Get Ready for ICD-10: 40 Days and Counting!
Kathy Mills Chang, MCS-P, CCPC

What We Have in Store
• The specific action steps and timelines necessary for this final 60-day push for success
• Why using one of the many conversion tools to translate ICD-9 into ICD-10 can set you up for a fall, including denied claims, stalled reimbursement, and worse
• Why your documentation details are critical to your successful transition from ICD-9 and ICD-10, and how to get on top of them
• Which site-specific terms you need to know, and how to begin using them in your documentation now to ensure smooth sailing for ICD-10

What You Need
• Your ICD-10 Action Plan: Getting Started
• Map Your Codes: ICD-9 to ICD-10 the Easy Way
• Find the Codes: FAST!
• Important Terminology and Anatomy for the Whole Team
• Documentation Requirements in ICD-10
• Master the Tabular List for Pinpoint Accuracy
• Make Your Case: Real World Practice with Real Case Studies

Why Do We Need ICD-10?
Today's data needs are dramatically different than they were 30+ years ago when ICD-9 was introduced. ICD-10 will advance healthcare in many ways, with benefits accruing in quality measurement, public health, monitoring, and performance, and health IT advances.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field Length</td>
<td>3-5 characters</td>
<td>3-7 characters</td>
</tr>
<tr>
<td>Available Codes</td>
<td>Approximately 13,000 codes</td>
<td>Approximately 68,000 codes</td>
</tr>
<tr>
<td>Code Composition (numeric or alpha)</td>
<td>Digit 1 = alpha or numeric Digit 2+ = numeric</td>
<td>Digit 1 = alpha Digit 2+ = numeric</td>
</tr>
<tr>
<td>Available space for new codes</td>
<td>Limited</td>
<td>Flexible</td>
</tr>
<tr>
<td>Overall detail embedded within codes</td>
<td>Ambiguous</td>
<td>Very specific</td>
</tr>
<tr>
<td>Latency</td>
<td>Does not identify right versus left</td>
<td>Other identifies right versus left</td>
</tr>
<tr>
<td>Specify</td>
<td>Generic terms for body</td>
<td>Detailed descriptions of body parts</td>
</tr>
</tbody>
</table>

ICD-10 Delay
Senate Passes SGR Bill. No ICD-10 Delay.
The Senate has voted to pass the Medicare Access and CHIP Reauthorization Act of 2015, which would delay the October 1, 2015 compliance deadline for ICD-10 coding. The bill now goes to the House, where it will face a tough fight. In a statement on the Senate floor before the vote, Senator Lamar Alexander said: “We have to keep our commitment to the medical profession and our seniors.”

Start Here: What’s ICD-10?
ICD-10 Delay: Start Here: What’s ICD-10?
What Have YOU Done So Far?

Should be completed by: You

- Determine and designate the team member who will serve as your ICD-10 Project Manager.
- Ask the mailing list for the ICD-10 Industry Email Updates from CMS by registering here: http://www.cms.gov/Medicare/Coding/ICD-10-ICD-10-Industry-Email-Updates.html
- Create an ICD-10 Transition electronic and/or paper file system to serve as a repository for all your ICD-10 training and transition materials.
- At this point, your software should have been updated to Version 5010 for electronic transactions. If not, do it now.
- Contact your practice management software vendor and find out their plans and timelines for ICD-10 transition.
- Contact your electronic health records software vendor and find out their plans and timelines for ICD-10 transition.
- Make a list of and/or gather together all contracts your office holds with third party payers, create a plan to contact each payer to find out their plans and timelines for ICD-10 transition.
- Based on your findings so far, update and review your transition budget for ICD-10. Be sure you have allowed for additional doctor and staff training, software updates, coding policy purchases, and other expenses associated with transition.

Testing Anyone?

- Begin testing claims.
- CMS has a process.
- Check with each additional carrier.
- When do they accept testing?

Who’s In Charge?

