if the physician (NP, PA) has given the appropriate detailed information.

Code Sets

- CPT
  - What you did
- ICD-9-CM
  - Why you did it
- HCPCS Level II
  - Supplies and medications you used

A coder/biller can code from an Xray report or a pathology report but not from a laboratory report – Why?
Specificity Must Match!
Diagnosis assigned on claim form (checked on charge ticket or encounter form) must be as specific as that noted in the documentation and vice-versa.

Medical Necessity
Payors looking for:
- Knowledge of the emergent nature or severity of the patient’s complaint or condition, and
- All facts regarding signs, symptoms, complaints, or background facts describing the reason for care.

ICD-10
- Adopted by the World Health Assembly in 1990
- US has used since 1999 for mortality (causes of death)
- Waiting on CMS for final implementation date (October 1, 2014 proposed date)
  - Date of service for outpatient and physician claims
  - Date of discharge for inpatient claims

ICD-10-CM
- ICD-10-CM – Clinical Modifications - in draft version as early as 2002.
- ICD-10-PCS – Procedural Coding System will NOT affect physician coders – it will replace ICD-9 volume 3 for hospital coders
- Will be used by all HIPAA-compliant entities (Worker’s compensation will not be required to use it, but ICD-9 will not be maintained.)

General Equivalency Mappings
- Released by NCHS for bidirectional mapping
- Not to be used for actual coding – cannot provide a one-to-one match because of differences in guidelines and clinical information presented

Partial Code Freeze
- Last regular, annual updates to both ICD-9-CM and ICD-10 will be made on October 1, 2011
- On October 1, 2012 there will be only limited code updates to both ICD-9-CM & ICD-10 code sets to capture new technology and new diseases.
- On October 1, 2013 there will be only limited code updates to ICD-10 code sets to capture new technology and new diseases.
Skip over ICD-10 to ICD-11?
Not feasible!

The process of developing CM and PCS takes 10-12 years – ICD-11 has just been released in beta version

According to WHO official, jumping from ICD-9 to ICD-11 would be analogous to learning to walk before learning to crawl

Preparing the Physicians
• Many physicians do not understand ICD-9-CM coding and do not appreciate the importance as they are largely paid on CPT codes
• Some question why they should document more specifically
• Evaluate samples of various types of medical records to determine whether documentation supports level of detail found in ICD-10
• Implement documentation improvement strategies where needed

Ask Your PM/EHR System Vendors
• What systems upgrades or replacements are needed to accommodate ICD-10?
• What costs are involved and will upgrades be covered by existing contracts?
• When will upgrades or replacement systems be available for testing and implementation?
• What customer support and training will they provide?
• How will their products/services accommodate both ICD-9 and ICD-10 as you work with claims submitted both before and after 10/1/13?

Physician-EHR Challenges
• As many EHRs use drop-down boxes for providers to choose diagnoses, the physicians must understand what they are choosing
• Careful wording of the narrative description of the code choices is key
• Educating physicians should begin now – we still have 2+ years for ICD-9-CM coding
(Pet Peeve: Implementing EHR without coding involvement!)

Education Needs
• Who will need education?
• What type and level of education will they need?
• How will the education be delivered?
• What is the most appropriate and cost-effective method of providing ICD-10 education to the different categories of individuals who need training?

Preparing the Coders/Billers
• Conduct gap analysis of coding professionals’ knowledge and skills
• Assess coding professionals’ knowledge in biomedical sciences (anatomy and physiology, pathophysiology), medical terminology, and pharmacology
• Arrange for additional training in areas identified during assessment
Budget Considerations

• Software modifications
• Hardware/software upgrades
• Redesign/reprint paper forms
• Consulting services
• Training for staff and physicians
• Decreased productivity and decreased accuracy
• Potential reimbursement delays as payers transition

Comparison

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three to five characters</td>
<td>Three to seven characters</td>
</tr>
<tr>
<td>First digit is numeric but can be alpha (E or V)</td>
<td>First character always alpha</td>
</tr>
<tr>
<td>2-5 are numeric</td>
<td>All letters used except U</td>
</tr>
<tr>
<td>Always at least three digits</td>
<td>Character 2 always numeric: 3-7 can be alpha or numeric</td>
</tr>
<tr>
<td>Decimal placed after the first three characters</td>
<td>Always at least three digits</td>
</tr>
<tr>
<td>Alpha characters are not case-sensitive</td>
<td>Decimal placed after the first three characters</td>
</tr>
</tbody>
</table>

