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President & CEO, AAPC

Author of many AMA publications including:
- ICD-10 Implementation Guide, Make the Transition Manageable,” AMA Press
- Principles of ICD-10-CM Coding (Coming Fall 2011)

What’s all the Hype?

• Largest change to ever happen to healthcare
• Will take many practices years to accomplish
• May require significant funding
• May take years to Recover
ICD-10 Will Change Everything

Physician Practices: What Will Change?

Manager's Office

- **New Policies and Procedures:** Any policy or procedure tied to a diagnosis code, disease management, tracking or PQRI must be changed.
- **Vendor and Payer Contracts:** All contracts must be evaluated and updated as needed.
- **Budgets:** All of these changes—software, training, new contracts, new paperwork—will have to be paid for.
- **Training Plan:** Everyone in your practice will need training. You'll need to determine how much and how you will get it done.
ICD-10 Will Change Everything

Clinical Area
- Changes to patient coverage:
  Health plan policies, payment limitations, and
  now, ABN forms are all possible.
- Changes to superbill:
  All superbills must be revised. Paper superbills
  may be impossible.
- Changes to ABN:
  Health plans will revise all policies linked to
  LCDs or NCDs, etc., ABN forms will need to
  be reformatted and patients will need to be
  educated.

ICD-10 Will Change Everything

Physician’s Office
- Changes to documentation:
  The need for specificity will increase draconi-
  cally: physicians will need to document later-
  ally, stages of healing, weeks in pregnancy,
  episodes of care, and much more.
- Code training:
  Codes will grow from 17,000 to 140,000.
  Physicians must be trained.
ICD-10 Will Change Everything

Nurse’s Station
- Changes to forms:
  Every single order must be changed, revised or redone.
- Changes to documentation:
  Nurses will need to make sure to document with greatly-increased specificity.
- Changes to prior authorizations:
  All policies on prior authorizations may change, requiring training and updates to all forms.

Lab
- Changes to documentation:
  Labs will need to make sure to document with greatly-increased specificity.
- Changes in reporting:
  Health plans will have new requirements for the ordering and reporting of services.
ICD-10 Will Change Everything

Billing
- Policies and procedures:
  All payer reimbursement policies may be revised.
- Training:
  Billers must be trained on new policies and procedures and the ICD-10-CM code set.

Coding
- Changes to code set:
  Codes will grow from 17,000 to 140,000. Code books and styles will completely change. More detailed knowledge of anatomy and medical terminology will be required. Coders may need to use ICD-9 and ICD-10 concurrently for a time.
Why is ICD-10 Such a Big Deal?

Just a version change?
1. A cornerstone of Health Information
   - ICD9/10 diagnosis codes define the health state of the patient
2. Major change in the sheer number of codes
   - Major changes in structure of the codes
   - Major changes in coding rules
   - Major changes in terminology
3. Pervasive use through most healthcare systems
   - Many business functions Impacted
   - Many IT systems impacted
   - Paper and electronic
Why Are There So Many Diagnosis Codes?

- 34,250 (50%) of all ICD-10-CM codes are related to the musculoskeletal system
- 17,045 (25%) of all ICD-10-CM codes are related to fractures
  - 10,582 (62%) of fracture codes to distinguish ‘right’ vs. ‘left’
- ~25,000 (36%) of all ICD-10-CM codes to distinguish ‘right’ vs. ‘left’
ICD-10 Compliant Code Set Reporting

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Code Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounters</td>
<td></td>
</tr>
<tr>
<td>09/30/2013</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>Date of Discharge</td>
<td>Code Set</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td></td>
</tr>
<tr>
<td>09/30/2013</td>
<td>ICD-9-CM</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>ICD-10-CM &amp; ICD-10-PCS</td>
</tr>
</tbody>
</table>

On October 1, 2013, the usual coding rule for inpatient services will apply. Providers and insurers will use ICD-9-CM edits and payment logic for claims relating to encounters and hospital discharges occurring prior to October 1, 2013. Beginning on October 1, 2013, ICD-10 will be used for all encounters and hospital discharges. For hospital inpatient claims, the code in use on the date of discharge and NOT the date of admission will be used. HCPC and CPT codes will not be affected.

