

MODULE 10

Introduction to ICD-10-CM Coding

ICD-10-CM Coding

Welcome to week ten of this twelve-week online course. You should now be familiar with CDT codes. This week we will explore the history of ICD codes along with basic knowledge of ICD-10-CM coding.

Objectives

After reading this module you should be able to:

- Have in-depth knowledge of the history of ICD codes
- In-depth knowledge of how to use the ICD-10-CM coding manual
- Explain what the tabular list is and its function
- Explain what the Index is and its function
- Explain what General Notes are in the ICD-10-CM coding manual
- Explain punctuation, abbreviations, and color coding in the ICD-10-CM manual
- General knowledge of official guidelines for coding and reporting
- In-depth knowledge of step by step coding

History of ICD Codes

Back in the 1700s, the first attempt at classifying diseases was made by a French physician, François Boissier de Sauvages de Lacroix, who wrote the first book on the subject "Nosologia Methodica." Many different physicians followed up on his process, upgrading it to better reflect diseases as more were discovered.

In 1853, at the first International Statistical Congress in Paris, it was agreed that there should be a uniform classification of diseases for the world to use. In 1855, the first standards for classification were introduced, and from that point on, there was an outline for how the coding process should work.

For the next 95 years, there were multiple revisions and changes to the code, but no universal agreement on the standards. Many countries developed their own coding system, although all used the bases that were already established in categorizing these diseases.

In 1938, Canada introduced a proposal for the listing of causes of diseases. The Fifth International Congress adopted the ruling although there was no formal action taken on it. By 1944, there was a provisional list of diseases and injuries, presented by the U.S. and the United Kingdom.

It wasn't until 1948, just after the creation of the World Health Organization, that there was a committee put together to establish one revision to represent all countries. The idea was to put together not only a classification of causes of death, but also classifications of illnesses and injuries. This became known as the Sixth Revision of the International Lists. The committee created the "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death" from the data, which was in two volumes. By the time of the 7th revision, in 1955, the name International Classification of Diseases had been adopted.

The 9th version of ICD came about in 1977. To date, it's the last version that every country adopted at the same time. Incorporated into it were many of the category extensions of diseases and morbidities that several represented countries wanted for better clarity of what was occurring in their areas.

In 1983, ICD-10 was introduced as being a critical part of medical billing by physicians and hospitals, and was further embedded by the passage of the Medicare Catastrophic Coverage Act.

The next update for ICD was supposed to begin in 1985, following what had become a 10-year process for working on ICD codes. However, it was pushed back to 1989, and continuing delays kept it from coming out until 1995.

While most of the world has switched to ICD-10, the U.S. remained on the current system because of billing and payment issues.

That act was later repealed, but the payment process was already set, as other insurance companies adopted the same standards. The department of Health and Human Services (HHS) published the final rule regarding the adoption of ICD-10-CM in the January 16, 2009, federal register (45 CFR part 162 [CMS-0013-F]). The initial compliance date for implementation to replace ICD-9-CM was set for October 1, 2013. On April 17, 2012, the Department of Health and Human Services released a notice to postpone the date to October 1, 2014 in an effort to allow providers enough time to comply with ICD-10 changes. Then on April 1, 2014 congress enacted the Protecting Access to Medicare Act of 2014 which allowed for one more delay, the ICD-10-CM code set adoption became final and mandatory on October 1, 2015.

History and Introduction of ICD-10-CM

The ICD-10-CM classification system was developed by the National Center for Health Statistics (NCHS) as a clinical modification to the ICD-10 system developed by the World Health Organization or WHO, this development was a unique system setup for use in the United States to track morbidity and mortality rates.

ICD-10 is a copyrighted product of the World Health Organization (WHO), which has authorized the development of a clinical modification (CM) of ICD-10 for use in the United States. This development was conformed to the conventions for ICD and was developed and evaluated by a panel of physician groups, clinical coders, and other industry experts.