Costs of ICD-10-CM Implementation

<table>
<thead>
<tr>
<th>Business Aspect</th>
<th>Typical Small Practice (2 providers)</th>
<th>Typical Medium Practice (10 providers)</th>
<th>Typical Large Practice (100 providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>$2,405</td>
<td>$4,745</td>
<td>$46,280</td>
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<tr>
<td>Process Analysis</td>
<td>$6,900</td>
<td>$12,000</td>
<td>$48,000</td>
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<tr>
<td>Changes to Superbills</td>
<td>$2,985</td>
<td>$9,950</td>
<td>$99,500</td>
</tr>
<tr>
<td>IT Costs</td>
<td>$7,500</td>
<td>$15,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Increased Documentation Costs</td>
<td>$44,000</td>
<td>$178,500</td>
<td>$1,785,000</td>
</tr>
<tr>
<td>Cash Flow Disruption</td>
<td>$19,500</td>
<td>$65,000</td>
<td>$650,000</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$83,290</td>
<td>$285,195</td>
<td>$2,728,780</td>
</tr>
</tbody>
</table>

Specifically for Coders!

• Never code what you do not understand.

• Do not simply look up a word in the ICD9/ICD-10 or CPT index without knowing what it means – also know the synonyms, or other interchangeable terms.

Coding and 7th Character Extensions

Category | Etiology, anatomic site, severity

Coding and Use of 7th Character

• Obstetrics
• Injury
• External cause

• Either alpha or numeric

• Placeholder X

• Meanings vary

Injury and External Cause - Identifies Injury

Initial – receiving active treatment

Subsequent – receiving routine care during healing or recovery (after active treatment)

Sequela – complications or conditions arising as result of injury
Coding and Use of 7th Character

Aftercare - Z codes are not used for aftercare for injuries

Combination codes for poisonings and external cause (accidental, intentional self-harm, assault, undetermined)

Chapter 15 – represents fetus in multiple gestation affected by condition being coded

NOTES

Includes and Inclusion Terms are the same in ICD-9-CM as in ICD-10-CM
ICD-9-CM has one note for Excludes
ICD-10-CM has
- Excludes 1 – NOT CODED HERE!
  The two conditions cannot occur together.
- Excludes 2 – Not included here. Must use a second code if both conditions are present.

NEC and NOS

Same meaning in both ICD-9-CM and ICD-10-CM
- NEC - “Not elsewhere classifiable”
  This abbreviation in the Tabular represents “other specified”. When a specific code is not available for a condition the Tabular includes an NEC entry under a code to identify the code as the “other specified” code.
- NOS - “Not otherwise specified”
  This abbreviation is the equivalent of unspecified.

See – See Also – And - With

Same meaning in ICD-9-CM and ICD-10-CM
- See – must go to the category referenced for the correct code
- See Also – another category may be appropriate, but if this category provides the needed code, you may use it
- And – means and/or
- With – additional information, not necessarily in alphabetical order

Punctuation

Same in ICD-9-CM as in ICD-10-CM
- [ ] - Brackets are used in the tabular list to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Index to identify manifestation codes.
- ( ) - Parentheses are used in both the Index and Tabular to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.
- : - Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.

Steps to Correct Coding

- In determining the first-listed diagnosis the coding conventions of ICD-9-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines.
- Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.
- The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.
Steps to Correct Coding

ICD-9
• The appropriate code or codes from 001.0 through V83.89 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

ICD-10
• The appropriate code or codes from A00.0 through T88.9, Z00-Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

ICD-9-CM
• Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has not been confirmed by the physician.

ICD-10-CM
• Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (codes R00-R99) contain many, but not all codes for symptoms.

Steps to Correct Coding

• For accurate reporting of ICD-9-CM/ICD-10-CM diagnosis codes, the documentation should describe the patient’s condition, using terminology which includes specific diagnoses as well as symptoms, problems or reasons for the encounter.