The Code Freeze

• On October 1, 2012, there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173
• On October 1, 2013, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173
  – There will be no updates to ICD-9-CM, as it will no longer be used for reporting
• On October 1, 2014, regular updates to ICD-10 will begin
Advantage of Moving to ICD-10

- More consistent with the rest of the world
- Considerably more information per code
- Greater expandability in codes
- More logical tabular structure
- Better definition of co-morbidities, complications and disease manifestations
- Improved support for analysis related to:
  - Risk and severity
  - Predictive modeling
  - Quality and cost efficiency analysis
  - Population epidemiologic research

Let’s Look at a Snapshot
ICD-10-CM
**ICD-10 CM Format**

- **X X X**
- **X X X**
- **X**
  - Category
  - Etiology, Anatomical site, Severity
  - Extension

**Hierarchy Structure**

- Differences in ICD-10-CM
  - Alphanumeric Structure
  - Addition of 6 and 7 digit extensions to provide a higher level of specificity
  - More specificity
  - Reorganizing and adding chapters
  - Diagnostic codes will be more precise
  - Expanded to include health-related conditions
  - Creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition
  - The new structure will allow further expansion than was possible with ICD-9-CM
Additional Observations and Challenges

• The addition of information relevant to ambulatory and managed care encounters
• Expanded injury codes in which ICD-10-CM groups injuries by site
• Diabetes codes include over 210 choices
• Creation of combination diagnosis/symptom codes which reduced the number of codes needed to fully describe a condition
• The length of codes being a maximum of seven characters as opposed to five digits in ICD-9-CM
• Challenges for OB/GYN with codes beginning with letter “O” which can be confused with number “0”
  – Potential keying errors which could lead to claim denials

<table>
<thead>
<tr>
<th>Laterality</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>931 Foreign body in ear</td>
<td>T16.1xxa Foreign body in right ear, initial encounter</td>
<td></td>
</tr>
<tr>
<td>T16.2xxd, Foreign body in left ear, subsequent encounter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T16.3xxq, Foreign body in ear, unspecified ear, sequelae</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Up to Sixth Character Subclassification

- A six character sub-classifications represents the most accurate level of specificity
  - L89.510 Pressure ulcer of right ankle, unstageable
  - L89.511 Pressure ulcer of right ankle, stage 1
  - L89.512 Pressure ulcer of right ankle, stage 2
  - L89.513 Pressure ulcer of right ankle, stage 3
  - L89.514 Pressure ulcer of right ankle, stage 4
  - L89.519 Pressure ulcer of right ankle, unspecified stage

Seventh Character Extension

- Certain ICD-10-CM categories have applicable 7 characters
  - The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct
  - If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters
Dummy Placeholders

- The ICD-10-CM utilizes a placeholder character “x”. The “x” is used as a 5th character placeholder at certain 6 character codes to allow for future expansion.
- Example:
  - 032.1 Maternal care for breech presentation of fetus 1
  - Code requires 7th character
    - Code reportable: 032.1xx1
Note: 7th character 1-9 identifies multiple gestations to report the fetus which the code applies.

Combination Codes

- ICD-10-CM consists of greater specificity. Sample
- Examples
  - 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
Complications

- T81.535 - Perforation due to foreign body accidently left in body following heart catheterization
- T81.530 - Perforation due to foreign body accidently left in body following surgical operation
- T81.524 - Obstruction due to foreign body accidently left in body following endoscopic examination
- T81.516 - Adhesions due to foreign body accidently left in body following aspiration puncture or other catheterization
  - 7th character required

Code Mapping Example
Maps 2:1

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Description</th>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>625.6</td>
<td>Stress Incontinence, Female</td>
<td>N39.3</td>
<td>Stress incontinence, female, male</td>
</tr>
<tr>
<td>788.32</td>
<td>Stress Incontinence, Male</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Code Mapping Example
Maps 1:2

