ICD-10
9 Months Later

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Objectives

- Biggest Challenges for Agencies
- Changes and Clarifications in ICD-10
- Complexities of coding in ICD-10
- Problematic areas leading to potential denials
- October changes to ICD-10

Hospice – Major Coding Changes Continue

- 2016 Hospice Wage index states to code all unresolved diagnoses on a hospice patient's claim, not just those that are related to the terminal diagnosis.
- It cited the importance of a comprehensive approach to the hospice patient care, the fact that a large majority of hospice claims still include only one diagnosis and the confusion about "related" versus "unrelated" diagnoses as reasoning for the rule change.
- Therefore you are to code primary terminal diagnosis, all related diagnosis and all unrelated diagnoses.
Related & Unrelated Diagnoses

- The Medical Director, along with the Clinician, should be defining & documenting the primary terminal diagnosis before going to the coder.
- Also Clinician and Medical Director should list all unrelated and related before going to the coder.
- Many software systems require related diagnosis to be grouped first followed by unrelated.
- So if the clinician / Medical Director hasn’t assigned related and unrelated before the coder codes, they will have to modify codes afterwards.

Hospices Must Follow All Coding Rules

- The primary terminal diagnosis, as well as all of the other diagnoses, should be as specific as possible.
- Ex: unspecified cerebrovascular disease is not desired – work with the attending physician, the Medical Director & IDG to get more specific type of cerebrovascular disease when possible.
- If the patient has several chronic diagnoses or symptomatic conditions that, when combined, are leading to the patient having a life expectancy of 6 months or less, the DO makes a clinical decision as to which of the diagnoses is the most contributory to the terminal prognosis.
- Be sure to follow the Coding Guidelines!
- If the clinician / Medical Director states ESRD is primary terminal diagnosis, AND the pt. has HTN, the “HTN in CKD” diagnosis must be the terminal diagnosis, followed by the ESRD.
- Never assign debility (R53.81) and adult failure to thrive (R62.7), as well as unspecified dementia (F03.9) and dementia manifestation codes (F02.8) as primary terminal diagnoses.
- Look for underlying disease processes – e.g. is vascular dementia caused from a Sequela of CVA with cognitive residuals.

Specific patient information upon referral

- Setting the specific information and diagnoses in referral info is so necessary to code in ICD-10.
- H&P, Consultation reports, PT/OT/DT summaries from physicians.
- Intake staff need to work closely with referral sources to get as complete information as possible at referral.
- Request the documents you want that will give you the best physician confirmed information and diagnoses.
  - Ex: hospice agency that gets 60 pages of SNF daily clinician notes.
Clinician Assessment & Documentation

- Clinicians need to assess and document detailed information on patient assessment.
- Therefore clinicians need to know what is needed for accurate coding in ICD-10.
- If unsure of any diagnosis information then must query the physician to get clarification.
  - Examples: wound types, specificity or inconsistency in a diagnosis, pt stating a diagnosis that there is no documentation on in referral information, etc.
- Best to do at end of admission assessment—give report and get clarification of diagnoses, as well as meds, etc.

Physician confirmation of Diagnoses

- All diagnoses on the plan of care must be documented in the medical record by the physician.
- These may be in the FTF and/or H&P, Discharge summaries, Diagnoses List, etc.
- If Diagnoses are not in these documents, then they are to be documented as having been confirmed with the physician by the HHA.
- Diagnoses are not coded based solely on medications, treatments, or patient/caregiver report without contacting the physician to confirm in most cases.

Clinician documentation to code without physician verification

- There are 3 areas that are coded by what the clinician assesses and identifies and then documents:
  - Body Mass Index (BMI)
  - Pressure ulcer stages
  - Depth of tissue damage in non-pressure chronic ulcers
Body Mass Index (BMI)

- Hospice patients should have a BMI done by the clinician (on most patients).
  - BMI will be coded on SOC and recerts.
  - This code supports the decline of the patient over time. Document in clinical record charts as well.
  - The physician does not have to confirm the BMI.

Challenging Assessment & Coding: Wound Types

- Although the clinician assesses the pt. wounds and identifies the types - this should always be confirmed with physician documentation - from referral information, wound clinic, or clarifying with the physician.
- Wound Types - most common area that Coder cannot code because of lack of specific information or inconsistencies!
- Commonly due to non specific site, type of wound, stage of pu and / or depth of non pressure ulcer.