CRITICAL!!! If the provider does not document the condition, it cannot be coded! No assuming allowed!

ICD-9-CM
• A code is invalid if it has not been coded to the full number of digits required for that code.

ICD-10-CM
• ICD-10-CM is composed of codes with either 3, 4, 5, 6 or 7 digits. Codes with three digits are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth fifth digits, sixth or seventh digits which provide greater specificity.

• A three-digit code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character extension, if applicable.

• List first the ICD-9-CM/ICD-10-CM code for the diagnosis, condition, problem or other reason for the encounter shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions.

ICD-10-CM adds the following sentence:
In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.
• Do not code diagnoses documented as “probable”, “suspected”, “questionable”, “rule out”, or working diagnosis. Rather, code the condition(s) to the highest degree of certainty for that encounter, such as symptoms, signs, abnormal test results, or other reason for the visit.

But...do not code the symptom if the cause is known and coded.

• Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).

• Code all documented conditions that coexist at the time of the encounter, and require or affect patient care, treatment, or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10 – V19 in ICD-9-CM, Z80-Z87 in ICD-10-CM) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

• For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnoses documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

• For patients receiving preoperative evaluations only, sequence a code from category V72.8/Z01.81, to describe the preoperative consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

• For surgery, code the diagnosis code for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.
Chapter-Specific Guidelines

Focusing on Pediatrics

Included in ICD-9-CM but moved to chapter-specific guidelines in ICD-10-CM –
• For routine outpatient prenatal visits when no complications are present, codes V22.0, Supervision of normal first pregnancy, or V22.1, Supervision of other normal pregnancy, should be used as the principal diagnosis. These codes should not be used in conjunction with chapter 11 codes.

Included in ICD-10-CM but not ICD-9-CM
• The subcategories for encounters for general medical examinations, Z00.0-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first listed diagnosis. A secondary code for the abnormal finding should also be coded.

Chapter 1 – Certain Infectious and Parasitic Diseases
• Includes: diseases generally recognized as communicable or transmissible
• Use additional code for any associated drug resistance (Z16)
• New section called infections with a predominantly sexual mode of transmission (A50-A64) – HIV is not in this section

Acute vs. Chronic
• If the same condition is described as both acute and chronic, and codes exist for both, code both – list the code for the acute condition first
• The physician must state acute or chronic – otherwise, we must code unspecified.

• Categories B90-B94 are to be used to indicate conditions in categories A00-B89 as the cause of sequelae, which are themselves classified elsewhere.
• Code first condition resulting from (sequela) the infectious or parasitic disease
• Bacterial and viral infectious agents (B95-B97) are provided for use as supplementary or additional codes to identify the infectious agent(s) in diseases classified elsewhere
  – Index
    • Infection
    • Organism (Streptococcus)
Example

Strep pharyngitis

ICD-9-CM:
034.0 – Streptococcal sore throat

ICD-10-CM:
J02.0 – Streptococcal pharyngitis
(Moved to Chapter 10 – Respiratory System)

Example

Viral Syndrome

ICD-9-CM:
079.99 – Unspecified viral infection

ICD-10-CM:
B34.9 – Viral infection, unspecified

Viremia

Use, Abuse, Dependence

• When the provider documentation refers to use, abuse, and dependence of the same substance, only one code should be used
  – Use and abuse – code abuse
  – Abuse and dependence – code dependence
  – Use and dependence – code dependence

Attention Deficit Disorder

In ICD-9-CM, primarily two codes:
314.00 – ADD without mention of hyperactivity
314.01 – Attention Deficit Hyperactivity Disorder

Other codes for developmental delay or conduct disorder
314.1 – Hyperkinesis with development delay
314.2 – Hyperkinetic conduct disorder

Chapter 5 – Mental and Behavioral Disorders

• Unique codes for alcohol and drug use and abuse and dependence
• Continuous or episodic no longer classified
• History of drug or alcohol dependence coded as “in remission”
• Combination codes
• Blood alcohol level (Y90.-)
• Now parallel the DSM-IV TR in most cases