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Description</th>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>454.0</td>
<td>Varicose veins of lower extremity, with ulcer</td>
<td>I83.099</td>
<td>Varicose veins of unspecified lower extremity with ulcer of unspecified site</td>
</tr>
<tr>
<td>454.0</td>
<td></td>
<td>I83.019</td>
<td>Varicose veins of right lower extremity with ulcer of unspecified site</td>
</tr>
</tbody>
</table>

DOCUMENTATION CHALLENGES
Diabetes Mellitus

- Over 210 codes to identify
- Documentation must include:
  - Type of Diabetes (1 or 2)
  - Manifestations
  - Other mitigating factors

Diabetes Mellitus

- There are six diabetes mellitus categories in the ICD-10-CM
  They are:
  - E08 Diabetes mellitus due to an underlying condition
  - E09 Drug or chemical induced diabetes mellitus
  - E10 Type I diabetes mellitus
  - E11 Type 2 diabetes mellitus
  - E13 Other specified diabetes mellitus
  - E14 Unspecified diabetes mellitus
  
  Note: All the categories above (with the exception of E10) include a note directing users to use an additional code to identify any insulin use, which is Z79.7. The concept of insulin and noninsulin is a component of the diabetes mellitus categories in ICD-10-CM.
Diabetes with Manifestation

• A 60 year old patient presents with Type 1 diabetes has a **chronic left heal ulcer with muscle necrosis** due to the diabetes.

• Diagnosis code(s):
  – E10.622-Type 1 diabetes mellitus with other skin ulcer
    • A note underneath the code identifies to “Use additional code to identify site of ulcer
  – Secondary diagnosis-L97.413  Non-pressure chronic ulcer of right heel and mid-foot with necrosis of muscle
Gestational Diabetes

• A patient with gestational diabetes is seen by the OB/GYN for her routine visit during her seventh month of pregnancy. The patient is doing well and her gestational diabetes is well controlled with diet.

• O24.4 Gestational diabetes mellitus
• O24.41 Gestational diabetes mellitus in pregnancy
• O24.410 Gestational diabetes mellitus in pregnancy diet controlled
• O24.414 Gestational diabetes mellitus in pregnancy insulin controlled
• O24.419 Gestational diabetes mellitus in pregnancy, unspecified control
  • Diagnosis Code: O24.410 gestational diabetes mellitus in pregnancy, diet-controlled

Burns

• Information necessary in documentation:
  – Burn or corrosion
  – Depth of burn (first, second, third degree, etc)
  – Extent burn or corrosion
  – Agent
  – Burn codes used for thermal burns except sunburns that come from heat source
    • Fire
    • Hot appliance
  – Corrosions burns due to chemicals
  – 7th character required
    • A Initial encounter
    • D Subsequent encounter
    • S Sequela
Example

• A patient who has Type 1 diabetes mellitus is treated for a second-degree burn on her left knee which radiated down to her ankle. The patient was burned when a hot skillet fell and hit her left knee causing the burn. She was in her kitchen when the injury occurred.

How it is Coded

• Tabular List: L24.222-Second degree burn of left knee
• When reviewing the tabular list instructions, the instructions indicate a 7th character is required. The choices in category T24 are:
• The appropriate 7th character is to be added to each code from category T24.
• A Initial encounter
• D Subsequent Encounter
• S Sequela
How it is Coded

• In addition, the instruction notes instruct the user to select a code to identify the source, place and intent of the burn.
• Since the patient was injured by a skillet which fell on her knee while she was cooking in the kitchen at home, the following needs to also be reported.
  – What injury occurred
  – Place of Occurrence

How it is Coded

• Correct diagnosis code sequence and reporting:
  – First listed diagnosis: L24.222-Second degree burn of left knee
  – Secondary diagnosis: X15.3XXA- Contact with hot saucepan or skillet
  – Tertiary diagnosis: Y92.010 - Kitchen of single-family (private) house as the place of occurrence of the external cause
  – Fourth diagnosis:E10.69 – Type1 diabetes mellitus with other specified complication
Fractures

• Documentation required:
  – Anatomic site
  – Laterality
  – Fracture type
  – Displaced or Non-displaced
  – Open or closed
  – 7th character extension required