- Have you selected an ICD-10 project manager?
- Someone must coordinate and ensure all the steps get done.
- What gets measured gets managed!

Can We Just Crosswalk from ICD-9?

- General Equivalence Mappings (GEMs)
- Some pointing based on the initial set up.
- Three possible ways to define subluxation: M99.01, M99.11, or S13.11.
- Now we know.
One-to-one Mapping

723.1 Cervicalgia → 723.1 Cervicalgia

M54.2 Cervicalgia → M54.2 Cervicalgia

One-to-Five Mapping

• 724.4 Thoracic or lumbosacral neuritis (radicular syndrome of the lower limbs)
  • ICD-10 = M54.14, M54.15, M54.16, M54.17, M54.18 Radiculopathy
  • M54.14 Radiculopathy, thoracic region
  • M54.15 Radiculopathy, thoracolumbar region
  • M54.16 Radiculopathy, lumbar region
  • M54.17 Radiculopathy, lumbosacral region
  • M54.18 Radiculopathy, sacral and sacroccygeal region

Combination Mapping

724.3 Sciatica → 724.3 Sciatica

• M54.30 Sciatica, unspecified side
  • M54.31 Sciatica, right side
  • M54.32 Sciatica, left side

• M54.40 Sciatica with lumbago, unspecified
  • M54.41 Sciatica with lumbago, right side
  • M54.42 Sciatica with lumbago, left side

Conversion Tools

Let's Review
What is the Tabular List?

Tabular list is the ONLY index where ALL code information is found

Contains specific and complete code detail necessary to code correctly

Allows for coding to the highest level of specificity

Final codes to be selected will be identified in this list

Tabular list layout

Chapter

Block

Ranges of categories (related conditions)

Categories

3 characters (more specific condition)

Subcategories

4th or 5th characters (etiology, location, etc.)

Codes

6th or 7th characters (laterality, encounter, etc.)

ChiroCode Complete and Easy ICD-10 Coding for Chiropractic

Pages 1-43: Complete guide to understanding ICD-10-CM coding

Pages 44-56: Commonly Used Codes*

Pages 57-134: Code Map (GEMs)*

Pages 135-454: Tabular list (abridged)

Pages 455-472: Alphabetic Index*

Pages 473-511: Coding Guidelines
Tabular list layout

Chapter 21 of them from A to Z (body system or condition)

Ranges of categories (related conditions)

Categories

3 characters

Subcategories

4th or 5th characters (more specific condition)

Codes

6th or 7th characters (etiology, location, etc.)

Why the 7th Digit?
• Most categories in chapter 19 have seventh character extensions
• Required for each applicable code, and most categories have three extensions
• A, Initial encounter
• D, Subsequent encounter
• S, Sequela

Note: Codes may be complete with fewer than 6 characters. Some codes only have 3.

A vs. D

FACT: The revised ICD-10 CM 2015 Official Guidelines for Chapter 19 injury codes, (page 66) states, "While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is making the entry for the encounter. Active treatment is considered to exist while the patient remains under treatment for the condition and is receiving routine care for the condition during the healing or recovery phase. Therefore, once the patient is no longer receiving active treatment, the condition and care can be considered the healing or recovery phase. At that time, the provider would communicate this change in the patient’s condition to the payer, by dropping the seventh character ‘A’ and replacing it with the character ‘D’ on that diagnosis code.

What’s an Encounter?

We can refute the aforementioned statement that the term “encounter” in ICD-10 is not the same as an office visit. An encounter refers to the treatment phase – not the type of visit (e.g., new patient, established patient). It is important to look at this from the perspective of the patient’s condition when choosing the most appropriate 7th character rather than from the provider’s perspective of type of visit.

In regards to subsequent encounter, the guideline states: ‘D’ subsequent encounter is used for encounters after the patient has received active treatment for the condition and is receiving routine care for the condition during the healing or recovery phase. Therefore, once the patient is no longer receiving active treatment, and the condition is stabilizing, then it can be considered the healing or recovery phase. At that time, the provider would communicate this change in the patient’s condition to the payer, by dropping the seventh character ‘A’ and replacing it with the character ‘D’ on that diagnosis code.