ADHD in ICD-10-CM

F90.0 – predominantly inattentive type
F90.1 – predominantly hyperactive type
F90.2 – combined type
F90.8 – other type

Code separately for anxiety, mood disorders, developmental disorders
Chapter 6
Diseases of the Nervous System

• Diseases of the sense organs have been given their own chapters – 7 for eyes and adnexa, 8 for ear and mastoid process

• Category G81, G82, G83 – hemiplegia and paralysis
  – Used only when listed conditions are reported without further specification, or are stated to be old or longstanding, with unspecified cause

Example
The patient is seen for management of juvenile myoclonic epilepsy. The patient did not respond to treatment and was diagnosed with an intractable seizure.
ICD-9-CM:
345.11 – Generalized convulsive epilepsy with intractable epilepsy
ICD-10-CM:
G40.319 – Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus

Chapter 7
Diseases of the eye and adnexa

• Concept of laterality
  – Right
  – Left
  – Bilateral
  – Unspecified

If bilateral is not available, assign code for right and left

Example
Acute mucopurulent conjunctivitis, right eye
ICD-9-CM:
372.03 – other mucopurulent conjunctivitis
ICD-10-CM:
H10.021 – other mucopurulent conjunctivitis, right eye
**Example**

Acute conjunctivitis, right eye

ICD-9-CM:
372.00 – Acute conjunctivitis, unspecified

ICD-10-CM:
H10.31 – Unspecified acute conjunctivitis, right eye

**Example**

Conjunctivitis, right eye

ICD-9-CM:
372.30 – Conjunctivitis, unspecified

ICD-10-CM:
H10.9 – Unspecified conjunctivitis
(Note that you lose the laterality)

**Example**

The patient is seen for acute ear pain. Examination reveals bilateral acute serous otitis media with a total perforated tympanic membrane of the right ear.

ICD-9-CM:
381.01 – Acute serous otitis media
(Note that TM perforation not coded with OM in ICD-9)

ICD-10-CM:
H65.03 – Acute serous otitis media, bilateral
H72.821 – Total perforations of the tympanic membrane, right ear

**Chapter 8 – Diseases of the ear and mastoid process**

Otitis media
- In ICD-10-CM, you will use an additional code for any associated perforated tympanic membrane (H72.1) – not coded separately in ICD-9-CM
- Use additional code to identify:
  - exposure to environmental tobacco smoke (Z77.22)
  - exposure to tobacco smoke in the perinatal period (P96.81)
  - history of tobacco use (Z87.891)
  - occupational exposure to environmental tobacco smoke (Z57.31)
  - tobacco dependence (F17.1)
  - tobacco use (Z72.0)

**Chapter 10 – Diseases of the Respiratory System**

- New terminology for asthma
- Respiratory condition in more than 1 site (not specifically indexed) classified to lower anatomic site
- Additional code notes
- Certain codes moved from other locations, for example, streptococcal sore throat
Example
Asthma – Bronchial not severe/prolonged
(from Pediatric Clinic superbill)

ICD-9-CM:
493.90 – Asthma (bronchial)(allergic NOS), unspecified

ICD-10-CM:
J45.909 – unspecified asthma, uncomplicated

Example
Croup

ICD-9-CM:
464.4 – Croup

ICD-10-CM:
J05.0 – Acute obstructive laryngitis (croup)

In both cases, use additional code to identify infectious agent/organism

ICD-9-CM Descriptors - Asthma
Extrinsic
  allergic with stated cause
  childhood
  atopic
  hay
  platinum
Intrinsic
  late-onset
Unspecified
Each can be specified as with exacerbation or status asthmaticus

ICD-10-CM Descriptors - Asthma
Mild – Moderate – Severe
Persistent – Intermittent
Unspecified

Each can be specified as with exacerbation or status asthmaticus

Chapter 11
Diseases of the Digestive System
• Diseases of the liver have their own category
• The term “hemorrhage” is used when referring to ulcers
• The term “bleeding” is used when classifying gastritis, duodenitis, diverticulosis, diverticulitis
• Obstruction is no longer a classification for ulcers
• Crohn’s disease expanded
• Gastroenteritis – Infectious or Viral coded in Chapter 1 – Infectious Diseases in both ICD-9-CM and ICD-10-CM