Fractures

• S42.022-Displaced fracture of shaft of left clavicle initial encounter for closed fracture
  – Requires 7th character A for initial encounter
  – S42.022A
  – Site-Left Clavicle
  – Laterality-left
  – Initial encounter
Fractures

• Fracture codes require seventh character to identify if fracture is open or closed

• The fracture 7th character extensions are:
  – 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 Sequelae

• S42.022-Displaced fracture of shaft of left clavicle initial encounter for closed fracture
  – Requires 7th character A for initial encounter
  – S42.022A

Example

• A patient underwent surgery for an open burst fracture of the first lumbar vertebra which became unstable.
  – First listed diagnosis: S32.012B-unstable burst fracture of first lumbar vertebra
  • Seventh character “B” identifies the initial encounter for the open fracture.
Injury Coding

• Injury Coding
  – Initial encounters generally require three codes

• External cause codes
  – Are used for the length of treatment
  – 7th digit extender changes with stage of healing

• Place of occurrence
  – Used only once at the initial encounter
  – No 7th digit extender

• Activity code
  – Used only once at the initial encounter
  – No 7th digit extender

Example

• CC: Hurt left knee-TV fell on it

• HPI: Patient hurt her knee and it is bruised and it hurts to walk. She was moving a TV in her bedroom last night and she fell into the TV with her knee causing her to collide with it. Her lower back has been hurting since then as well.

• A/P: L knee strain
  – Lumbar strain

• S86.812A—Strain, left knee, initial encounter

• S39.012A—Strain, Back, initial encounter

• W18.09xA—Fall striking other object, initial encounter(activity) Y92.013—House, single family home, bedroom (place of occurrence)
Cardiology Example

• A 75-year-old male, 2 days post-coronary bypass grafting patient, presents today with unstable angina and shows a fresh thrombus in the saphenous vein graft. A PTCA is performed in addition to a percutaneous intracoronary thrombectomy to remove the thrombus.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>996.72-Other complications</td>
<td>T82.817A Embolism of cardiac prosthetic devices, implants and grafts, initial encounter</td>
</tr>
<tr>
<td>of internal (biological)</td>
<td>T82.827A Fibrosis of cardiac prosthetic devices, implants and grafts, initial encounter</td>
</tr>
<tr>
<td>(synthetic) prosthetic device,</td>
<td>T82.837A Hemorrhage of cardiac prosthetic devices, implants and grafts, initial encounter</td>
</tr>
<tr>
<td>implant, and graft</td>
<td>T82.847A Pain from cardiac prosthetic devices, implants and grafts, initial encounter</td>
</tr>
<tr>
<td></td>
<td>T82.857A Stenosis of cardiac prosthetic devices, implants and grafts, initial encounter</td>
</tr>
<tr>
<td></td>
<td><strong>T82.867A Thrombosis of cardiac prosthetic devices, implants and grafts, initial encounter</strong></td>
</tr>
<tr>
<td></td>
<td><strong>T82.897A Other specified complication of cardiac prosthetic devices, implants and grafts, initial encounter</strong></td>
</tr>
<tr>
<td></td>
<td><strong>T82.9XXA Unspecified complication of cardiac and vascular prosthetic device, implant and graft, initial encounter</strong></td>
</tr>
</tbody>
</table>
Asthma

• Documentation for Asthma includes:
  – Severity of disease (mild intermittent, moderate, persistent, etc.)
• Does acute exacerbation exist?
• Does status asthmaticus exist?