Wound Types:

- Diabetic, Arterial, Venous – Non Pressure Ulcers – add severity to measurement
- Pressure Ulcers
  - Be sure to follow updates from WOCN and NPUAP
  - NPUAP - new guidelines for staging in April of 20
- Trauma Wounds – open wounds from Laceration, Abrasion, Puncture, etc.
- Surgical Wounds – aftercare or complications? Need to know
- Superficial Wounds – skin tears
National Pressure Ulcer Advisory Panel (NPUAP) - changes 4-2016

- Changes definitions, stages for pressure ulcers
- The term “pressure injury” will replace “pressure ulcer”
- Arabic numbers will now be used in the names of the stages instead of Roman numerals.
- The term “suspected” has been removed from the Deep Tissue Injury diagnostic label
- Addition of Medical Device Related Pressure Injury and Mucosal Membrane Pressure Injury.

NPUAP - Changes to staging

- Clarification made to Stage 2 pressure ulcers, NPUAP states these wounds cannot have granulation, slough or eschar.

- Do not mark a shallow Stage 3 pressure ulcer with slough or eschar as a Stage 2 on the OASIS responses only because it is not that deep.

More details on wound changes

- Pressure injury. The change to pressure injury more accurately describes pressure injuries to both intact and ulcerated skin.
- DTPI (Deep Tissue Pressure Injury) has been confusing as Stage 1 and Deep Tissue Injury both described injured intact skin rather than open ulcers.
- The term “injury” is more accurate, as not all pressure injuries result in a break in the skin or ulceration.
- Rather is an injury related to consistent pressure from external force in conjunction with internal forces of bony prominences causing compression of the vasculature to the area and resulting tissue damage.
- “Suspected” was removed from deep tissue pressure injuries. This clarifies for clinicians as the injury is present by evidence and not just suspected.
Coding Wounds – **Non Pressure** Wounds Depth

- ICD-10 codes – L97 for non-pressure wounds, *require* the depth of tissue affected by the wound.
- Includes diabetic, arterial, and venous stasis ulcers.
- The L97 codes combine the site and the depth:
  - L97.212 Non-pressure chronic ulcer of right calf with fat layer exposed.
  - The 6th character 1 indicates right leg, and the 7th digit 2 indicates fat layer depth.
- The clinician is responsible for assessing depth and documenting it.
- Unspecified should be rarely used!
- Agency needs to provide clinician with in-service (and pictures) to allow the clinician to be accurately assessing the depth of non-pressure wounds.

**Codes for Depth of Non Pressure Wounds**

- **L97.201** - Non-pressure chronic ulcer of unspecified calf limited to breakdown of skin.
- **L97.202** - Non-pressure chronic ulcer of unspecified calf with fat layer exposed.
- **L97.203** - Non-pressure chronic ulcer of unspecified calf with necrosis of muscle.
- **L97.204** - Non-pressure chronic ulcer of unspecified calf with necrosis of bone.
- **L97.209** - Non-pressure chronic ulcer of unspecified calf with unspecified severity – USE RARELY!
Coding Wounds – Trauma Wounds

• Like many ICD-10 codes are more specific than ICD-9
• Example:
  • Instead of open wound (included all types) of forearm in ICD-9: 881.0
  • ICD-10 is coded: S51.811- Laceration without foreign body of right forearm

Guidelines Accompany Code Set

• ICD-10-CM Official Guidelines for Coding and Reporting set conventions and instructions
• To ensure accurate coding, providers must use these guidelines in conjunction with the code set
• Adherence to the official coding guidelines in all health care settings is required under HIPAA
• Coders MUST read the guidelines! Many errors in coding from not following the guidelines!

