Gold Coast Health Plan℠
A Public Entity

Countdown to ICD-10: Are You Ready?

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Introductions

Racheal Reeves

- ICD-10 Approved Trainer with over 11 years of consulting experience
- Experience in CPT, MS-DRG, CMS-DRG, APR-DRG, LTACH-PPS, IRF-PPS, IPF-PPS, OPPS/APC and ASC methodologies

Michelle Schurig

- Manager at Optimity Advisors with over 15 years of consulting and local and federal government experience

Learning Objectives

- Define ICD-10 and why the transition is necessary
- Understand the main differences between ICD-9 and 10
- Learn what clinical documentation changes are needed
  - Claims and Authorizations
  - Providers, Hospitals and Facilities
- Discover where to access other available resources

Agenda
ICD-10 Overview
Clinical Documentation
Case Studies
Additional Resources

ICD-10 Overview

International Classification of Disease (ICD) codes are a series of codes developed by the World Health Organization to standardize diagnosis, surgical and medical procedures and patient health status.

- ICD codes are revised periodically and are currently in its tenth revision, ICD-10
- For US HIPAA-covered entities, the mandated compliance date is October 1, 2015

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ICD-10 Major Objectives:

- Increased coding accuracy, standardization, and expandability
- Better identification of members for care management
- Potential for deeper population-level analytics for public health
- Improved quality and outcomes data

ICD-9 vs. ICD-10: Key Differences

ICD-10 represents a major change in the medical coding system

- Much greater specificity in ICD-10
- New code structure and coding rules
- New terminology to define medical procedure (CPT/HCPC not impacted)

ICD-9	ICD-10
3–5 digits in length, V and E are the only alpha characters	3–7 alpha-numeric characters in length
CM: 14,000 codes, 3–5 characters	CM: 68,000 codes, 3–7 characters
*PCS: 3,000 codes, 3–4 characters	*PCS: 87,000 codes, 7 characters

All GCHP providers will use the ICD-10 CM (diagnosis) code set; only hospitals and facilities will use ICD-10 PCS (procedure) code set. The CPT/HCPC codes will not be impacted.

ICD-10 Implications for Authorizations

Authorization Legend
Pre-Service Authorization Requests: Authorization requested before services will be performed (including urgent)
Concurrent Authorization Requests: Authorization being requested at the same time services are being performed
Retro Authorization Requests: Authorization requested after services have already been performed (provider has 60 days to submit request; GCHP has 30 days to review request)

	Scenario	Pre-Service Requests	Concurrent Requests	Retro Requests
Inpatient*	Prior to 10/1/15	Receipt Date prior to 10/1/15: ICD-9	Receipt Date prior to 10/1/15: ICD-9	Admit Date prior to 10/1/15: ICD-9
	On/after 10/1/15	Receipt Date after 10/1/15: ICD-10	Receipt Date after 10/1/15: ICD-10	Admit Date on/after 10/1/15: ICD-10
	Spans 10/1/15	ICD-9/ICD-10 (based on date of receipt)	ICD-9*	ICD-9
Outpatient	DOS was prior to 10/1/15	Receipt Date prior to 10/1/15: ICD-9	N/A	DOS prior to 10/1/15:ICD-9
	DOS was on/after 10/1/15	Receipt Date after 10/1/15: ICD-10	N/A	DOS on/after 10/1/15:ICD-10
	Spans 10/1/15	ICD-9/ICD-10 (based on date of receipt)	N/A	ICD-9/ICD-10 (based on DOS of initial service)

