Get Ready for ICD-10: 60 Days and Counting!

ICD-10 Mastery Series
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

Start Here: What’s ICD-10?

ICD-10 Delay

Senate Passes SGR Bill: No ICD-10 Delay.

Committee to sign it into law.

For the first time in more than a year, Congress has passed a bill to avert automatic, retroactive penalties for the lack of a proper transition period to the new ICD-10 coding system.

The new law, which was signed into law by President Barack Obama, includes provisions that will extend the transition period for one year, from Oct. 1, 2013, to Oct. 1, 2014. 

The delay will allow more time for hospitals and other health care providers to prepare for the transition to ICD-10, which is expected to result in significant savings for Medicare and Medicaid.

The delay will also provide more time for the government to develop and test the new ICD-10 coding system, which is designed to improve the accuracy and efficiency of medical coding.

The delay is expected to result in significant savings for Medicare and Medicaid, as well as for private health insurers.

Why Do We Need ICD-10?

ICD-10, or International Classification of Diseases, Tenth Revision, is the latest version of the disease classification system used by health care providers, researchers, and policymakers around the world.

ICD-10 is designed to improve the accuracy and efficiency of medical coding by providing a more detailed and comprehensive description of diseases, injuries, and other health conditions.

The new ICD-10 codes are expected to result in significant savings for Medicare and Medicaid, as well as for private health insurers.

The delay will also provide more time for the government to develop and test the new ICD-10 coding system, which is designed to improve the accuracy and efficiency of medical coding.
What Have YOU Done So Far?

- 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/ICD10/ICD-10-Industry-Email-List.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 5.00 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 billing supplier and find out their plans and timelines for ICD-10 transition.
- Make a list of all vendors and contact them to verify their software vendor and find out their plans and timelines for ICD-10 transition.
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- Based on your findings so far, update and revise 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.
- Confirm that your Medicare Administrative Carrier (MAC) has updated the Local Coverage Determination (LCD) for chiropractic. It should contain the ICD-10 codes and coding guidelines for billing Medicare. Print this out and review it at a glance. Schedule a consultation with KMC, if necessary, to review how these new codes will affect your practice.
- Ensure that your software can handle both ICD-9 and ICD-10 codes as necessary, as it’s possible that Patient Injury and Workers’ Compensation claims will continue to use ICD-9 codes as well as coded using ICD-10 codes.
- Continue contributing to your recommended savings plan to protect your practice in case there are disruptions to the revenue cycle that delay billing payments during the first quarter of 2015.
- Identify the carriers you most commonly deal with. Review and download new payer Medical Necessity Policy from the website containing updates for ICD-10. Pay close attention to the codes used most frequently in your practice. Make necessary changes to documentation and coding practices to comply with the updated ICD-10 policy.

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!

ICD-9 to ICD-10 Mapping Possibilities

- Exact Match: One ICD-9 Code = One ICD-10 Code
- Approximate Match: One ICD-9 Code = Similar ICD-10 Codes
- Combination Match: Two ICD-9 Codes = One ICD-10 Code

* Difference is more specific in ICD-10
** In combination e.g. fractures, with coding
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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>M54.14</td>
<td>Radiculopathy, thoracic region</td>
</tr>
<tr>
<td>M54.15</td>
<td>Radiculopathy, thoracolumbar region</td>
</tr>
<tr>
<td>M54.16</td>
<td>Radiculopathy, lumbar region</td>
</tr>
<tr>
<td>M54.17</td>
<td>Radiculopathy, lumbosacral region</td>
</tr>
<tr>
<td>M54.18</td>
<td>Radiculopathy, sacral and sacrococcygeal region</td>
</tr>
</tbody>
</table>

Combination Mapping

724.3 Sciatica  →  724.3 Sciatica

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M54.30</td>
<td>Sciatica, unspecified side</td>
</tr>
<tr>
<td>M54.31</td>
<td>Sciatica, right side</td>
</tr>
<tr>
<td>M54.32</td>
<td>Sciatica, left side</td>
</tr>
</tbody>
</table>

OR

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M54.40</td>
<td>Sciatica with lumbago, unspecified</td>
</tr>
<tr>
<td>M54.41</td>
<td>Sciatica with lumbago, right side</td>
</tr>
<tr>
<td>M54.42</td>
<td>Sciatica with lumbago, left side</td>
</tr>
</tbody>
</table>

Conversion Tools

Conversion Tools

ICD10Data.com

Convert ICD-9-CM 729.1 to ICD-10-CM

ICD-9-CM 729.1 converts approximately to:
- 2015 ICD-10-CM M88.0 Mynest, unspecified
- 2015 ICD-10-CM M86.1 Myalgia
- 2015 ICD-10-CM M78.7 Fibromyalgia
Let’s Review

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

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 21 of them from A to Z

Body system or condition

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.)
ICD-10: The Magic 7th Digit

A, D or S??