So sayeth ACA, Chiro Code, and KMC University

<table>
<thead>
<tr>
<th>847.0</th>
<th>Sprains and strains; Neck (whiplash injury)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$13.4x</td>
<td>Spinal of ligaments of cervical spine ** §</td>
</tr>
<tr>
<td>$13.8x</td>
<td>Spinal of joints and ligaments of other part of neck ** §</td>
</tr>
<tr>
<td>$16.1x</td>
<td>Strain of muscle, fascia, and tendon at neck level ** §</td>
</tr>
</tbody>
</table>

A D or S
What Does Mac Daddy Medicare Say?

Sprain and Strain Codes:
• Initial encounter only?
• Subsequent encounters listed as part of initial encounter
• Noridian, National Gov’t Services, and others ONLY list the A
• A seems to be for “active treatment only”

Could the “D” Be Appropriate?
• What about the rehab phase of care?
• What if the patient was referred out and came back to finish treatment?
• What if the patient returned for an exacerbation?
Would the “S” Ever Be Appropriate?

- Extension S, sequela of “late effects”
- Complications or conditions that arise as a direct result of an injury, such as scar formation after a burn
- The scars are sequela of the burn
- When using extension S, 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
- Sequence the sequela first, then injury code

ICD-10 Excludes Notes
Who’s In and Who’s Out?

So What is “Excludes 1” or “Excludes 2”?

- Similar to Correct Coding Initiative Edits for CPT Codes
- Dictates when certain codes can be used together and when not
- The explanation will be helpful in the long run

The Technical Explanation

Two Types of Excludes Notes
- Excludes 1 - Indicates that the code excluded should never be used with the code where the note is located (do not report both codes).
  - Example: Q81 = Congenital hydrocephalus
  - Excludes 1: Acquired hydrocephalus (M41.1)
- Excludes 2 - Indicates that the condition excluded is not part of the condition represented by the code but a patient may have both conditions at the same time, in which case both codes may be assigned together (both codes can be reported to capture both conditions)
  - Example: Q27.2 = Dementia due to ingested food
  - Excludes 2: Dementia due to head in contact with skin (L235.5, L24.5, L25.4)
What’s the Difference?

• Excludes 1
  A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE!” An Excludes 1 note indicates that the excluded condition should never be used at the same time as the code. An Excludes 1 note indicates that two conditions at the same time. When an Excludes 1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

• Excludes 2
  A type 2 Excludes note represents “Not included here.” An Excludes 2 note indicates that the excluded condition is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes 2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.
**723.1 Cervicalgia = M54.2**

M542 - Cervicalgia

Excludes1: cervicalgia due to intervertebral cervical disc disorder (M50.6)

M50-M54 Excludes1: current injury – see injury of spine by body region disorders NOS (M46.4–)

**More Significant than Cervicalgia Alone**

**847.0 = S13.4XXX**

S13.4.XXX - Sprain of ligaments of cervical spine, initial encounter

- Sprain of anterior longitudinal (ligament), cervical
- Sprain of atlanto-axial (joints)
- Sprain of atlanto-occipital (joints)
- Whiplash injury of cervical spine

S13.4 Includes:

- Avulsion of joint or ligament at neck level
- Laceration of cartilage, joint or ligament at neck level
- Sprain of cartilage, joint or ligament at neck level
- Traumatic hematoma of joint or ligament at neck level
- Traumatic subluxation of joint or ligament at neck level

S13 Excludes2: any associated open wound

S16.1 = Strain

S16.1.XXX - Strain of muscle, fascia and tendon at neck level

- Strain of muscle, fascia and tendon at neck level, initial encounter
- Strain of muscle, fascia and tendon at neck level, subs
- Strain of muscle, fascia and tendon at neck level, sequela