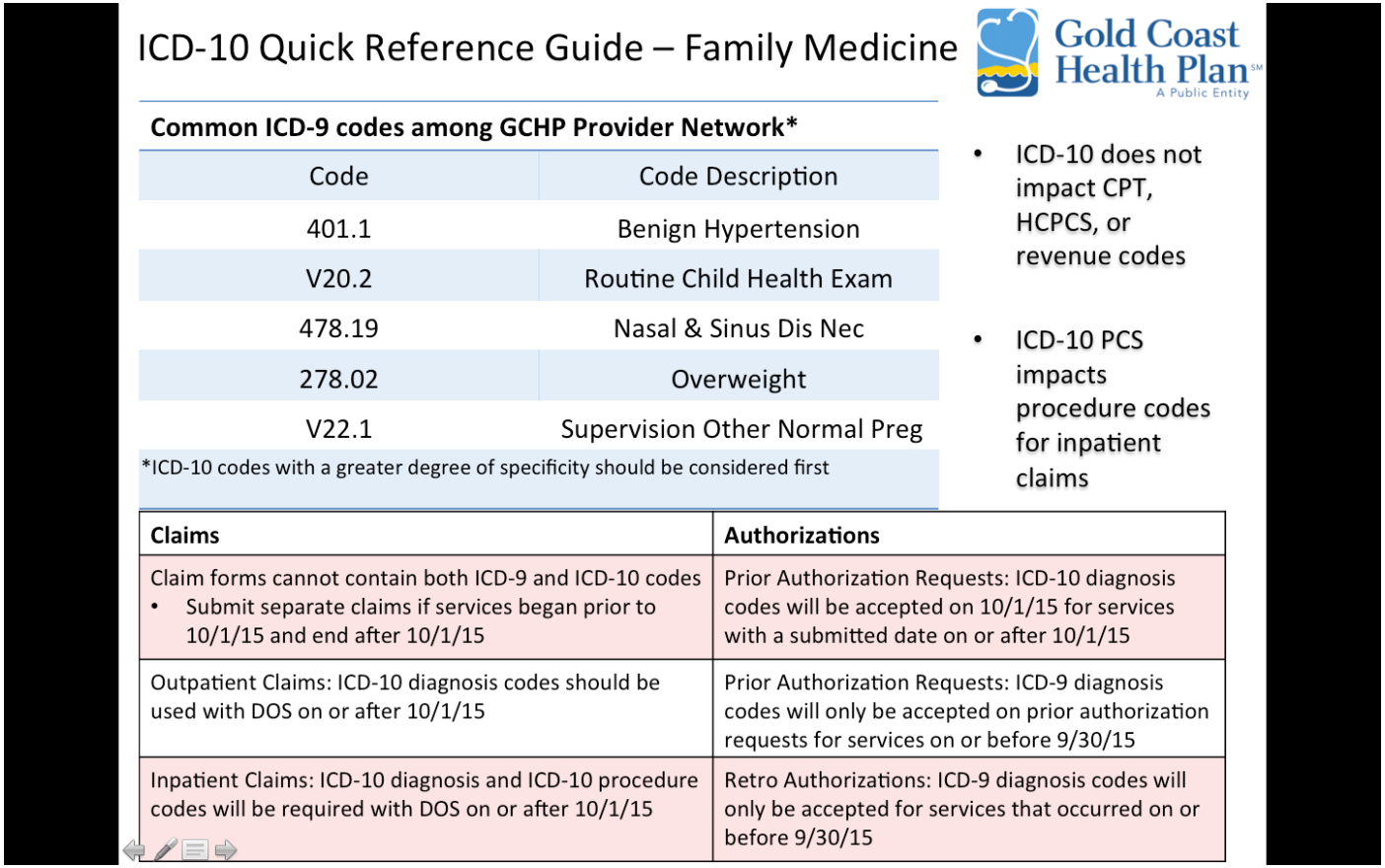
*For LTCs-Based on Statement beginning date; not first DOS

ICD-10 Implications for Claims

For Professional Claims and/or Hospital Claims, separate claims are required if services began prior to 10/1/15 (ICD-9) and end after 10/1/15 (ICD-10)

	Scenario	Examples
Inpatient	**DOS Prior** to 10/1/15; ICD-9 diagnosis codes required	
	DOS On/after 10/1/15; ICD-10 diagnosis and ICD-10 procedure codes required	
	DOS Prior to 10/1/15 and **spans** beyond 10/1/15; ICD-9 diagnosis codes required for DOS prior to 10/1/15. ICD-10 diagnosis and ICD-10 procedure codes required for DOS on or after 10/1/15	Requires Split Billing (two separate claims) DOS 09/28/15-10/07/15; 1st claim=09/28/15-9/30/15 ICD-9 codes 2nd claim=10/01/15-10/07/15 ICD-10 codes
Outpatient	DOS **Prior** to 10/1/15; ICD-9 diagnosis codes are required with DOS	
	DOS was **On/after** 10/1/15; ICD-10 diagnosis codes are required	

Reference Guides include the most common ICD-9 codes used in the GCHP Provider Network



ICD-10 Quick Reference Guide – Family Medicine

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Common ICD-9 codes among GCHP Provider Network*

Code	Code Description
401.1	Benign Hypertension
V20.2	Routine Child Health Exam
478.19	Nasal & Sinus Dis Nec
278.02	Overweight
V22.1	Supervision Other Normal Preg

*ICD-10 codes with a greater degree of specificity should be considered first

- ICD-10 does not impact CPT, HCPCS, or revenue codes
- ICD-10 PCS impacts procedure codes for inpatient claims

Claims	Authorizations
Claim forms cannot contain both ICD-9 and ICD-10 codes • Submit separate claims if services began prior to 10/1/15 and end after 10/1/15	Prior Authorization Requests: ICD-10 diagnosis codes will be accepted on 10/1/15 for services with a submitted date on or after 10/1/15
Outpatient Claims: ICD-10 diagnosis codes should be used with DOS on or after 10/1/15	Prior Authorization Requests: ICD-9 diagnosis codes will only be accepted on prior authorization requests for services on or before 9/30/15
Inpatient Claims: ICD-10 diagnosis and ICD-10 procedure codes will be required with DOS on or after 10/1/15	Retro Authorizations: ICD-9 diagnosis codes will only be accepted for services that occurred on or before 9/30/15

Myth or Fact?