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

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 taking the patient for the first time. The character A, Initial encounter, is used while the patient is receiving active treatment for the condition. Examples of active treatment are: evaluation and continuing treatment by the same or a different physician.”

So sayeth ACA, Chiro Code, and KMC University
What's an Encounter?

We can look at 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 event (e.g., new patient, established patient) — and it is important to look at this from the perspective of the patient's condition when choosing the most appropriate 5th character rather than from the perspective of type of visit.

In regard to a subsequent encounter, the guideline is that any subsequent encounter is used for encounters after the patient has received active treatment. The condition is receiving routine care for the condition during the healing or recovery phase. Therefore, once the patient is no longer receiving active treatment, and all other codes that would normally be assigned to the condition have been considered the healing or recovery phase. And that time, the provider would communicate this change in the patient's condition to the payer, by dropping the seventh character 'K' and replacing it with the character 'D' on that diagnosis code.

847.0 Sprains and strains; Neck (whiplash injury)
$13.4xx_ Sprain of ligaments of cervical spine ** §$ $13.8xx_ Sprain of joints and ligaments of other part of neck ** §$ $16.1xx_ Strain of muscle, fascia, and tendon at neck level ** §$

847.1 Sprains and strains, Thoracic

$23.3xx_ Sprain of ligaments of thoracic spine ** §$
$23.8xx_ Sprain of other specified parts of thorax ** §$
$29.01x_ Strain of muscle or tendon of thorax ** §$

847.2 Sprains and strains, Lumbar

847.3 Sprains and strains, Sacrum

$33.5xx_ Sprain of ligaments of lumbar spine ** §$
$39.01_ Strain of muscle, fascia and tendon of abdomen, lower back and pelvis ** §$
$33.8xx_ Sprain of sacroiliac joint ** §$
$33.8xx_ Sprain of both parts of lumbar spine and pelvis ** §$
$39.01_ Strain of muscle, fascia and tendon of abdomen, lower back and pelvis ** §$

847.1 Sprains and strains, Thoracic

$23.3xx_ Sprain of ligaments of thoracic spine ** §$
$23.8xx_ Sprain of other specified parts of thorax ** §$
$29.01x_ Strain of muscle or tendon of thorax ** §$
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

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 code excluded should never be used at the same time as the code above the Excludes 1 note. 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 condition excluded 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.

Read the Instructions!

723.1 Cervicalgia = M54.2

More Significant than Cervicalgia Alone

847.0 = S13.4XXX
S16.1 = Strain

S16 Injury to fascia, tendon and muscle at neck level
Code Analysis: Strain at neck level

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S16.1</td>
<td>Strain of muscle, fascia and tendon at neck level, initial encounter</td>
</tr>
<tr>
<td>S16.1X</td>
<td>Strain of muscle, fascia and tendon at neck level, acute onset</td>
</tr>
<tr>
<td>S16.1XX</td>
<td>Strain of muscle, fascia and tendon at neck level, sequelae</td>
</tr>
</tbody>
</table>

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

724.4 - Lumbosacral IVD, w/Radiculopathy

M81.1 - Intervertebral disc disorder with radiculopathy, lumbosacral region

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M81.1</td>
<td>Intervertebral disc disorder, lumbar (M81.1)</td>
</tr>
<tr>
<td>M81.2</td>
<td>Intervertebral disc disorder, sacral (M81.2)</td>
</tr>
<tr>
<td>M81.3</td>
<td>Intervertebral disc disorder, unspecified (M81.3)</td>
</tr>
</tbody>
</table>

Note(s):

- The anatomical subcode following the code for the musculoskeletal condition, if applicable, to identify the cause of the musculoskeletal condition.
- Codes for musculoskeletal conditions and the associated radicular symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (M81-M84).

Why Is Documentation So Important?

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- Because...if it wasn’t written down, it didn’t happen!
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 back pain; denial says that the claim is denied because sleeping is an activity of daily living.