Guideline Examples

• For assignment of hemiplegia/hemiparesis, if the documentation specifies which side is affected but not whether it is the dominant or non-dominant side, code selection is guided by the following:
  • If the right side is affected, code as dominant
  • If the left side is affected, code as non-dominant

• When a patient has bilateral glaucoma and each eye is documented as having a different type or stage, assign the appropriate code for each eye rather than the code for bilateral glaucoma
Guidelines - Laterality

• Laterality (which side of the body is affected) has been added in ICD-10-CM to allow better identification of anatomic site
• If condition is bilateral but only one side of focus of treatment during current encounter, assign bilateral code
• Do Not put Unspecified for Laterality

Guidelines- Use of 7th Character

• 7th character is not used in all ICD-10-CM chapters
• Used in Musculoskeletal, Obstetrics, Injuries, External Causes chapters
• Must always be used in the 7th character position
• Use Placeholder 'X' if code is less digits
• When 7th character applies, codes missing 7th character are invalid

Guidelines – 7th character S (Sequela)

• **Sequela (Late Effect):** Residual effect (condition produced) arising as a direct result of an acute condition
  • Examples: Traumatic arthritis following previous gunshot wound
  • Quadriplegia due to spinal cord injury
  • Skin contractures due to previous burns
  • Arthritis due to previous burns
  • Chronic respiratory failure following drug overdose
• Physician must state it’s a sequela
CMS Coding example - 7th Character
Displaced fracture of medial malleolus, right ankle

• Step 1 - Look up term in Alphabetic Index:
  - Fracture, traumatic - ankle, medial malleolus (displaced) S82.5
• Step 2 - Verify code in Tabular:
  - S82 Fracture of lower leg, including ankle
• Note: A fracture not indicated as displaced or nondisplaced should be coded to displaced
• Assign laterality
• The appropriate 7th character is to be added to all codes from category S82

• Code Assignment: S82.51xD
  - WHAT DOES THE 1 IN THE 5th DIGIT MEAN?
  - WHAT DOES THE X IN THE 6th DIGIT MEAN?
  - WHAT DOES THE D IN THE 7th DIGIT MEAN?

Changes in guidance for ICD 10 to date
“A” Character Usage

• 7th digit is typically A, D, S (many more for fractures)
  - A has meant Initial Encounter
  - D is Subsequent Encounter – and has primarily been for homecare & hospice
  - S is Sequela - Late Effect - used for residual symptoms
• Home Health and Hospice have not been able to use “A” characters in 7th digit before (and home health has not received case mix rates for the ‘A’ character).
  - This has been challenged and has been revised!

Changes in guidance for ICD 10 to date
“A” Character Usage

The Guidance has been changed so that now we will think of “A” character as “Active Treatment”

• “Active Treatment” does NOT mean routine homecare, so MAY be used fairly infrequently
• Main example given by the Coding Clinic is: post op infection requiring homecare for wound vac and/or IV antibiotics
• Therefore, “D” for subsequent is still the most common 7th character for homecare and hospice
The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care.

For example, for aftercare of an injury, assign the acute injury code with the 7th character “D” (subsequent encounter).

7th character “S”, sequela, is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn.

When using 7th character “S”, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself.

The “S” is added only to the injury code, not the sequela code. The 7th character “S” identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

Excludes 1 & 2 Notes

- **Excludes 1**: An excludes 1 note is a pure excludes note. It means “NOT CODED HERE”.
  - Indicates the codes listed should never be used at the same time as the code above the Excludes 1 notes.
- **Excludes 2**: An excludes 2 note represents “NOT INCLUDED HERE”.
  - Indicates the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time.

Changes to Excludes 1 Notes – Non Related Diagnoses

- If the two conditions are not related to one another, it is permissible to report both codes despite the presence of an Excludes1 note.
- For example, the Excludes1 note at code range R40-R46, states that symptoms and signs constituting part of a pattern of mental disorder (F01-F99) cannot be assigned with the R40-R46 codes.
- However, if dizziness (R42) is not a component of the mental health condition (e.g., dizziness is unrelated to bipolar disorder), then separate codes may be assigned for both dizziness and bipolar disorder.
Changes to Excludes 1 Notes - Non Related Diagnoses

- Code range I60-I69 (Cerebrovascular Diseases) has an Excludes1 note for traumatic intracranial hemorrhage (S06-).
- Codes in I60-I69 should not be used for a diagnosis of traumatic intracranial hemorrhage.
- However, if the patient has both a current traumatic intracranial hemorrhage and sequela from a previous stroke, it would be appropriate to assign codes from S06- and I69-.