The increased number of codes in ICD-10-CM will make it much more difficult to find codes quickly and efficiently.

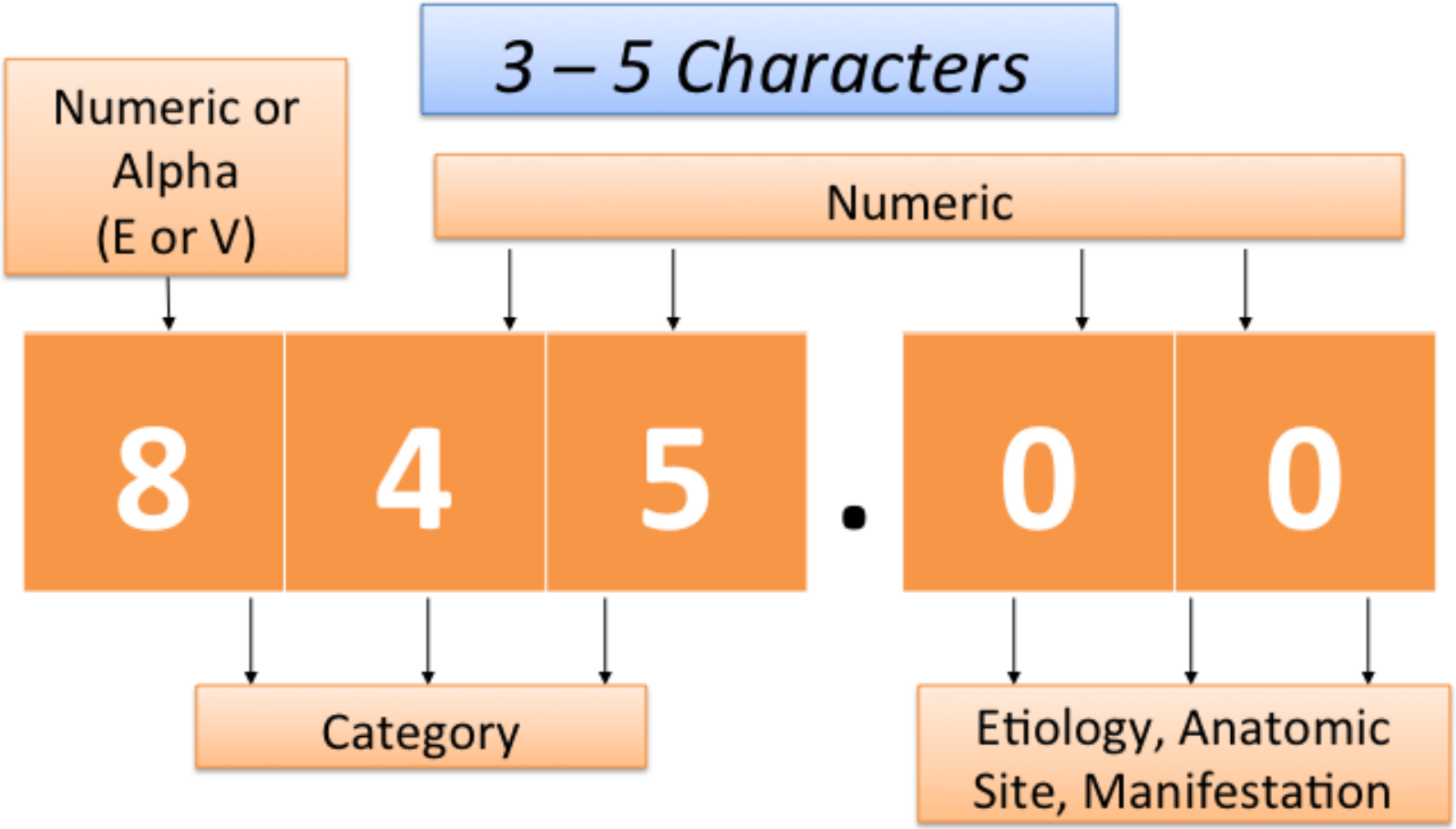
MYTH

ICD-10-CM will allow for greater specificity which makes it easier to find codes. In addition, the improved structure of ICD-10-CM will facilitate the development of increasingly sophisticated electronic coding tools that will assist in faster code selection.