**Read the Instructions!**
847.2 = $33.50

847.2 - Sprain of ligaments of lumbar spine, initial encounter

Includes:
- avulsion of joint or ligament of lumbar spine and pelvis
- laceration of cartilage, joint or ligament of lumbar spine and pelvis
- sprain of cartilage, joint or ligament of lumbar spine and pelvis
- traumatic subluxation of joint or ligament of lumbar spine and pelvis
- traumatic tear of joint or ligament of lumbar spine and pelvis
- any associated open wounds

Excludes:
- nontraumatic rupture or displacement of lumbar intervertebral disc NOS (LS3.1)
- traumatic tear of joint or ligament of lumbar spine and pelvis
- strain of muscle of lower back and pelvis (N39.01)

Exclusion modifier character is to be added to each code from category 72:
A - initial visit
D - subsequent encounter
S - sequela

Why Is Documentation So Important?

- Ensures quality patient care
- Meets licensure requirements to protect the public
- Guards against malpractice action
- Secures appropriate reimbursement
- Because...if it wasn’t written down, it didn’t happen!

Know your Audience

- Another health care provider
- Your board
- A malpractice attorney
- Third party payer’s medical necessity auditor
- Each has different, but necessary requirements of your documentation

Job 1--Dr. Listening

- Patient history, written and spoken
- Ask thoughtful questions about paperwork
- Chief and additional complaints
- HPI, ROS, and PFSH
- Begin to formulate thoughts about Examination

Mechanism of Injury (MOI)

- The manner in which a physical injury occurred, such as a fall from a height, ground-level fall, high or low speed MVA, etc.

724.4 Lumbarcaal LJD, w/Radiculopathy

724.4 - Intervertebral disc disorders with radiculopathy, lumbosacral region

Includes:
- Intervertebral disc disorders with radiculopathy, lumbosacral region (S33.1)
- Sciatica due to intervertebral disc disorder (S33.0)

Excludes:
- Intervertebral disc disorders with radiculopathy, cervical region (S33.3)
- Sciatica due to intervertebral disc disorder (S33.0)

Know your Audience

- Another health care provider
- Your board
- A malpractice attorney
- Third party payer’s medical necessity auditor
- Each has different, but necessary requirements of your documentation

Job 1--Dr. Listening

- Patient history, written and spoken
- Ask thoughtful questions about paperwork
- Chief and additional complaints
- HPI, ROS, and PFSH
- Begin to formulate thoughts about Examination

Mechanism of Injury (MOI)

- The manner in which a physical injury occurred, such as a fall from a height, ground-level fall, high or low speed MVA, etc.

Know your Audience

- Another health care provider
- Your board
- A malpractice attorney
- Third party payer’s medical necessity auditor
- Each has different, but necessary requirements of your documentation

Job 1--Dr. Listening

- Patient history, written and spoken
- Ask thoughtful questions about paperwork
- Chief and additional complaints
- HPI, ROS, and PFSH
- Begin to formulate thoughts about Examination

Mechanism of Injury (MOI)

- The manner in which a physical injury occurred, such as a fall from a height, ground-level fall, high or low speed MVA, etc.
Documentation in History

• Best to record a mechanism of trauma for every new patient or new episode.
• Ask leading questions of your patient to elicit a specific incident that precipitated the pain that the patient is experiencing.
• “Prior to experiencing your low back pain, did you slip or fall? Were you doing any unusual activity? When did you first experience the pain? Can you recall anything unusual that happened prior to experiencing the pain?”
• Record any incident that the patient can relate that ties to the pain that brought them into your office.

Medicare Specifics

• Claims can be denied without documented mechanisms of injury.
• Per Medicare: patient can’t just come in with a headache and expect Medicare to pay for the care of that headache.
• Some Medicare contractors are even going so far as to say that the injury can’t be incurred during activities of daily living.
• For example, patient wakes up in the morning with bad neck pain; denial says that the claim is denied because sleeping is an activity of daily living.