Example
Recurrent right inguinal hernia with gangrene and obstruction

ICD-9-CM:
550.01 - Inguinal hernia with gangrene, recurrent unilateral or unspecified inguinal hernia

ICD-10-CM:
K40.41 – Unilateral inguinal hernia, with gangrene, recurrent
### Example

**Gastroenteritis**

ICD-9-CM:
558.9 – Other and unspecified noninfectious gastroenteritis and colitis

ICD-10-CM:
K52.9 – Noninfectious gastroenteritis and colitis, unspecified

### Example

**Cellulitis, left finger – staph**

ICD-9-CM:
681.00 – Cellulitis and abscess of finger, unspecified
041.10 – Staphylococcus, unspecified

ICD-10-CM:
L03.012 – Cellulitis of left finger
B95.8 – Unspecified staphylococcus as the cause of diseases classified elsewhere

### Chapter 12 – Diseases of skin and subcutaneous tissue

- Complete restructuring in ICD-10-CM
- Laterality identified when appropriate
- Subchapter for radiation-related disorders
- Combination code for pressure ulcers

### Chapter 13 – Diseases of the musculoskeletal system and connective tissue

- Almost every code has been expanded to include very specific sites and laterality
- Some codes require the use of 7th character extension

### Example

**Cellulitis, left finger**

ICD-9-CM:
681.00 – Cellulitis and abscess of finger, unspecified

ICD-10-CM:
L03.012 – Cellulitis of left finger

No bilateral code – code both if on both L and R

### Example

**Ongoing juvenile rheumatoid arthritis found only in both ankles**

ICD-9-CM:
714.33 – Monoarticular juvenile rheumatoid arthritis

ICD-10-CM:
M08.071 – Unspecified juvenile rheumatoid arthritis, right ankle and foot
M08.072 - Unspecified juvenile rheumatoid arthritis, left ankle and foot
Chapter 14
Diseases of the genitourinary system

• Many codes require gender specificity
• Some situations require additional codes for symptoms

Example
Urinary Tract Infection
ICD-9-CM:
599.0 – UTI, site not specified

ICD-10-CM:
N39.0 – UTI, site not specified

In both cases, use an additional code to identify the organism

Chapter 16 and 17
Division between certain conditions originating in perinatal period – chapter 16 – and congenital malformations, deformations, and chromosomal abnormalities – chapter 17

• Categories for birth weight and gestational age – both should be coded if documented
• Chapter 17 codes used throughout the life of the patient

Example
Premature “crack” baby born in the hospital by caesarean section to a mother dependent on cocaine. The newborn did not show signs of withdrawal, but does show signs of dehydration. Birth weight 1247 grams, 31 completed weeks of gestation.

ICD-9-CM:
V30.01 – Single liveborn, born in hospital, delivered by cesarean delivery
765.14 – Other preterm infants, 1,000-1,249 gms
765.26 – 31-32 completed weeks of gestation
775.5 – dehydration in newborn

Example
Nocturnal Enuresis
ICD-9-CM:
788.36 – Nocturnal enuresis

ICD-10-CM:
N39.44 – Nocturnal enuresis

Note that this is a symptom code in ICD-9-CM, but is included in the Genitourinary System for ICD-10-CM
ICD-10-CM:

Z38.01 – Single liveborn, caesarean delivery
P04.41 – Newborn (suspected to be) affected by maternal use of cocaine
P07.14 – low birthweight newborn, 1000-1249 gms
P07.31 – preterm newborn, 28-31 completed weeks
P74.1 – dehydration of newborn

Example

Diarrhea

ICD-9-CM:
787.91 - Diarrhea

ICD-10-CM:
R19.7 – Diarrhea, unspecified
(Excludes functional diarrhea, neonatal diarrhea, psychogenic diarrhea)

Example

Wheezing

ICD-9-CM:
786.07 – Wheezing
(Not to be used in a patient with asthma)

ICD-10-CM:
R06.2 – Wheezing
(Not to be used in a patient with asthma)

Chapter 18 – Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified

Symptoms that point to a given diagnosis have been classified in the chapter for that diagnosis.