Clinical Documentation

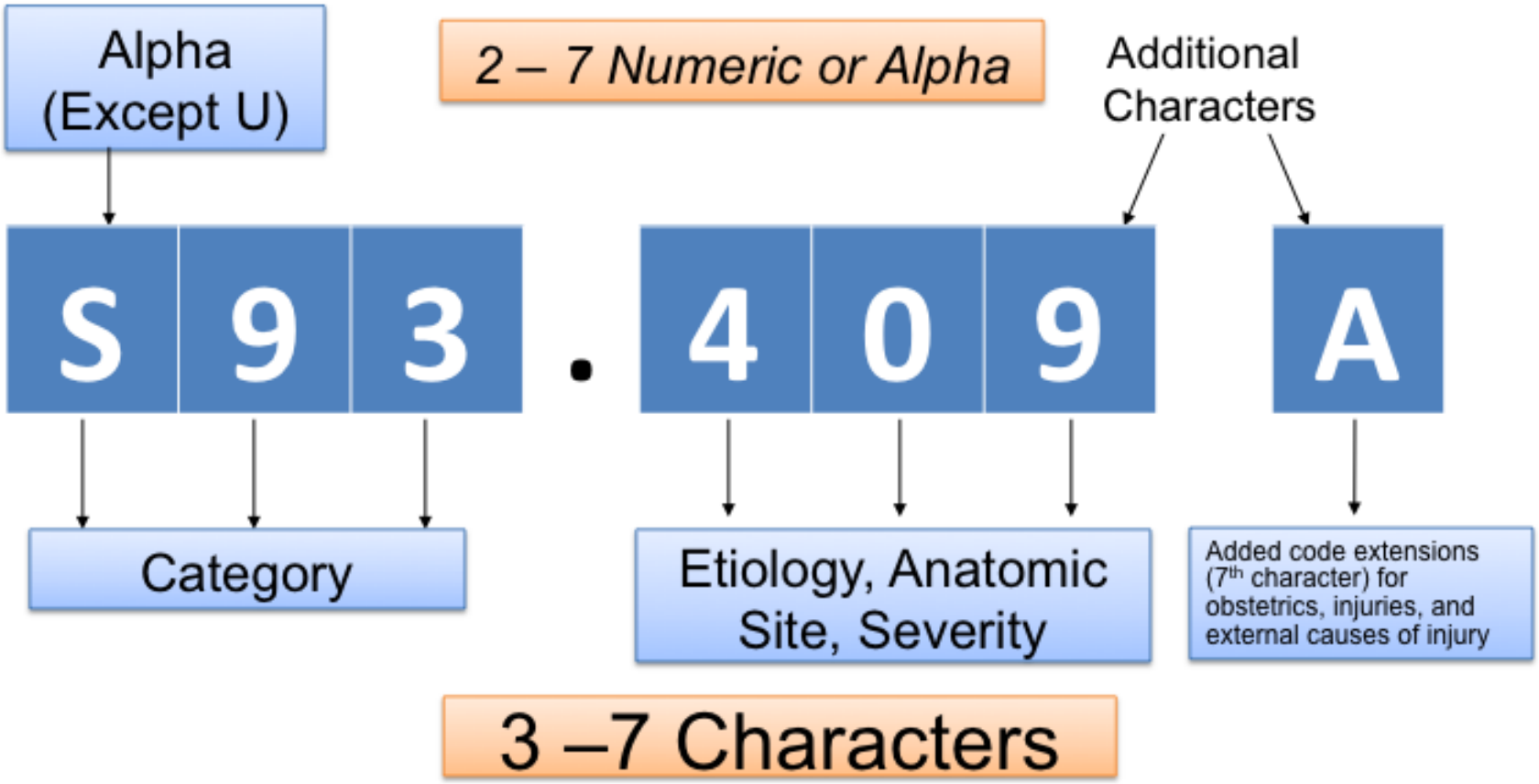
ICD-9 CM Code Layout

Unspecified site of ankle sprain and strain



ICD-10 CM Code Layout

Unspecified site of ankle sprain and strain



* Please see slide 36 in the Appendix for greater specificity regarding ICD-Coding

Query	Documentation to Consider
Who?	Male/female, mom and/or baby, adult, child, driver, passenger, pedestrian
What?	Type of diagnosis, disease, condition, type of injury
Where?	Organ, laterality, quadrant, proximity, location of accident, vessel
When?	Frequency, recurrent, chronic, acute, trimesters, weeks
How?	Circumstance of occurrence, “Due to…”
Type/ Complexity?	Infectious organism, severity…