The following revisions were made to ICD-10 by this panel

- Expanded injury codes
- Creation of combination diagnosis/symptom codes
- Addition of 6th and 7th character classification
- Classifications specific to laterality (specific body part or side)

This new structure allows for further expansion than was possible with the ICD-9-CM classification/coding system. The Department of Health and Human Services (HHS) published the final rule regarding adoption of ICD-10-CM in the January 16, 2009, Federal Register (45 CFR part 162 [CMS-0013-F]). The initial compliance date for implementation was set of

October 1, 2013. The Department of Health and Human Services released a notice to postpone the date on April 17, 2012 due to certain entities not having enough time to comply. The replacement date was then set for October 1, 2014 but was once again postponed on April 1, 2014 when congress enacted the Protecting Access to Medicare Act of 2014. This act contained a provision to delay implementation of ICD-10-CM by at least one year and thus prohibited the Department of Health and Human Services (HHS) from adopting the ICD-10-CM code sets as the mandatory standard until October 1, 2015. As of today, ICD-10-CM has been adopted and should currently be used on all provider claims.

Steps for Successful ICD-10 Implementation

Follow these 9 steps for successful and correct ICD-10 implementation.

1- Inform

5 – Prepare

9 - Evaluate

2 – Assign

6 - Train

3 – Assess

7 - Test

4 – Plan

8 - Implement

Step 1: Inform

Give all providers, office managers, and any other practice decision maker a high-level overview of ICD-10...

Make sure to prepare briefing material for both providers and any other appropriate staff member to review related to the scope of work needed for the implementation of ICD-10 and HIPAA 5010. You may find appropriate briefing material along with education material on the HHS website. (<https://www.cms.gov/Medicare/Coding/ICD10/index.html>)

Meet with practice decision makers to explain what ICD-10 is, how it is to be used, and why ICD-9 is being phased out.

Step 2: Assign

Assign teams to oversee the implementation effort...

Assign a “Coding Project Manager” the ownership of the ICD-10 implementation project. This role should be filled by a key staff member such as a Certified Dental Coder (CDC), Certified Dental Coding-Specialist (CDC-S), or Certified Dental Practice Auditor (CDPA). The individual

selected need to fully understand the scope of this project and be able to effectively manage and implement it. Establish communication committee's utilizing billing staff if possible to assist in this implementation. Finally, schedule regular meetings with activity and result reporting for providers and staff.

Step 3: Assess

Assess all areas of practice and determine what need to change...

The coding project manager should complete a review of regulatory requirements of ICD-20 to identify possible impacts to the practice. Evaluate clinical documentation to determine if current specificity allows an ICD-10 code to be assigned. Determine ICD-10 requirements and expectations from all departments, system users, and system vendors to determine product timelines for upgrades, testing, and changes for each system.

Step 4: Plan

Plan the implementation of ICD-10 for your practice or facility...

Create a budget based on areas that will be impacted such as IT systems, software, hardware, staff training, documentation readiness audits, and education. Makes sure you are working with your vendors to schedule appropriate timeframes for practice management systems to include coding system upgrades. Plan staff training schedules on implementation documentation, code set, and system reviews.

Step 5: Prepare

Prepare the changes for ICD-10...

Create staff training materials such as coding worksheets, flow charts, and documentation templates. Make sure to update all internal policies where ICD-10 may be affected.

Step 6: Train

Train all staff on the changes made for ICD-10...

It is a good idea to re-train dental providers on specificity requirements of ICD-10 by utilizing documentation from patient encounters. This may be the time to hire an independent auditor to audit, review, and recommend improvements to documentation. An independent auditor or firm may also be a great resource for training of ICD-10 and documentation requirements for providers and billing staff with limited clinical knowledge.

Step 7: Test

Make sure to perform both internal and external testing for software to verify compatibility with upgrades and existing systems. Test your systems with both your clearinghouse and payers. Re-evaluate clinical documentation by providers to check for ICD-10 specificity. Finally test the knowledge of all billing staff for ICD-10 readiness.

Step: 8 Implement

Implement ICD-10 into your practice...