Asthma Codes

<table>
<thead>
<tr>
<th>J45</th>
<th>Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>J45.2</td>
<td>Mild intermittent asthma</td>
</tr>
<tr>
<td>J45.20</td>
<td>Mild intermittent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.21</td>
<td>Mild intermittent asthma, with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.22</td>
<td>Mild intermittent asthma, with status asthmaticus</td>
</tr>
<tr>
<td>J45.3</td>
<td>Mild persistent asthma</td>
</tr>
<tr>
<td>J45.30</td>
<td>Mild persistent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.31</td>
<td>Mild persistent asthma, with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.32</td>
<td>Mild persistent asthma, with status asthmaticus</td>
</tr>
<tr>
<td>J45.4</td>
<td>Moderate persistent</td>
</tr>
<tr>
<td>J45.40</td>
<td>Moderate persistent, uncomplicated</td>
</tr>
<tr>
<td>J45.41</td>
<td>Moderate persistent with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.42</td>
<td>Moderate persistent with status asthmaticus</td>
</tr>
</tbody>
</table>
Asthma Codes

<table>
<thead>
<tr>
<th>J45</th>
<th>Asthma</th>
</tr>
</thead>
<tbody>
<tr>
<td>J45.4</td>
<td>Moderate persistent</td>
</tr>
<tr>
<td>J45.40</td>
<td>Moderate persistent, uncomplicated</td>
</tr>
<tr>
<td>J45.41</td>
<td>Moderate persistent with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.42</td>
<td>Moderate persistent with status asthmaticus</td>
</tr>
<tr>
<td>J45.5</td>
<td>Severe persistent</td>
</tr>
<tr>
<td>J45.50</td>
<td>Severe persistent, uncomplicated</td>
</tr>
<tr>
<td>J45.51</td>
<td>Severe persistent with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.52</td>
<td>Severe persistent with status asthmaticus</td>
</tr>
<tr>
<td>J45.9</td>
<td>Other and unspecified asthma</td>
</tr>
<tr>
<td>J45.90</td>
<td>Unspecified asthma</td>
</tr>
<tr>
<td>J45.901</td>
<td>Unspecified asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.901</td>
<td>Unspecified asthma with status asthmaticus</td>
</tr>
<tr>
<td>J45.99</td>
<td>Other asthma</td>
</tr>
<tr>
<td>J45.990</td>
<td>Exercise induced bronchospasm</td>
</tr>
<tr>
<td>J45.991</td>
<td>Cough variant asthma</td>
</tr>
<tr>
<td>J45.998</td>
<td>Other asthma</td>
</tr>
</tbody>
</table>

Hypertension

- ICD-10-CM code range for hypertension is I10 – I15.9
- In order to code hypertension in ICD-10-CM the following is necessary:
  - Essential or Secondary
  - Causal relationship of other conditions
  - Elevated blood pressure versus hypertension
Hypertension

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential hypertension</td>
<td>I10</td>
</tr>
<tr>
<td>Hypertensive heart disease with heart failure</td>
<td>I11.0</td>
</tr>
<tr>
<td>Hypertensive heart disease without heart failure</td>
<td>I11.9</td>
</tr>
<tr>
<td>Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease</td>
<td>I12.0</td>
</tr>
<tr>
<td>Hypertensive chronic kidney disease with stage 1 through 4 chronic kidney disease or unspecified chronic kidney disease</td>
<td>I12.9</td>
</tr>
<tr>
<td>Hypertensive heart and chronic kidney disease with heart failure and stage 1 through 4 chronic kidney disease, or unspecified chronic kidney disease</td>
<td>I13.0</td>
</tr>
<tr>
<td>Hypertensive heart and chronic kidney disease without heart failure, with stage 1 through 4 chronic kidney disease, or unspecified chronic kidney disease</td>
<td>I13.10</td>
</tr>
<tr>
<td>Hypertensive heart and chronic kidney disease without heart failure, with stage 5 chronic kidney disease, or end stage renal disease</td>
<td>I13.11</td>
</tr>
<tr>
<td>Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease</td>
<td>I13.2</td>
</tr>
<tr>
<td>Renovascular hypertension</td>
<td>I15.0</td>
</tr>
<tr>
<td>Hypertension secondary to other renal disorders</td>
<td>I15.1</td>
</tr>
<tr>
<td>Hypertension secondary to endocrine disorders</td>
<td>I15.2</td>
</tr>
<tr>
<td>Other secondary hypertension</td>
<td>I15.8</td>
</tr>
<tr>
<td>Secondary hypertension, unspecified</td>
<td>I15.9</td>
</tr>
<tr>
<td>Elevated Blood pressure reading</td>
<td>R30.0</td>
</tr>
</tbody>
</table>