ICD-10 CM: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T98)

Practice Case

Forearm Fracture

- Who? 9 yo male
- What? Fracture
- Where? Ulna, shaft, left
- When? Initial encounter
- How? Fall from skates
- Type/Complexity? Greenstick (Closed)
- Location of accident? Tennis court

ICD-10 CM Code Layout: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T98)

VALUES	INJURIES & EXTERNAL CAUSES
A	Initial Encounter (Closed fracture)
B	Initial Encounter for open fracture type I or II, NOS
C	Initial Encounter for open fracture type IIIA, IIIB, or IIIC
D	Subsequent Encounter (Closed fracture)(Routine Healing)
E	Subsequent Encounter for open fracture type I or II, routine healing
F	Subsequent Encounter for open fracture type IIIA, IIIB or IIIC, routine healing
G	Subsequent Encounter (Closed) fracture with delayed healing
H	Subsequent Encounter for open fracture type I or II, delayed healing
J	Subsequent Encounter for open fracture type IIIA, IIIB or IIIC, delayed healing
K	Subsequent Encounter (Closed) fracture with nonunion
M	Subsequent Encounter for open fracture type I or II, nonunion
N	Subsequent Encounter for open fracture type IIIA, IIIB or IIIC, nonunion
P	Subsequent Encounter (Closed) fracture with malunion
Q	Subsequent Encounter for open fracture type I or II, malunion
R	Subsequent Encounter for open fracture type IIIA, IIIB or IIIC, malunion
S	Sequela

Some Codes Exist in Both ICD-9 and ICD-10, but Mean Different Things

ICD-9-CM Code & Description	ICD-10-CM Code & Description
V70.0: Routine general medical examination at a health care facility	V70.0: Driver of bus injured in collision with pedestrian or animal in non-traffic accident
V20.2: Routine infant or child health check	V20.2: Unspecified motorcycle rider injured in collision with pedestrian or animal in non-traffic accident
V76.2: Screening for malignant neoplasms of cervix	V76.2: Person on outside of bus injured in collision with other non-motor vehicle in non-traffic accident
V22.1: Supervision of other normal pregnancy	V22.1: Motorcycle passenger injured in collision with two or three wheeled motor vehicles in non-traffic accident

Documentation needed to select the correct code: Diabetes

Type	• Type 1 • Type 2 • Drug/chemical induced • Due to underlying condition • Other specified type
Control	• Inadequate control • Out of control • Poorly Controlled • Hypoglycemia • Hyperglycemia
Other	• Insulin use • Associated diagnoses/conditions

Manifestation/Complication (document link to diabetes)	• Circulatory complications • Hyperosmolarity • With or without coma • Hypoglycemia • Ketoacidosis • Kidney complications • Neurological complications • Ophthalmic complications • Oral complications • Skin complications • Arthropathy • Other (specify)

* Please see slides 40-42 in the Appendix for additional conditions including Asthma, Otitis Media and Pregnancy

ICD-10 CM: Symptoms, Signs and Abnormal Clinical and Laboratory Findings, not Elsewhere Classified (R00-R99)

Practice Case

Chief Complaint: Pain

- Who? 14 yo male
- What? Pain
- When?
- Where? Abdominal
- How?

ICD-10 CM: Symptoms, Signs and Abnormal Clinical and Laboratory Findings, not Elsewhere Classified (R00-R99)

ICD-9-CM Coding Index
Pain (s) (*see also* Painful) 780.96
- abdominal 789.0

ICD-10 CM Coding Index
Pain (s) (*see also* Painful) R52
- abdominal R10.9
- - colic R10.83
- - generalized R10.84
- - - with acute abdomen R10.0
- - lower R10.30
- - - left quadrant R10.32
- - - pelvic or perineal R10.2
- - - periumbilical R10.33
- - - right quadrant R10.31
- - rebound —*see* Tenderness, abdominal, rebound
- - severe with abdominal rigidity R10.0
- - tenderness —*see* Tenderness, abdominal
- - upper R10.10
- - - epigastric R10.13
- - - left quadrant R10.12
- - - right quadrant R10.11

Myth or Fact?

The ICD-10 CM code layout has more characters when compared to the ICD-9 code layout.

FACT

The ICD-10-CM code layout can have 3-7 characters compared to 3-5 characters in the ICD-9 CM-code layout.