Begin using ICD-10 instead of ICD-9 code sets. Make all new policies and procedures effective and turn all software systems live.

Step: 9 Evaluate

Make sure to continually audit and evaluate provider documentation for compliance and retrain any providers as necessary. Audit systems and software for accuracy along with monitoring and measuring productivity outcomes of all staff. Finally analyze any claim denials, and make appropriate adjustments to reduce them.

Overview of ICD-10-CM

Format

The ICD-10-CM coding manual is comprised of two main parts; the index, which is an alphabetic list of terms and their corresponding code, and the tabular list, which is a sequential alphanumeric list of codes divided into chapters based on body system or condition.

The index has “main terms” meaning terms that are used frequently such as PAIN, FRACTURE, and DISORDER. Also in the index you will find the Neoplasm Table along with a Table of Drugs and Chemicals.

The tabular list contains categories, subcategories, and valid codes. The code is broken down in an alphanumeric fashion where the first character of a three-character category is a letter. The second and third characters may be numbers or alpha characters. Subcategories may contain four or five characters. Subcategory characters include either letters or numbers. Codes may be three, four, five, six, or seven characters in length.

The ICD-10-CM may use the letter “X” as a place holder. An example of this place holder would be Fracture of ramus of mandible, initial encounter for closed fracture S02.64XA. If you look in your coding manual the code call for seven characters however there are only six characters, therefore the “X” is used as a placeholder since there is no sixth character only a seventh character

Punctuation

[] In the tabular list, brackets are used to enclose synonyms, alternative wording, or explanatory phrases. These brackets are used to identify manifestation code simply meaning an event, action, or object that clearly shows something.

() Parentheses are used in both the Index and the tabular list to enclose nonessential modifiers. A non-essential modifier simply means that a supplementary word may or may be present in the statement of a disease or procedure without affecting the code number to which it is assigned.

: Colons are used in the tabular list after an incomplete term that needs one or more of the modifiers following the colon to make it assignable to a category. An example of a colon may be found under code K05.

K05 Gingivitis and periodontal diseases

Use additional code to identify:

alcohol abuse and dependence (F10.-)

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.-)

tobacco use (Z72.0)

Abbreviations

NEC

The abbreviation NEC meaning “Not elsewhere classifiable” represents “other specified” in the ICD-10-CM coding manual. When an index entry states NEC it is directing the coder to an “other specified” code in the tabular list. These codes usually have a fourth or sixth character of 8 and a fifth character 9. This is usually seen when the information in the health record provides detail for which a specific code does not exist.

NOS

The abbreviation NOS meaning “Not otherwise specified” in the tabular list is often interpreted as “unspecified”. Unspecified codes in the tabular list usually are identified with a fourth or sixth character of 9 and a fifth character of 0. These codes are used when the information in the health record is insufficient to assign a more specific code.

General Notes

Boldface

Boldface type is used for main term entries in the alphabetic index and all codes and descriptions in the tabular list. For example, Gingivitis is in boldface type.

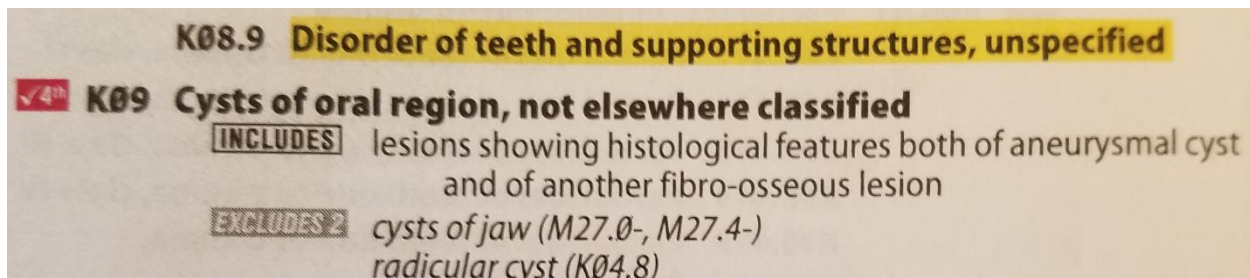
Gingivitis K05.10

- acute (catarrhal) K05.00
- necrotizing A69.1
- non-plaque induced K05.01
- plaque induced K05.00

Includes Notes

The word Includes appears immediately under certain categories to further clarify, give an example, or define the content of a code category.