External Causes of Morbidity - ICD-10-CM codes in Chapter 20 VWXY

- No national requirement for mandatory ICD-10-CM external cause code reporting
- External cause of injury data are used at the national, state, and local levels to identify high-risk populations, set priorities, and plan and evaluate injury prevention programs
- Data are primarily used for measuring Emergency Medical Services (EMS) and trauma care systems
- Some coders spend hours trying to find very specific code out of these thousands. Put this in perspective when you are coding
- Ex: why or how a pt fell is a good supporting code
  - W19.xxxD - Unspecified fall, subsequent
  - W18.30XD - Fall on same level, unspecified, subsequent encounter
  - W00.0XXD - Fall on same level due to ice and snow, subsequent encounter

CONVENTION for Diagnoses ‘With’ Clarified by Coding Clinic

- Coding Clinic has clarified guidance published in the first quarter 2016 issue of AHA Coding Clinic
- According to the latest clarification, the subterm “with” in the Index should be interpreted as a link between Diagnoses, ex Diabetes, and ANY of those conditions indented under the word “with.”
Convention ‘With’

- The word ‘with’ should be interpreted to mean ‘associated with’ or ‘due to’ when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular list.

- The word "with" in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.

- Ex: ANY diabetes manifestation listed under the main term ‘diabetes’, followed by the subentry 'with' should be coded without the physician stating the conditions are linked, unless the physician states they are unrelated.

- Type 2 diabetes mellitus
  - E11.0 - Type 2 diabetes mellitus with hyperosmolarity
  - E11.1 - Type 2 diabetes mellitus with kidney complications
  - E11.2 - Type 2 diabetes mellitus with diabetic nephropathy
  - E11.21 - Type 2 diabetes mellitus with diabetic chronic kidney disease
  - E11.22 - Type 2 diabetes mellitus with diabetic chronic kidney disease
  - E11.29 - Type 2 diabetes mellitus with other diabetic kidney complication
  - E11.3 - Type 2 diabetes mellitus with ophthalmic complications
  - E11.4 - Type 2 diabetes mellitus with neurological complications
  - E11.40 - Type 2 diabetes mellitus with diabetic neuropathy, unspecified
  - E11.5 - Type 2 diabetes mellitus with circulatory complications
  - E11.51 - Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
• E11.6 - Type 2 diabetes mellitus with other specified complications
• E11.61 - Type 2 diabetes mellitus with diabetic arthropathy
• E11.621 - Type 2 diabetes mellitus with foot ulcer
• E11.622 - Type 2 diabetes mellitus with other skin ulcer
• E11.64 - Type 2 diabetes mellitus with hypoglycemia
• E11.65 - Type 2 diabetes mellitus with hyperglycemia
• E11.69 - Type 2 diabetes mellitus with other specified complication

Guidelines - Unspecified codes

• Unspecified codes should be reported when they most accurately reflect what is known about the patient’s condition at the time of that particular encounter
• When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code
• It would be inappropriate to select a specific code that is not supported by the medical record documentation
• These guidelines are part of the ICD-10-CM Official Guidelines for Coding and Reporting, which all HIPAA-covered entities must comply with

Common Unspecified Codes

• Heart Failure (CHF) - ICD-10: I50.9
• Anemia - ICD-10: D64.9
• Abdominal pain - ICD-10: R10.9
• Angina - ICD-10: I20.9
• Chronic obstructive pulmonary disease - ICD-10: J44.9
"Unspecified" Coding Example

• Chest pain, unspecified (Not documented as Angina)

  **Step 1**
  • Look up term in Alphabetic Index:
  • Pain, chest (central) R07.9

  **Step 2**
  • Verify code in Tabular:
  • R07.9 Chest pain, unspecified

Problematic areas causing RTP’s and potential denials

  **“X” place holders**
  • Diagnosis codes require a certain number of digits that will be notated
  • Confusing as the code is actually 5 codes, for example, but the code requires a 7th digit code, A, D or S
  • Common errors are: putting the A, D or S in a spot prior to the 7th digit or not putting it at all. Both of these will be rejected
  • When 7th character applies, codes missing 7th character are invalid