Case Studies

Additional Documentation Needs for ICD-10 CM Endocrine, Nutritional, and Metabolic Disorders (E00-E90)

Improved Documentation Guidance			
Documented Diagnosis	**ICD-9-CM Reported**	**ICD-10-CM Documented**	**Notes**
"Diabetes uncontrolled"	250.02 Diabetes mellitus w/o complication, type 2, stated as uncontrolled	E11.9 Type 2 diabetes mellitus without complication	• This code assignment does not reflect the acute problem of the patient's visit.
"Diabetes w/ hyperglycemia"	250.00 Diabetes mellitus w/o complication, type II, not stated as uncontrolled	E11.65 Type 2 diabetes mellitus with hyperglycemia	
"Hypercholesterolemia"	272.0 Pure hypercholesterolemia	E78.0 Pure hypercholesterolemia	• The code assignment is dependent on the lipoprotein(s) involved. • When both low density and very low density lipoproteins are elevated, this should be specified.
"Mixed hyperlipidemia"	272.2 Mixed hyperlipidemia	E78.2 Mixed hyperlipidemia	

*ICD-9 and ICD-10 codes provided only for training purpose

Case Study

The 34-year-old male patient is being seen for ongoing management of diabetes mellitus. Blood sugar is elevated today. Patient is obese and has recent results of cholesterol screening with elevated cholesterol and triglycerides. The patient's diabetes is managed with insulin which he has been taking for the last two years.

*Please see slides 44-46 in the Appendix for an additional case study

ICD-9 CM Clinical Documentation

Case Study: SOAP

S: 34yo male with elevated BS for 2 weeks. F/U on labs from previous visit.

O: HEENT: Clear. Chest: Clear. Abdomen: Exam limited by obesity. Labs: Today blood glucose is 320. Fasting lipid study shows LDL 220 and triglycerides 280. Remaining systems not examined.

A: Diabetes uncontrolled* Hypercholesterolemia
Obesity

P: Supplement Insulin with Glucophage.
Diet. Repeat lipid study in 4 months.

S: Subjective O: Objective A: Assessment P: Plan

ICD-10 CM Clinical Documentation

Case Study: Revised SOAP

S: 34yo male with elevated BS for 2 weeks. F/U on labs from previous visit.

O: HEENT: Clear. Chest: Clear. Abdomen: Exam limited by obesity. Labs: Today blood glucose is 320. Fasting lipid study shows LDL 220 and triglycerides 280.

A: Diabetes with hyperglycemia. Long term insulin use. Combined (mixed) hyperlipidemia. Obesity

P: Supplement Insulin with Glucophage. Dietary counseling. Weight check and repeat lipid study in 4 mos.

S: Subjective O: Objective A: Assessment P: Plan

Additional Documentation Needs for ICD-10 CM: Certain Infectious and Parasitic Diseases (A00-B99)

Improved Documentation Guidance			
Documented Diagnosis	ICD-9-CM Reported	ICD-10-CM Documented	Notes
"Viral Illness"	079.99 Unspecified viral infection	R69 Illness, unspecified	• Using the term illness alone indexes to a symptom code for an unspecified illness (R69). • Since the condition is specified as viral, the parenthetical note to "see also Disease" should be observed. • Replacement of the term illness with "disease" or "infection" provides terminology more easily indexed to the appropriate code assignment. • The specificity can be improved by providing a site of infection if known.
"Viral Infection"	079.99 Unspecified viral infection	B34.9 Viral infection, unspecified	• The category for Viral Infection of unspecified site provides more specific codes for Adenovirus, Enterovirus, Rhinovirus, etc.

*ICD-9 and ICD-10 codes provided only for training purpose

Case Study

This 6-year-old male patient was seen with fever, cold symptoms, and headache. 4 yo sibling in with fever and viral exanthema diagnosed as “Fifth disease” approximately one week ago. A CBC performed in the office is suggestive of a virus. No other significant complaints or findings.

*Please see slides 44-46 in the Appendix for an additional case study

ICD-9 CM Clinical Documentation

Case Study: SOAP

S: Fever, headache, cold symptoms. Sibling with Fifth disease last week.

O: HEENT: Clear with minimal nasal secretions. Chest: Clear. Skin: No rash. Remaining systems not examined.

A: Viral illness, possibly Fifths disease.

P: Symptomatic treatment with acetaminophen. No school until fever resolved 24 hours.