Ulcers

- Information required in documentation:
  - Type of Ulcer
  - Acute or chronic
  - Hemorrhage
  - Perforation
  - Hemorrhage with perforation
  - Without hemorrhage or perforation
### Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K25.0</td>
<td>Acute gastric ulcer with hemorrhage</td>
</tr>
<tr>
<td>K25.1</td>
<td>Acute gastric ulcer with perforation</td>
</tr>
<tr>
<td>K25.2</td>
<td>Acute gastric ulcer with both hemorrhage and perforation</td>
</tr>
<tr>
<td>K25.3</td>
<td>Acute gastric ulcer without hemorrhage or perforation</td>
</tr>
<tr>
<td>K25.4</td>
<td>Chronic or unspecified gastric ulcer with hemorrhage</td>
</tr>
<tr>
<td>K25.5</td>
<td>Chronic or unspecified gastric ulcer with perforation</td>
</tr>
<tr>
<td>K25.6</td>
<td>Chronic or unspecified gastric ulcer with both hemorrhage and perforation</td>
</tr>
<tr>
<td>K25.7</td>
<td>Chronic gastric ulcer without hemorrhage or perforation</td>
</tr>
<tr>
<td>K25.9</td>
<td>Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation</td>
</tr>
</tbody>
</table>

### Hernia

**Diagnosis codes range from K40.00-K46.9**

- Documentation required
  - Site of hernia
  - Laterality when appropriate (Unilateral-bilateral)
  - If gangrene or obstruction is present
  - If condition is recurrent

**Categories:**

- Inguinal (K40.0-)
- Femoral (K41.0-)
- Umbilical (K42.0-)
- Ventral (K43.0-)
- Diaphragmatic (K 44.0-)
- Other abdominal hernia (K45.0-)
- Unspecified abdominal hernia (K46.0-)

---

**3/28/2011**
Hernia Repairs

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K40.00</td>
<td>Bilateral inguinal hernia, with obstruction, without gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.01</td>
<td>Bilateral inguinal hernia, with obstruction, without gangrene, recurrent</td>
</tr>
<tr>
<td>K40.10</td>
<td>Bilateral inguinal hernia, with gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.11</td>
<td>Bilateral inguinal hernia, with gangrene, recurrent</td>
</tr>
<tr>
<td>K40.20</td>
<td>Bilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.21</td>
<td>Bilateral inguinal hernia, without obstruction or gangrene, recurrent</td>
</tr>
<tr>
<td>K40.30</td>
<td>Unilateral inguinal hernia, with obstruction, without gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.31</td>
<td>Unilateral inguinal hernia, with obstruction, without gangrene, recurrent</td>
</tr>
<tr>
<td>K40.40</td>
<td>Unilateral inguinal hernia, with gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.41</td>
<td>Unilateral inguinal hernia, with gangrene, recurrent</td>
</tr>
<tr>
<td>K40.90</td>
<td>Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent</td>
</tr>
<tr>
<td>K40.91</td>
<td>Unilateral inguinal hernia, without obstruction or gangrene, recurrent</td>
</tr>
</tbody>
</table>

Malignant Neoplasm Breast

- 54 choices for male/female breast
- Documentation must include:
  - Laterality
  - Location
  - Use of an additional code to identify estrogen receptor status
  - Example: C50.422 Malignant neoplasm of upper-outer quadrant of the left male breast
Malignant Neoplasm Breast

- Sixth character sub-classification
  - C50.- Malignant neoplasm of breast
  - C50.1- Malignant neoplasm of nipple and areola
  - C50.2- Malignant neoplasm of upper-inner quadrant of breast
  - C50.3- Malignant neoplasm of lower-inner quadrant of breast
  - C50.4- Malignant neoplasm of upper-outer quadrant of breast
  - C50.5- Malignant neoplasm of lower-outer quadrant of breast
  - C50.6- Malignant neoplasm of axillary tail of breast
  - C50.8- Malignant neoplasm of overlapping sites of breast
  - C50.9- Malignant neoplasm of breast of unspecified site

