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On the topic:
Understanding the ICD-10-CM Guidelines
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Understanding the ICD-10-CM Guidelines

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OFFICIAL CONVENTIONS

- **Format** – The ICD-10-CM book is divided into an alphabetical index and a tabular list. In ICD-10, to code correctly it is imperative to use both the alphabetical index and the tabular list.

- **Characters** - An ICD-10-CM code can be complete at either the three, four, five, six or seven digit level. Some codes will not expand past three digits. It may be necessary to use a place holder X if the code ends at four, five or six digits and a 7th character is needed.
OFFICIAL CONVENTIONS

• Punctuation and Abbreviations
  ▪ Brackets are used to either enclose synonyms or to identify manifestation codes.
  ▪ Parentheses enclose supplemental words that may or may not affect a code.
  ▪ Colons are used in the tabular list to identify an incomplete term.
  ▪ Abbreviations NOS (not otherwise specified) and NEC (not elsewhere classified) aid in coding to help choose the appropriate digits.

• Excludes and Includes notes
  ▪ Includes notes in the tabular listing mean that the code is included in that section.
  ▪ Excludes notes are very important to note because of how some of our commercial insurance carriers are interpreting these.
    ▪ Excludes 1 means not coded here.
    ▪ Excludes 2 means that although not usually included there may be two codes needed to fully describe the condition.
OFFICIAL CONVENTIONS

• **Note** – This term appears only in the tabular list and gives additional information for correct coding.

• These are all important terms:
  - “And” is interpreted to mean “and” or “or”;
  - “With” should be interpreted to mean “associated with” or “due to”
  - “See” and “See also” direct you to different parts of the book for additional information
  - “Code first” and “Use Additional” are in the tabular list. These informational notes guide you through the correct coding sequence. These are what your insurance carriers are paying close attention to.

ADDITIONAL ANNOTATIONS

• **Color coding symbols** – identify new and revised codes or additional character requirements

• **Age and sex edits** – identify codes used specifically for male or female or certain age groups

• **Medicare code edits** – identify codes that may require additional research to see if covered by Medicare

• **Manifestation codes** – identify codes that are caused by something and should not be used as a first listed code

• **Medicare Advantage Risk Adjustment Edits/HCC** – identify diagnosis codes that fall into a Hierarchical Coding Category and must be coded correctly for a risk adjustment model.
OTHER GUIDELINES TO CONSIDER

• **Level of Detail** – there is much more detail so it is important to code based on the documentation in the medical record.

• **Signs and Symptoms** – you may code using a sign or symptom if there is not a definitive diagnosis. You may or may not need to include signs and symptoms depending on whether or not the sign or symptom is an integral part of the diagnosis.

• **Acute and Chronic Conditions** – if there is a combination code for an acute and chronic condition, that is the code that should be utilized. If not, then code both listing the acute condition as the primary code.

OTHER GUIDELINES TO CONSIDER

• **Combination codes** – this is utilizing one code to document two conditions

• **Sequela/Late Effects** – these codes are utilized when the causal condition has terminated and these residual effects are what is being treated

• **Laterality** – when there is not a listing for a bilateral code both right and left must be coded if the condition is stated to be bilateral
CHAPTER SPECIFIC GUIDELINES

• It is IMPROPER CODING to NOT utilize the CHAPTER SPECIFIC GUIDELINES!

• These guidelines are broken down by each chapter to guide you through coding of specific conditions. Not all conditions from that organ system will need specific guidance.

• Sequencing of certain diagnoses that involve other conditions or manifestations are also listed.

• These guidelines also help to guide you through any additional coding as needed for that specific body system.