Example

Diarrhea

ICD-9-CM:
787.91 - Diarrhea

ICD-10-CM:
R19.7 – Diarrhea, unspecified
(Excludes functional diarrhea, neonatal diarrhea, psychogenic diarrhea)

Chapter 19 – Injury, Poisoning, and Certain Other Consequences of External Causes

Injuries grouped by body part rather than category of injury

- Head
- Neck
- Thorax

Symptoms

Rules for coding symptoms in chapter 18 are the same as in ICD-9-CM:
- When no more specific diagnosis can be made
- Signs and symptoms proved to be transient
- Provisional diagnosis when a patient fails to return
- Cases referred elsewhere before diagnosis was made
- Certain symptoms that represent important problems in medical care in their own right
**Fractures**

- Greater specificity
  - Type of fracture
  - Specific anatomical site
  - Displaced vs nondisplaced
  - Laterality
  - Routine vs delayed healing
  - Nonunion
  - Malunion
  - Type of encounter
    - Initial
    - Subsequent
    - Sequela

**Notes:**
- Encompasses 2 alpha characters
  - S
    - Injuries related to body region
  - T
    - Injuries to unspecified region
    - Poisonings, external causes
- NOTE: Use secondary code(s) from Chapter 20 to indicate cause of injury
- Codes within T section that include the external cause do not require an additional external cause code

- A fracture not indicated as displaced or nondisplaced should be coded to displaced
- A fracture not designated as open or closed should be coded to closed

**Fractures, 7th character**

- A – Initial closed
- B – Initial open
- D – Subsequent routine
- G – Subsequent delayed
- K – Subsequent nonunion
- P – Subsequent malunion
- S – Sequela

**Initial encounter**
- The patient is receiving active treatment for the injury
  - Surgical treatment
  - Emergency department encounter
  - Evaluation and treatment by a new physician

**Subsequent encounter**
- After patient received active treatment of injury and receiving routine care during healing or recovery phase
  - Cast change or removal
  - Removal of external or internal fixation device
  - Medication adjustment
  - Other aftercare and follow-up visits following injury treatment.
**Sequela**
- Complications or conditions that arise as a direct result of an injury
  - Scar formation after burn
  - Use both the injury code that precipitated sequela and code for sequela
  - “S” added only to injury code, not sequela code.
  - “S” identifies injury responsible for sequela.
  - Specific type of sequela (like scar) sequenced first, followed by injury code.

**Example**
Sprained ankle, right, initial encounter

ICD-9-CM:
845.00 – sprain and strain, ankle, unspecified site
*(More specific codes for specific ligaments)*

ICD-10-CM:
S93.401A – Sprain of unspecified ligament of right ankle, initial encounter
*(More specific codes for specific ligaments)*

**Poisoning, Adverse Effect, Underdose**

<table>
<thead>
<tr>
<th>Poisoning</th>
<th>Overdose of substances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse effect</td>
<td>“Hypersensitivity,” “reaction,” or correct substance properly administered</td>
</tr>
<tr>
<td>Underdosing</td>
<td>Taking less of medication than is prescribed or instructed by manufacturer either inadvertently or deliberately</td>
</tr>
</tbody>
</table>

**Example**
Nursemaid’s elbow, right arm, initial encounter

ICD-9-CM:
832.2 – Closed posterior dislocation of elbow

ICD-10-CM:
S53.031A – Nursemaid’s elbow, right arm, initial encounter
*(Subsequent encounter would use 7th character D, Sequela (late effect) would use 7th character S)*

- The physician needs to specify the circumstances behind the ingestion/administration of the drug or other substance (if known)
ICD-9-CM Coding

Poisoning
1. Poisoning code from Table of Drugs and Chemicals
2. Manifestation
3. E-code for circumstances

Adverse Effect
1. Manifestation
2. E-code for circumstances – from Therapeutic Use column of Table of Drugs and Chemicals

Example
Toddler ate several acetaminophen when he found an open bottle at home.