20. Chapter 20: External Causes of Morbidity (V00-Y99)

The external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis.

External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental), or intentional, such as suicide or assault), the place where the event occurred (the activity of the patient at the time of the event), and the person’s status (e.g., civilian, military).

There is no requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or those codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

V – Y Codes

Chapter 20: Guidelines for external causes of morbidity (V00-Y99)

• Never sequenced first
• Provide data about the cause, intent, place, activity, or status of the accident or patient
• No national requirement to use these codes, but voluntary reporting is encouraged

Y92 Place of occurrence should be listed after other codes, used only once an initial encounter, in conjunction with Y93

Y93 Activity code should be used only once, at initial encounter

Do You Use E Codes Now?

• E codes are intended to identify how a poisoning or injury occurred, the cause; whether the injury was accidental or intentional, the intent; and the place where the accident or event took place, i.e., place of occurrence. E codes identifying the “place of occurrence,” E849.X, are to be used in conjunction with E codes from ranges E850-E869 and E880-E928

ICD-10-CM Diagnosis Codes

20. External causes of morbidity (V00-Y99)

V00.01-20.28.99: Accidents

Y00.00-Y99.99: External causes of morbidity (V00-Y99)
Job 2 -- Dr. Finding

- Must be driven by history
- Include tests and measurements to quantify history
- Distinguish between important nuances
- Record everything in the patient’s record
- Determine whether additional diagnostic testing rationale exists

Job 3 -- Dr. Thinking

- This is initial assessment (S+O)
- H + E = D => Tx Plan
- Diagnosis for each region you plan to treat
- Treatment plan is obvious based on DX
- DX and plan for each component service

Job 4 -- Dr. Fixing

- Clarify and execute your plan
- Goals are associated with the plan
- Medical necessity is clear, if necessary
- It’s logical to expect to see the treatment coded that you chose

When Using Exam Findings

- You must be able to defend your diagnosis
- Kemp’s test is positive in most facet syndromes, but in some facet syndromes are not
- Be able to tell a third party what your thought process was using what’s written in your patient record

So? I’m a Full Spine Adjuster!

- Medical necessity definition dictates that you must prioritize each area of complaint
- Every visit:
  - S + O (P + ART) for every region treated
  - 2 DX codes for each region
  - Treatment plan for each/short and long term goals

Why It LOOKS Fishy...

Table 1: Medicare Allowed Amounts for Each CPT Code for Chiropractic Services (in $)

<table>
<thead>
<tr>
<th>Period</th>
<th>CPT 99840</th>
<th>CPT 99841</th>
<th>CPT 99842</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1 - May 31, 2010</td>
<td>24.70</td>
<td>24.70</td>
<td>24.70</td>
</tr>
<tr>
<td>June 1 - December 31, 2010</td>
<td>27.30</td>
<td>27.30</td>
<td>27.30</td>
</tr>
<tr>
<td>January 1 - December 31, 2011</td>
<td>24.70</td>
<td>24.70</td>
<td>24.70</td>
</tr>
</tbody>
</table>
And Just Last Month...

Figure 2: Percentage of Services by CPT Code for CYs 2012 and 2013

What to Do Now: Forge Ahead

What Should I Do Now?
• Concentrate on perfecting documentation
• Learn the subtle nuances in your current diagnosis protocols
• Begin to discern what each means to you

Brainstorm Operational Impact
• Computers, software, memory, other IT concerns
• Upgrades to software and testing for billing—both paper and electronic
• Super Bills, Diagnosis Sheets, Existing SOP and Training Materials

Brainstorm Operational Impact

FindACode.com

www.findacode.com
Use Your Mapping Tool

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>209.4</td>
<td>209.48</td>
</tr>
<tr>
<td>209.5</td>
<td>209.58</td>
</tr>
<tr>
<td>209.6</td>
<td>209.68</td>
</tr>
</tbody>
</table>

Need help? info@kmcuniversity.com