S: Subjective O: Objective A: Assessment P: Plan

ICD-10 CM Clinical Documentation

Case Study: Revised SOAP

Use “Viral Infection”

S: Subjective O: Objective A: Assessment P: Plan

Additional Resources

Gold Coast Health Plan Resources

Gold Coast Health Plan Website:

http://www.goldcoasthealthplan.org/providers/welcome-providers.aspx

Quick Reference Guides and

ICD-10 Operational Readiness Checklist Are Available Here for Download:

http://goldcoasthealthplan.org/providers/resources.aspx#icd

Questions: Providerrelations@goldchp.org

ICD-10 Websites

CMS: ICD-10 General Information	www.cms.gov/ICD10
CMS: ICD-10 Provider Resources	www.cms.gov/ICD10/05a_ProviderResources.asp#TopOfPage
HIMSS ICD-10 Playbook	http://www.himss.org/library/icd-10/playbook
National Center for Health Statistics	www.cdc.gov/nchs/icd.htm
World Health Organization (WHO) ICD-10 Interactive Self-Learning Tool	apps.who.int/classifications/apps/icd/ICD10Training
Center for Disease Control and Prevention (CDC)	www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm
AHIMA	www.ahima.org/icd10 http://bok.ahima.org/PdfView?oid=300621
American Hospital Association	www.ahacentraloffice.org

Questions?

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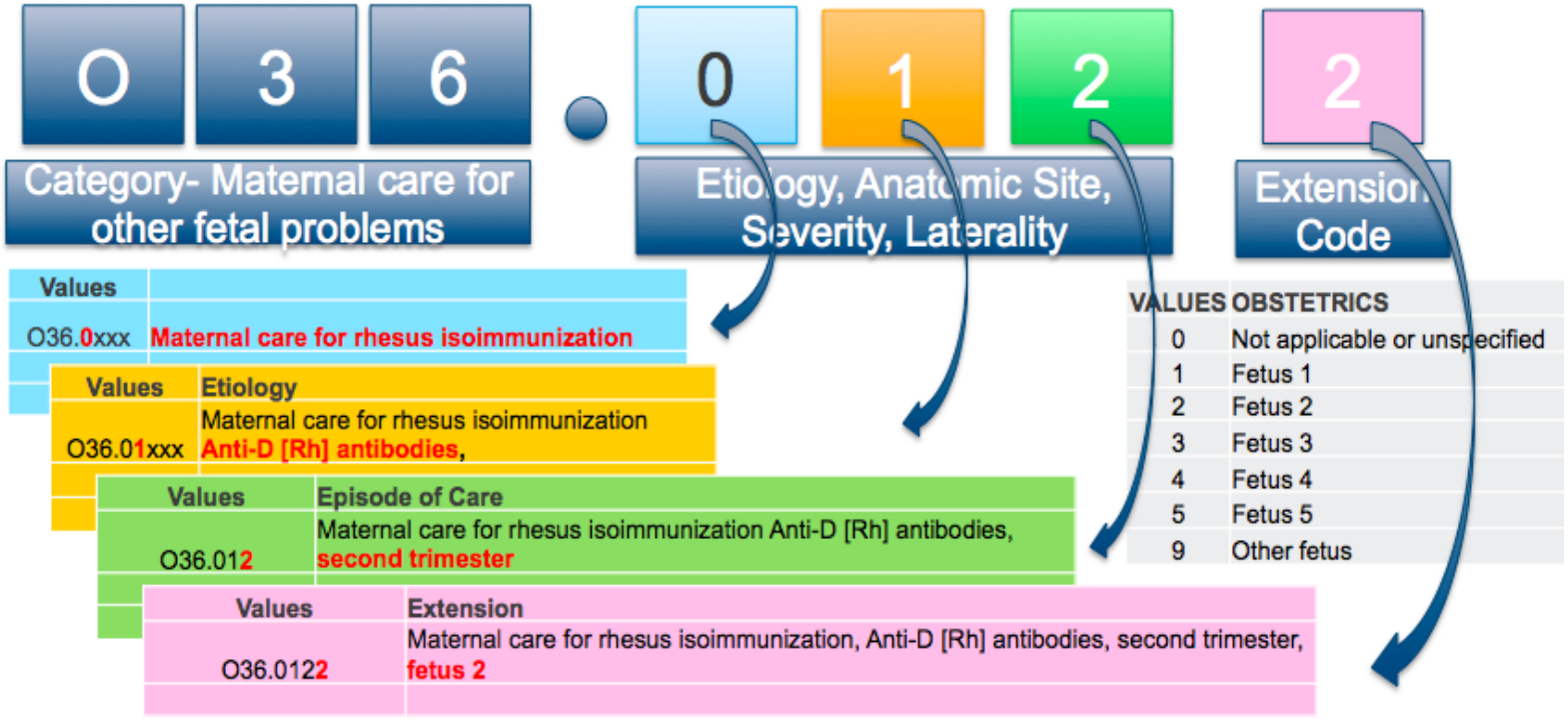
Appendix

ICD-10 Coding Example:
Maternal Care for Other Fetal Problems



DEPENDENT UPON CATEGORY
May not be required.