For example, ICD-10-CM Code K09 **Cysts of oral region, not elsewhere classified** has the word includes below see figure below



Excludes Notes

ICD-10-CM has two types of excludes notes with each of them having a different definition for use.

Excludes 1

This exclusion 1 note means it is a true exclusion. It is "NOT CODED HERE" indicating a mutually exclusive code in which two codes may not be reported together.

Excludes 2

An exclusion 2 note means "NOT INCLUDED HERE" it indicates that although a patient may have both conditions at the same time the excluded condition is not part of the condition. Therefore, you may use both the code and the excluded code together.

Default Codes

And

When the term “and” is used in a narrative statement or code title it simply means “and/or” and may be coded as such.

With

The word “with” simply means “associated with” or “due to” when it appears in a code title in both the Alphabetic Index or as a note in the Tabular List.

Code Also

A code “also note” alerts the coder or provider there is more than one code that may be required to fully describe the patient's condition.

Code First/Use additional code

These instructional notes provide sequencing instruction on code selection. These instructions signal the coder and provider that an additional code should be reported to provide a more complete picture of the diagnosis.

Additional Characters Required

- v4th This symbol denotes the code requires a 4th character
- v5th This symbol denotes the code requires a 5th character
- v6th This symbol denotes the code requires a 6th character
- v7th This symbol denotes the code requires a 7th character following a placeholder X. Codes with fewer than six characters that require a 7th character must contain the placeholder “X” to fill in the empty character(s)

General Coding Guidelines

1. Acute and Chronic Conditions

If the documentation has the same condition described as both acute and chronic, and separate subentries exist in the Alphabetic index at the same indentation level you are to code both acute and chronic and sequence the acute code first.

2. Signs and symptoms

If a definitive diagnosis has not been established or confirmed by the provider it is acceptable to use a code that describes a sign or symptom as opposed to a diagnosis. An example of this would be tooth pain.

3. **Sequela (Late Effects)**

This code is used to identify a residual effect (condition produced) after the acute phase of an illness or injury has passed. There is no time limit on when a sequela code may be used. The late effect may come days, months, or even years after the initial encounter. An example of this would be deviated septum due to a nasal fracture.

4. **Laterality**

You may find some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right, or bilateral (both sides). If no bilateral code exists and the condition is bilateral, assign separate codes for both right and left sides.

5. **Level of Coding**

Diagnosis codes are designed to be reported at their highest level (number or character). ICD-10-CM codes are comprised of 3,4,5,6 or 7 characters. A three-character code is to be used only if it is not further subdivided. Meaning if there is no 4th, 5th, 6th or 7th character indicated for the code. All codes MUST be coded to their highest level of specificity.

Dental Coding Usage

Diagnosis codes for dentistry are mainly found in Chapter 11 Diseases of the Digestive System codes starting with the Character K, Chapter 13 Diseases of the Musculoskeletal and Connective Tissue System codes starting with the character M, Chapter 19 Injury, Poisoning and Certain Other Consequences codes starting with the character S, and Chapter 21 Factors Influencing Health Status codes starting with the Character Z

Steps to Correct Coding

1. Look up the main term in the alphabetic index and scan for sub term entries as appropriate.
2. Make note of all nonessential modifiers that help in code selection
3. Pay close attention to the following instructions; “see”, “see also”, “with/without”, “omit codes”, and “due to”
4. Verify the code in the Tabular List to check for accuracy of the code
5. Read all instructional notations such as “includes”, “excludes”, “use additional code”, and 4th, 5th, 6th, and 7th character requirements
6. Confirm and assign the correct code
7. NEVER code by memory always consult the ICD-10-CM coding manual prior to code selection and assignment