  **Example:**
  • T81.31 Disruption of external operation (surgical) wound, not elsewhere classified
  • States 7 digits, however, does Not state that there is NO 6th digit, and that an "X" dummy place holder is to be assigned to the 6th spot
  • It just states that the 7th digit is to be and A, D or S
  • Therefore, errors are made with: T81.31 or T81.31D being submitted
  • The Correct is T81.83XD - for Subsequent Encounter
Problematic areas causing RTP's and potential denials

Non specific codes & Incorrect codes

- Read the Guidelines: do not just use cheat sheets
- Look on cheat sheet for the code, but then look up in the official book or online center to read Excludes 1 and 2 notes, Code First rules, and guidelines
- Use caution, when coding an unspecified code, particularly in the primary diagnosis spot: if it is unspecified, try to get a more specific diagnosis.
- Code appropriate number of digits: L97.20 Non-pressure chronic ulcer of unspecified calf requires 6 digits. The 6th is for Laterality.
- Code Laterality! Do not use 9 for unspecified site!
- Code the severity (depth) of non pressure ulcers: do not put unspecified unless cannot see it.

Incorrect codes

- When coding a sequela - late effect - of CVA, be careful not to use the I69.9 codes instead of the I69.3 codes.
- I69.952 Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side
- If you choose that without looking further you have unspecified cerebrovascular disease, not sequela of CVA
- Choose instead: I69.352 Hemiplegia and hemiparesis following cerebral infarction affecting left dominant side

Lack of documentation to support codes

- Auditors are looking for supportive documentation to support the ICD-10 codes that are entered.
- This should be in the form of physician narrative documentation, Referral information, such as H&P, Discharge summaries, etc
- Use caution if you are coding diagnoses without having this information as this may lead to denials down the road!
- So……. moral of story is to get as much information and document as specific as possible to avoid denials down the road!
Ready or Not...2670 Coding Changes!
Changes take effect October 1, 2016

• 1943 new codes
• 422 revised codes
• 305 deleted codes

WHY??? 2,670 Coding Changes in October

• Freeze on codes since 2011
• SO..... Major changes to the code set for first time
• MORE SPECIFIC
• Many more laterality replacing unspecified
• Many have same code but with addition of 7th characters
• So one ‘diagnosis’ can have many new codes

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### Code Changes:

- **A92.5, Zika virus, is expected to be in the final code set for 2017**
- **CVA - Deleted Code:**
  - I69.31 Cognitive deficits following cerebral infarction
  - New CVA cognitive Codes - more specific:
    - I69.310 Attention and concentration deficit following cerebral infarction
    - I69.311 Memory deficit following cerebral infarction
    - I69.312 Visuospatial deficit and spatial neglect following cerebral infarction
    - I69.313 Psychomotor deficit following cerebral infarction
    - I69.314 Frontal lobe and executive function deficit following cerebral infarction
    - I69.315 Cognitive social or emotional deficit following cerebral infarction
    - I69.318 Other symptoms and signs involving cognitive functions following cerebral infarction
    - I69.319 Unspecified symptoms and signs involving cognitive functions following cerebral infarction

### Cognitive CVA codes, continued

- I69.313 Psychomotor deficit following cerebral infarction
- I69.314 Frontal lobe and executive function deficit following cerebral infarction
- I69.315 Cognitive social or emotional deficit following cerebral infarction
- I69.318 Other symptoms and signs involving cognitive functions following cerebral infarction
- I69.319 Unspecified symptoms and signs involving cognitive functions following cerebral infarction
Chapter changes for codes:

- **New Codes:**
  - M97.01XD - Periprosthetic fracture around internal prosthetic right hip joint

- **Deleted codes:**
  - T84.040D - Periprosthetic fracture around internal prosthetic right hip joint

New Codes

- R73.03 Prediabetes
- Z79.84 Long term (current) use of oral hypoglycemic drugs
- R82.71 Bacteriuria

Conclusion

- ICD-10 Coding is complex!
- Recommend:
  - Audit what you have coded since ICD-10 to ensure you are accurate
  - Ensure that Referral information is sufficient to code diagnoses
  - Ensure that Clinician documentation is sufficient to code diagnoses
  - Be sure that Guidelines and Notes for diagnoses are being followed
  - Keep up with the Continual changes!
Thank You!!!

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