Documentation needed to select the correct code: Asthma

Type	• Cough variant • Childhood • Exercise induced bronchospasm • Extrinsic allergic • Idiosyncratic • Intrinsic nonallergic • Late-onset • Mixed • Other (specify)
Severity	• Mild intermittent • Mild persistent • Moderate persistent • Severe persistent

With	• Acute lower respiratory infection • COPD • Chronic obstructive bronchitis • Exacerbation • Status asthmaticus
Document	• Any associated diagnoses/conditions

Documentation needed to select the correct code: Otitis Media

Type	• Serous • Suppurative or Nonsuppurative • Tubotympanic • Atticoantral • Allergic and/or Mucoid
Laterality	• Right ear • Left ear • Bilateral
Incidence	• Acute/subacute • Acute recurrent • Chronic

With	• Spontaneous rupture of tympanic membrane • Without spontaneous rupture of tympanic membrane • Infectious or other external agent • Exposure to environmental tobacco smoke
Document	• Any other associated diagnoses/conditions

Documentation needed to select the correct code: Pregnancy

Specify Trimester	• First (less than 14 weeks, 0 days) • Second (14 weeks, 0 days to less than 28 weeks, 0 days) • Third (28 weeks until delivery)
Specify Preterm labor/delivery	

Document	• Gestational Diabetes and specification of diet controlled or insulin controlled
	• Any other associated diagnoses/conditions

Additional Documentation Needs for ICD-10 CM: Diseases of the Circulatory System (I00-I99)

Improved Documentation Guidance			
Documented Diagnosis	**ICD-9-CM Reported**	**ICD-10-CM Documented**	**Notes**
"Congestive heart failure"	428.0 Congestive heart failure	I50.9 Heart failure, unspecified	• Acuity of presenting condition not represented by this diagnostic statement or associated code assignment. • Severity of illness more appropriately reflected when the diagnosis includes etiology, acuity, and type of heart failure.
"Hypertensive heart disease with acute and chronic systolic failure"	402.9 Hypertensive heart disease, unspecified as malignant or benign 428.23 Acute and chronic systolic heart failure 427.31 Atrial fibrillation	I11.0 Hypertensive heart disease I50.23 Acute and chronic systolic heart failure I48.0 Paroxysmal Atrial fibrillation	• Benign or malignant are nonessential modifiers in ICD-10. • Heart failure due to HTN is often under reported due to lack of documentation. When CHF is due to HTN, two codes are required and the HTN code is sequenced first.

*ICD-9 and ICD-10 codes provided only for training purpose

Case Study

58 yo male patient with history of hypertension x 18 yrs and CHF presents with SOB. During chest xray, patient becomes dizzy with chest discomfort. Patient with past episode of atrial fibrillation. Currently on BP meds. Xray findings confirm congestive heart failure (CHF) and EKG shows atrial fibrillation. EKG: Atrial fibrillation converted spontaneously. CXR: Cardiomegaly with diffuse pulmonary infiltrate consistent with pulmonary edema.

ICD-9 CM Clinical Documentation

Case Study: SOAP

S: 58 yo male w/ HBP with SOB

O: BP: 170/92 Dyspnea w/ mild discomfort. HEENT: Normocephalic. Eyes, ears, & throat normal. Neck: Distended neck veins. Carotids without bruits. Chest: Scattered rhonchi throughout. Heart: Tachycardic and irreg. Abd: Non-tender w/ pos bowel sounds. Extremities: 2+ pitting edema of lower extremities. Pulses intact. EKG: Atrial fibrillation converted spontaneously. CXR: Mild cardiomegaly with diffuse pulmonary infiltrate consistent with pulmonary edema.

A: Congestive heart failure. Atrial fibrillation.

P: Change BP meds to Toprol XL.

S: Subjective O: Objective A: Assessment P: Plan

ICD-10 CM Clinical Documentation

Case Study: Revised SOAP

S: 58 yo male patient with history of hypertensive heart disease x 18 yrs and CHF presents with SOB.

O: During chest xray, patient becomes dizzy with chest discomfort. Patient with past episode of atrial fibrillation. Currently on BP meds. Xray findings confirm acute and chronic systolic congestive heart failure (CHF) and EKG shows atrial fibrillation. EKG: Atrial fibrillation converted spontaneously. CXR: Cardiomegaly with diffuse pulmonary infiltrate consistent with pulmonary edema.

A: Acute and chronic systolic heart failure. Paroxysmal Atrial fibrillation.

P: Change BP meds to Toprol XL.

S: Subjective O: Objective A: Assessment P: Plan