Mapping Examples

INTERPRETIVE FINDINGS: Exam reveals a stable knee under examination under anesthesia. The video arthroscopy examination reveals smooth articular surfaces throughout the entire knee. He has a lateral meniscus which is normal. His medial meniscus shows a locked bucket-handle medial meniscal tear which underwent excision. The cruciate ligament is intact.
Mapping Example

ICD-10 Will Change Everything

Documentation: Compliance and Quality

• In the clinical area, the largest impact to ICD-10-CM implementation is the documentation
  – Since ICD-10-CM is more robust and has up to seven digits of specificity, will documentation currently be in the medical record to support ICD-10-CM on the “Go-live” date?
  – By analyzing the documentation and conducting medical record documentation audits, the impact can be assessed
How to Approach?

• How is ICD-9 currently used in the clinical setting?
  – Random samples should be evaluated
  – Take an in-depth look at the current level of documentation
  – Running a frequency report of the most used procedures and diagnosis codes before you begin

How Do You Begin?

• Take an in-depth look at the current level of documentation in the medical record
  – Review the lack of specificity in the documentation and analyze how to begin the process of improvement
  – Based on the specialty of the practice, review the most common diagnosis codes used and frequency
Perform an ICD-10-CM Readiness Audit

• Practitioners either have staff that conduct audits in your medical practice or routinely have a consultant audit for appropriate documentation and coding
  – Important element of compliance and many practitioners have undergone this process from a comprehensive coding perspective
    • But take a different approach
      – Review the patient chart note to make sure the physician or non-physician practitioner is documenting a complete diagnosis to support an ICD-10-CM code

Performing an ICD-10-CM Readiness Audit

• ICD-10-CM readiness audit
  – different than the typical medical record documentation and coding audit
  – Auditor will assess the documentation and make a determination if:
    1. does the documentation support the current diagnosis reported, and
    2. will the documentation support an ICD-10-CM code(s)?
  – The auditor must be familiar with ICD-10-CM codes and guidelines in order to make this determination
Performing an ICD-10-CM Readiness Audit

• Once the audit has been conducted and analyzed:
  – the organization will have a good assessment of documentation deficiencies
    • will be able to develop a priority list of diagnoses that require more granularity
  – Audit will also help identify practitioners who would benefit from focused training to assist in making sure the practitioner will be able to support medical necessity using ICD-10-CM in 2013

How Do You Solve the Documentation Problem?

• Educate by showing the comparison between both coding systems
• Encourage the practitioner to begin documenting more specifically for ICD-10-CM
• Keep results and comprise a periodic summary
  – This summary should identify the percentage of correct documentation for both ICD-9-CM and ICD-10-CM with recommendation for improving documentation.
What Can You Do to Prepare?

ICD-10 Will Change Everything

Coder’s Roadmap to ICD-10

ICD-10 Timeline

Step 1: ICD-10 Fundamentals
- Understanding the ICD-10 Code Set
- Fundamentals of ICD-10 Coding
- Introduction to ICD-10 Coding
- Approximately 5 hours

Step 2: ICD-10 Anatomy and Pathophysiology
- Advanced training in the new ICD-10 code set
- Analysis and interpretation of the ICD-10 code set
- Approximately 2 hours

Step 3: General ICD-10 Code Set
- Comprehend the new ICD-10 code set
- Practice with ICD-10 code sets
- Approximately 1 hour

Step 4: Specialty or ICD-10 Code Set
- Specialty-specific ICD-10 code sets
- Advanced coding sessions
- Approximately 1 hour

Step 5: ICD-10 Implementation
- Implementation of the new ICD-10 code set
- Approximately 1 hour

Learn more at www.aapc.com/icd10coder

ICD-10 Will Change Everything
Conclusion

- It is evident after reviewing documentation that a lot of work must be completed to get ready for ICD-10-CM
- Audit the diagnosis and inpatient procedure documentation pre and post ICD-10-CM implementation
THE COUNTDOWN IS NOW!!!