CHAPTER SPECIFIC GUIDELINES

Chapter 1 – Infectious and Parasitic Diseases

• HIV – code only confirmed cases
  • B20 – HIV positive with symptoms
  • Z21 – HIV positive without symptoms
  • 098.7 – Pregnancy that is effected by HIV that is positive
  • Z11.4 – Screening for HIV
  • Z71.7 – Counseling for HIV

• Infectious Agents as the cause of the Disease – use only as a secondary code
  • B95-B97 use as a secondary code to identify the type of infectious agent causing the infection when a combination code is not listed

• Sepsis, Severe Sepsis, Septic Shock – first you must know the type of sepsis
  • Sepsis means infection in the blood, severe sepsis means that there is now organ failure and septic shock means that the patient is in circulator failure
  • Sepsis may be a combination code that identifies the infection
CHAPTER SPECIFIC GUIDELINES

Chapter 1 – Infectious and Parasitic Diseases

• Severe Sepsis – to code properly you will need to identify the infection, R65.2_ for the severe sepsis, and then the organ that is failing.

• Circulatory or Septic Shock is identified by the last digit of R65.2_.

• MRSA/MSSA – most of these codes will utilize a combination code; however there are times when you will need to add on code B95.62 to identify that the infection is caused by MRSA.

• Zika Virus – Code only a confirmed diagnosis.

CHAPTER SPECIFIC GUIDELINES

Chapter 2 – Neoplasms

• Type of Cancer – is it Malignant or Benign?

• Malignancies should be defined as Primary, Secondary or In Situ

• Try to avoid uncertain or unspecified codes (it is better to wait on the pathology report)

• Identify which cancer is being treated today; that is coded first even if it is a secondary cancer

• Identify if the patient is only in for chemotherapy, radiation, etc.

• Identify if the cancer is still active or should be coded to History of.
CHAPTER SPECIFIC
GUIDELINES

Chapter 4 – Endocrinology

• This chapter guideline is devoted entirely to the correct coding of Diabetes Mellitus.

• Type of DM:
  ▪ Primary - Juvenile or Adult Onset – can be coded as a first listed diagnosis (Categories E10 and E11)
  ▪ Secondary – Caused by a disease, drug or NEC – should be coded as a Secondary code after the cause (Categories E08-E13)

• What type of treatment is used? Insulin long term use or Oral drugs also need a code from the Z79 section.

CHAPTER SPECIFIC
GUIDELINES

Chapter 9 – Circulatory System

• Hypertension (HTN)
  – Identify whether the HTN is benign, malignant, essential (Category I10)
  – HTN that has manifested into Heart Disease and/or Kidney Disease will require two codes for accuracy
    ▪ HTN with Heart Disease is coded to Category I11 with an additional code to identify the type of Heart Disease or Failure
    ▪ HTN with Kidney Disease is coded to Category I12 with an additional code to identify the stage of Kidney Disease
    ▪ HTN with both is coded to Category I13 with additional codes to identify the Heart Disease and stage of Kidney Disease
  – It should also be documented and coded the smoking status or exposure of the patient
CHAPTER SPECIFIC GUIDELINES

Chapter 9 – Circulatory System

• Myocardial Infarction
  – The acute phase of a myocardial infarction is four weeks (Code I21). During this four weeks, if the patient has another MI it should be coded to a subsequent MI (Code I22).
  – Documentation and Coding should identify the site of the infarction.
  – Old Healed MI should be coded to I25.2

• Cerebrovascular Disease
  – These categories are not used for Trauma that has caused the CVD. This is used for spontaneous or disease related types of CVD.
  – Once the acute phase has ended then code as History of CVD unless there are late effects or sequela and those are coded from the I69 section.

Chapter 10 – Respiratory System

• Many of the codes from this section may be documented as acute or chronic. The rules for using either a combination code vs. an acute or chronic code or codes will need to be followed.

• Documentation may also need to show smoking history or exposure.

Chapter 12 – Skin and Subcutaneous Tissue

• Pressure and Non-Pressure Ulcers coded from this section will need to document the stage of the ulcer
CHAPTER SPECIFIC GUIDELINES

Chapter 13 – Musculoskeletal System

- Things to consider for this section include:
  - Site and laterality
  - Bone versus joint
  - Are pathological fractures involved?
  - Osteoporosis with or without fracture

Chapter 15 – Pregnancy, Childbirth and the Puerperium

- Codes from this section should include the trimester as well as the weeks of gestation. Information to identify this is found at the beginning of the tabular listings.