ICD-9-CM:
965.4 – Poisoning by aromatic analgesics, not elsewhere classified
(Would also have second code specifying manifestation if documented.)
E850.4 – Accidental poisoning by aromatic analgesics, not elsewhere classified
E849.0 - Home

ICD-10-CM:
T39.1x1A – Poisoning by 4-Aminophenol derivatives, accidental (unintentional), initial encounter
(Would also have second code specifying manifestation if documented.)
Y92.019 – unspecified area in home (only on first encounter)

• Combination codes for poisonings/external cause (accidental, intentional self-harm, assault, undetermined)
• Table of Drugs and Chemicals groups all poisoning columns together
– Followed by adverse effect and underdosing
• When no intent of poisoning is indicated, code to accidental
– Undetermined intent is only for use when there is specific documentation in record that intent cannot be determined

• Use additional code(s) for manifestations of poisoning and adverse effects
• Use additional code for intent of underdosing:
  – Failure in dosage during medical and surgical care (Y63.61, Y63.8-Y63.9)
  – Patient's underdosing of medication regime (Z91.12-, Z91.13-)

• External cause code may be used with any code in range A00.0-T88.9, Z00-Z99, that is health condition due to external cause
• Encompasses alpha characters V, W, X, and Y
• Assign external cause code, with appropriate seventh character for each encounter for which injury or condition is being treated
  – initial encounter
  – subsequent encounter
  – sequela
A transport accident is one in which vehicle must be moving or running or in use for transport purposes at the time of the accident.

Definitions of transport vehicles provided in classification.

Use additional code to identify:
- Airbag injury (W22.1)
- Type of street or road (Y92.4-)
- Use of cellular telephone at time of transport accident (Y93.c-)
Example

Patient has 2nd and 3rd degree burns of the back and left lower leg. He was burned when he was running and fell into the lit fireplace in his parent’s bedroom.

ICD-9-CM:
942.34 – 3rd degree burns, trunk
945.34 – 3rd degree burns, leg
948.30 - Burn (any degree) involving 30-39% of body surface with 3rd degree burn <10% or unspecified amount
E895 - Accident caused by controlled fire in private dwelling
E849.0 – Home
E001.1 – Running

Example

Medical examination of 4yo for admission to preschool.

ICD-9-CM:
V70.3 – General medical examination for school admission

ICD-10-CM:
Z02.0 – encounter for examination for admission to educational institution

Consequences of Poor Preparation for ICD-10-CM

- Increased claims rejections and denials
- Increased delays in processing authorizations and reimbursement claims
- Improper claims payment
- Coding backlogs
- Compliance issues
- Decisions based on inaccurate data
So, what do we do for the next 2 years?

• Study and apply ICD-9-CM guidelines – many of them do not change for ICD-10-CM.
• Review the ICD-10-CM guidelines for your specialty – begin to look for the additional information that would be needed in ICD-10-CM.
• Consider training needs – CMS recommends 12-16 hours of training for coders

CMS: "Although the final rule on the proposed ICD-10 deadline change has yet to be published, it is important to continue planning for the transition to ICD-10".

Resources

• CMS – http://cms.gov/icd10
• AHIMA (see next page)
• AAPC (see attached)

AAPC on ICD-10-CM

• You will be given two (2) years to take and pass, beginning October 1, 2013? (one year before implementation of ICD-10) and ending September 30, 2015? (one year after implementation)
• There will be 75 questions
• It will be open-book, online and un-proctored
• Coders will have two (2) attempts at passing for the $60 administration fee

Followup Questions?
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AHIMA Resources
http://www.ahima.org/icd10
• Practical guidance (free)
  – Putting the ICD-10-CM/PCS GEMs into Practice
  – ICD-10 Preparation Checklist
  – Role-based implementation models
  – ICD-10 Readiness and Prioritization Tool
• Books
  – Pocket Guide of ICD-10-CM/PCS
  – ICD-10-CM/PCS Preview
  – Implementing ICD-10-CM in Hospitals
  – Essential Guide to GEMs
• Online courses
  – ICD-10-CM and ICD-10-PCS overview courses
  – Fundamentals of GEMs course
• Proficiency assessments
• Academy for ICD-10 Trainers
  – Academy for ICD-10-CM/PCS (3 days)
  – Academy for ICD-10-CM only (1 ½ days)
• E-newsletter (free)
• Articles (many are free)
• Webinars/Conferences