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 causes 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 national 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 these 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

Chapter 20: External causes of morbidity (V00-Y99) (New Guidelines)

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>X00.XX-X99.XX</td>
<td>X00-X99 Accidents [X00-X99]</td>
</tr>
<tr>
<td>X10.XX-XX3.XX</td>
<td>X10-X33 Intentional self harm [X10-X33]</td>
</tr>
<tr>
<td>X40.XX-X49.XX</td>
<td>X40-X49 Assault [X40-X49]</td>
</tr>
<tr>
<td>Y10.YX-YS3.XX</td>
<td>Y10-YS3 Event of undetermined intent [Y10-YS3]</td>
</tr>
<tr>
<td>Y23.XY-YS2.XY</td>
<td>Y23-YS2 Legal intervention, operations of war, military operations, and terrorism [Y23-YS2]</td>
</tr>
<tr>
<td>Y92.0-YS9.9</td>
<td>Y92-YS9 Supplementary factors related to causes of morbidity classified elsewhere [Y92-YS9]</td>
</tr>
</tbody>
</table>

V00-V89 Transport accidents (V00-V89)

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V00.X0-09.X0</td>
<td>V00-V09 Pedestrian injured in road traffic accident [V00-V09]</td>
</tr>
<tr>
<td>V10.X0-29.X0</td>
<td>V10-V29 Pedestrian injured in road traffic accident [V10-V29]</td>
</tr>
<tr>
<td>V30.X0-49.X0</td>
<td>V30-V49 Motor vehicle injured in road traffic accident [V30-V49]</td>
</tr>
<tr>
<td>V40.XX-59.X0</td>
<td>V40-V59 Car occupant injured in road traffic accident [V40-V59]</td>
</tr>
<tr>
<td>V50.XX-69.X0</td>
<td>V50-V69 Car occupant injured in road traffic accident [V50-V69]</td>
</tr>
<tr>
<td>V80.XX-99.X0</td>
<td>V80-V99 Occupant of heavy transport vehicle injured in traffic accident [V80-V99]</td>
</tr>
<tr>
<td>Y00.XX-YS9.XX</td>
<td>Y00-YS9 Supplementary factors related to causes of morbidity classified elsewhere [Y00-YS9]</td>
</tr>
</tbody>
</table>
Good Documentation Tells a Story

Medical Review Policies

Aetna

BCBS

Clinical Policy Bulletin
Chiropractic Services

Spinal Sites

The following terms are used to classify spinal sites: occipital, cervical, thoracic, lumbar, sacral. Each term is followed by a numeric code representing the specific site.

- Occipital
- Cervical (C1-C7)
- Thoracic (T1-T12)
- Lumbar (L1-L5)
- Sacral (S1-S5)
- Croup

ICD-10 Documentation Reference Tool

ICD-10 codes must be chosen based on the most accurate and complete documentation. The codes should be chosen based on the specific condition documented.

FACT SHEET

FACT SHEET

ICD-10 Documentation Reference Tool

ICD-10 codes must be chosen based on the most accurate and complete documentation. The codes should be chosen based on the specific condition documented.
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

ICD-9 DX Coding

Novitas Medicare LCD Diagnosis List

Short Term (approximately 12 treatments)
• 723-724 Back Pain
• 728.85- Spasm of Muscle

Moderate Term (approximately 18 treatments)
• 720.1 Enthesopathy
• 721 Cervical Spondylosis
• 846-7 Sprains

Moderate-Long Term (approximately 24 treatments)
• 723.0 Stenosis
• 353 Nerve Root and Plexus Disorders

Long Term (approximately 30 treatments)
• 722 Degeneration of Intervertebral disc
• 724.3 Sciatica
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

Super CAs will Contribute at a High Level

FindACode.com

www.findacode.com
By August 2015:

- You need to start using the ICD-10 codes for procedures. For new patients, new conditions, and new services, begin using both ICD-9 and ICD-10 codes in the chart, but do not bill with ICD-10 codes until trained to do so. Make sure you reach out to KMC University or your vendor to consult with you and review these changes.

- Make sure that your software is up to date with the new ICD-10 codes and that your systems and processes are understood. Continuous ongoing internal training programs for doctors and staff members are needed.

An important detail: step-by-step actions will be necessary within the three-month period preceding the first documentation and claims submissions in October 2015. Because of this, KMC University is committed to continually updating this timeline and will update the details necessary to help you cross the finish line in October, exclusive of your path to ICD-10 proficiency. Check back with us for updated Fast Sheets as we approach the deadline. In the meantime, thank you for allowing us to assist you with your ICD-10 transition process.

The Finish Line Looks Good From Here!

Need help? info@kmcuniversity.com

ICD-10 Intervention!

Time is running out! Get step-by-step ICD-10 training paired with an expert to help keep you on track.

Call us to learn more! (855) 832-6562

Need help? info@kmcuniversity.com