- When a delivery occurs there should also be a code listed for the outcome of the delivery (Code Z37)

- Codes from Chapter 15 trump all other code sections so if there are pre-existing conditions from other chapters, there will be an “O” code from chapter 15 listed first followed by the sequencing from other chapters.

- It is also noted that codes from this section are only used on the mother’s record and never on the newborn record.
CHAPTER SPECIFIC GUIDELINES
Chapters 19 and 20 – Injury, Poisoning and External Cause

• These chapters are jointly used due to the injury or poisoning having some type of external cause.
• Coding of fractures, burns and other injuries are coded separately in order of severity.
• Many of the codes from Chapter 19 will require a 7th character to identify the phase of the visit. Is the injury still in the acute phase, subsequent or is this visit for a late effect of the injury?
• Fractures will require a 7th character to describe the healing phase.

CHAPTER SPECIFIC GUIDELINES
Chapters 19 and 20 – Injury, Poisoning and External Cause

• Burns will need to be documented as either thermal or corrosives
• Poisonings are coded from the Table of Drugs and Chemicals and will need to be coded to include the cause.
• Documentation should include the facts surrounding the injury:
  – Injury – coded from the S-T codes Alphabetic Index
    • Then from the External Cause Section of the ICD-10 Book Code:
      – How it happened: coded from the T-Y codes
      – Where it happened: coded from the Place of Occurrence section Y92.
      – What activity was the patient involved in when it happened: coded from Y93. section
      – The status of the patient: coded from the Y99. section
CHAPTER SPECIFIC GUIDELINES

Chapter 21 – Factors Influencing health status and contact with health service

- Categories in this section of the book include:
  - Contact/Exposure – to communicable diseases
  - Inoculations and vaccinations – routine vaccines
  - Status – includes acquired absence of organs or organ transplant status, allergy status and long term drug tx
  - History (of) – both personal and family history of diseases
  - Screening – for suspected conditions or routine age-related illness or disease
  - Observation – for suspected conditions
  - Aftercare – during the recovery phase
  - Follow-up – visits for continuing surveillance following completed treatment
  - Donor – donors of organs or tissues by live individuals
  - Counseling – for aftermath of illness or injury
  - Reproductive Encounters – Encounters for supervision of pregnancy or family planning
  - Newborns and Infants encounter exam – Encounters for routine exams or to record the birth of the baby
  - Routine and Administrative exams – Encounters for routine annual physicals or a special administrative exam
  - Miscellaneous Z codes - other healthcare encounters

WRAP UP SUMMARY

Four reasons to use our guidelines:

1. Our insurance carriers are becoming more savvy to the chapter specific guidelines and we MUST become familiar as well.
2. Many claims are denied that are payable claims due to not following the ICD-10-CM guidelines.
3. Medicare Advantage Plan audits are checking to see if we are following the Chapter specific guidelines and may recoup payments.
4. HCC coding is dependent on following the guidelines and payment for using these codes may be withheld if not followed.
Questions? Comments? Clarification?

Thank you for your attendance today. I hope that you found this information useful and informative.

QUESTIONS

- What are includes and excludes notes?
- What do the abbreviations “nec” and “nos” mean?
- How are acute and chronic conditions documented and coded?
- How do we code laterality?
- When do we use signs and symptoms codes?
- Where can information be found about coding from body systems?
ANSWERS

• Includes notes mean these are the terms for which the code is used
• Not elsewhere classified and not otherwise specified
• Acute and chronic conditions are coded with a combination code unless one does not exist. If one does not exist then code the acute condition first followed by the code for the chronic condition.
• Laterality codes can be coded as bilateral if the code exists. If not, then they should be listed separately identifying both the Right and Left sides of the body.

ANSWERS

• Signs and symptoms may be used if there is no definitive diagnosis made for the visit. They may also be added to the definitive diagnosis if they are not considered an integral part of the diagnosis.
• In the chapter specific guidelines!
Questions?

• Thank you for your attendance!

• Get your questions answered on PMI's Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp