ICD-10 Essentials *for* Long-Term Care

Your Guide to Preparation and Implementation

Karen L. Fabrizio, RHIA, CPRA

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About the Author

Karen L. Fabrizio, RHIA, CPRA, is a highly regarded health information professional with 25 years of experience. She has worked in many sectors, including acute care, long-term care, education, and consulting, and as a public speaker.

Fabrizio is currently the medical record administrator and HIPAA privacy and security officer at Van Duyn Home and Hospital, a 513-bed skilled nursing facility in Syracuse, N.Y. She is the system administrator for the electronic medical record (EMR) that was implemented in 2009, and actively participates in software development reviews. Fabrizio is active in the EMR user group, giving guidance to other users, and has served as a consultant for several nursing homes in New York and across the country, reviewing case mix and Minimum Data Set data. She is a member of HCPro's Certified Professional in Resident Assessment advisory committee.

Fabrizio has been an adjunct instructor at Onondaga Community College in Syracuse for more than 24 years and has taught all of the courses in the Health Information Technology program. Her first teaching experience was as a teacher's assistant at Ithaca College, teaching ICD-9-CM coding. She realized her love of coding and teaching during that semester and continues to teach, having recently transitioned from the traditional face-to-face classroom into the virtual classroom, teaching four online courses. Fabrizio promotes professional growth to her many students and encourages them to get involved.

She is the 2011–2012 president of the New York Health Information Management Association (NYHIMA), has participated in NYHIMA's Education Committee, and was the 2010 NYHIMA Annual Conference Co-Chairperson. Fabrizio contributed to the NYHIMA's Long-Term Care Coding Guidelines Updates and participated in the American Health Information Management Association's (AHIMA) EMR request-for-proposal taskforce. She is currently a member of the Virtual Lab Advisory Committee and the Professional Practice Experience

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Guide development team for AHIMA. Fabrizio is an AHIMA Action Community for Excellence member and mentor, and has been an AHIMA delegate, participating in the organization's Hill Day on Capitol Hill in Washington, D.C. She was recognized as NYHIMA's Distinguished Member in 2010.

Fabrizio is a graduate of Ithaca College and is currently pursuing her MBA in health services administration at State University of New York (SUNY) Institute of Technology in Utica, N.Y. Her favorite quote exemplifies her philosophy toward others: "If you see someone without a smile, give them one of yours."

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Acronym Guide

700	CMS form: Plan of Treatment for Outpatient Rehab
701	CMS form: Updated Plan of Progress for Outpatient Rehab
1500	CMS health insurance claim form
5010	Electronic Transaction Standard 5010
ABN	advance beneficiary notice
AHA	American Hospital Association
AHIMA	American Health Information Management Association
ARD	assessment reference date
BBA	Balanced Budget Act of 1997 (PL 105-33)
CAA	care area assessment
CASPER	Certification and Survey Provider Enhanced Reporting
CCP	comprehensive care plan
CDC	Centers for Disease Control and Prevention
C&M	ICD-9-CM Coordination and Maintenance Committee
CMS	Centers for Medicare & Medicaid Services
COPs	*Conditions of Participation* (Medicare)
DME	durable medical equipment
E&M	evaluation and management
FI	fiscal intermediary
FSS	fee for service
FY	fiscal year
HCPCS	Healthcare Common Procedure Coding System

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HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPPS	Health Insurance Prospective Payment System
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
LTC	long-term care
MAC	Medicare Administrative Contractor
MDS	Minimum Data Set
NCHS	National Center for Health Statistics
NQF	National Quality Forum
OBQI	outcome-based quality improvement
OBQM	outcome-based quality management
OIG	Office of Inspector General
OT	occupational therapist
PEP	partial episode payment
PI	performance improvement
POC	plan of care
PPS	prospective payment system
PT	physical therapist
QI	quality indicator
QIO	quality improvement organizations
QM	quality measures
RAC	Recovery Audit Contractor
RAI	Resident Assessment Instrument
RAVEN	Resident Assessment Validation and Entry
RBRVS	Resource-based Relative Value Scale
RUGs	Resource Utilization Groups
SOC	start of care
SLP	speech language pathologist
SNF	skilled nursing facility
UB-04	Uniform Bill 04

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DOWNLOAD YOUR MATERIALS NOW

ICD-10 Essentials for Long-Term Care will assist your facility staff in understanding the basics of ICD-10-CM and the specifics of long-term care coding. To download figures, forms, and tools that will further this understanding, visit the website below.

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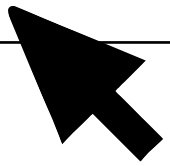

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CHAPTER 1

Introduction

Proper ICD-10-CM coding is essential for accurate case-mix management and statistical analysis. ICD-10-CM coding is based on a classification system that assigns a numeric code that describes a patient's various diseases, injuries, and procedures.

The World Health Organization issues ICD codes and the Centers for Medicare & Medicaid Services (CMS) publishes updates on a biannual basis. Long-term care regulations mandate the identification of the primary diagnosis and other pertinent diagnoses on the Minimum Data Set (MDS). Primary and secondary diagnoses are required fields on all insurance claim forms, including the CMS-1500 for billing of professional services and the UB-04 for billing of Medicare claims.

The purpose of this guide is to assist skilled nursing facility (SNF) staff in understanding the basics of the ICD-10-CM and the specifics of long-term care coding. The goal is to provide an introduction and overview of the common diagnoses used in the industry today to establish the framework for planning and preparing for the transition to ICD-10-CM. *ICD-10 Essentials for Long-Term Care: Your Guide to Preparation and Implementation* is divided into three parts:

- **Part I: Understanding the Fundamentals of ICD-10-CM Coding.** This section of the book encompasses Chapters 1–6 and addresses the basics of ICD-10 coding, provides a historical perspective on coding, and takes the reader through the critical steps in learning how to code.

- **Part II: Long-Term Care Specifics: What You Need to Know.** This part, which includes Chapters 7–13, teaches the specifics of coding correctly in a SNF and the documentation required for accurate coding.

- **Part III: ICD-10-CM Preparation and Implementation.** The final section, Chapters 14–20, reviews the extensive step-by-step preparation needed to be ready for ICD-10. Each key department is represented, as well as the issues facing that area.

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The main benefits to adequate preparation are correct coding for services rendered and compliance with local, state, and federal guidelines. Two secondary benefits to learning the correct way to code include accurate data collection for research and outcomes management and interoperability among electronic health records. Reimbursement from the Medicare benefit is paid under a prospective payment model. Payment categories, called Resource Utilization Groups (RUG), use the MDS assessment as the primary data collection tool. Incorrect coding can result in a change in RUG score, affecting resident-specific reimbursement and causing incorrect calculation of a facility's case mix.

Understanding the fundamentals of accurate coding with ICD-10-CM will allow for decreased turnaround time for claims and ensure continued interoperability among current electronic record interfaces for resident care. Planning now for the major change to ICD-10-CM coding will provide SNFs with the foundation needed for a smooth and successful transition.

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CHAPTER

2 The Origins of ICD Coding

ICD-10 is an acronym for the International Classification of Diseases, 10th Revision. ICD is an international classification system first endorsed by the World Health Organization (WHO) in 1990. WHO members began using it in 1994. ICD-10 has been drafted to code and classify mortality data from death certificates since 1999. In 2009, the U.S. Department of Health and Human Services (HHS) published a final rule requiring the replacement of ICD-9-CM with ICD-10-CM effective October 1, 2013. The "CM" in ICD-9-CM stands for *clinical modification*, which further defines diagnoses that have been modified from the original WHO version to better adapt to the practice of medicine in the United States. Some of the modifications made include expanded injury codes, the addition of the sixth and seventh characters, and laterality.

Editor's note: As stated above, ICD-10-CM was originally slated for implementation October 1, 2013. In February 2012, HHS announced that it was considering an implementation delay. Reasons for the delay stem from concerns expressed by provider groups about their ability to meet the October 1, 2013 compliance date. The concerns are based on their experience meeting HHS compliance deadlines for the Version 5010 standards for electronic healthcare transactions. Compliance with Version 5010 is a prerequisite for implementation of ICD-10.

On April 17, 2012, HHS published a proposed rule that would delay the ICD-10-CM compliance date to October 1, 2014. The ICD-10 compliance date change is part of a proposed rule that would adopt a standard for a unique health plan idetifier (HPID) and a data element that would serve as an "other entity" identifier (OEID), and add a National Provider Identifier (NPI) requirement.

Source: www.cms.gov/apps/media/press/factsheet.asp

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Historical Perspective

The ICD was developed in 1893 to collect data on causes of death. Its initial purpose was to systematically report, analyze, and interpret medical data. The ICD provides a standardization of mortality and morbidity information. The WHO revises the ICD classification system approximately every 10 years.

The United States is required to use ICD under an agreement with the WHO. ICD-9 was developed in the 1970s and implemented in 1979. Today, with advances in modern medicine, many of the new procedures and clinical concepts in medicine are not captured correctly in the ICD-9 system. ICD-9's structure limits the expansion and addition of new codes as our healthcare system improves with diagnosis specificity and technological advances. The WHO has made major revisions to the ICD and no longer supports ICD-9.

The next generation of codes, ICD-10, has been implemented by Australia, Asia, Canada, and most of Europe. ICD-10 is designed to provide a more accurate accounting of today's practice of medicine. It also is better suited for today's electronic environment. The system enables the sharing of public health data with 99 other countries. ICD-10 is available in 36 languages including Arabic, Chinese, English, French, Russian, and Spanish.

Since 1999, mortality data has been reported in ICD-10 format, which also supports quality outcomes. In addition, ICD-10 is used to help improve patient safety activities and to provide a more accurate form of reimbursement.

By providing more specificity, ICD-10 also improves the public health data collection system for reporting vital health statistics and identifying public health concerns. Further, it is a useful tool for monitoring bioterrorism, as well as for monitoring compliance with government regulations by reporting data for quality and cost-effectiveness.

The United States is implementing a conversion to ICD-10-CM (diagnoses) and ICD-10-PCS (procedures) as of October 1, 2014. The ICD-10 manual is available for viewing on the Centers for Disease Control and Prevention (CDC) website at *www.cdc.gov/nchs/icd/icd10cm.htm*. It is important to note that ICD-10-PCS will be used in inpatient hospital settings only. The transition to ICD-10 does not affect Current Procedural Terminology (CPT) coding for outpatient procedures. Skilled nursing facilities (SNF) submitting Medicare Part B claims will continue to use CPT/Healthcare Common Procedure Coding System for professional services, procedures, and immunizations.

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Diagnostic coding became mandatory for all Medicare claims after the passage of the Medicare Catastrophic Coverage Act of 1988. Medicaid and private insurance carriers followed suit and also began requiring diagnostic coding on all billing forms. The Health Insurance Portability and Accountability Act of 1996 requires all providers and payers of healthcare services to use standard forms and codes for all claims. In order for ICD-10-CM codes to be accepted, all vendors/payers must upgrade their electronic claims transaction standard to Version 5010. Providers were required to test and begin submitting claims using the 5010 transaction standard as of January 1, 2012. If providers did not comply with this mandate, they faced problems with claims submission, eligibility inquiries, and remittance advice information.

The original purpose of ICD—to provide classification for morbidity and mortality information for statistical purposes—has been far surpassed. Now the functions of ICD include research, case-mix identification, reimbursement, and outcome measurement.

Why ICD-10?

An upgrade of the coding classification system was needed because ICD-9 has become outdated. Under ICD-9, codes for new technologies, procedures, and even diagnostic specificity are not detailed enough to capture the necessary data. ICD-10-CM also is consistent with other classification systems, including the *Diagnostic and Statistical Manual for Mental Disorders* and International Classification of Diseases for Oncology, which is used by tumor registry programs as well as nursing classification systems.

A coding system needs to have flexibility to add emerging diagnoses and procedures, and to capture accurate diagnoses for quality and reimbursement purposes. One area that ICD-9-CM does not capture is laterality. If a patient has bilateral fractures of the wrist, only one code to identify the fracture can be documented and coded. ICD-10-CM allows for both the fractures to be coded. ICD-10-CM will provide greater accuracy of diagnostic information through its increased specificity and increased number of code selections.

ICD-9-CM	814.00	Fracture wrist (bilateral not captured)
ICD-10-CM	S62.101A	Fracture of unspecified carpal bone, right wrist, initial encounter
	S62.102A	Fracture of unspecified carpal bone, left wrist, initial encounter

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ICD-10-CM also allows clarification about the episode of care. In the above example for fracture of the carpal bone, 814.00 does not indicate where the patient is in treatment of the fracture. In the ICD-10 example, the seventh digit, "A," indicates initial encounter for a closed fracture. SNFs will be able to use a seventh digit of "D" to show subsequent encounter for fracture with routine healing, while a seventh digit of a "G" indicates a subsequent encounter for fracture with delayed healing. The use of the seventh digit may help justify continued stay for residents in a SNF.

Benefits of ICD-10-CM

ICD-10-CM offers significant benefits over ICD-9-CM in the following areas:

- Ability to compare data internationally
- Compatibility with other classification systems
- Greater expansion of codes
- Identification of new diseases and injuries
- Identification of comprehensive codes for preventive services
- Greater specificity for more accurate claims
- Reduction in coding errors
- Decreased need to provide supporting documentation with claims
- Designed to suit an electronic environment
- Improved ability to measure quality and safety outcomes
- Improved public health surveillance data collection

Similarities between ICD-10-CM and ICD-9-CM

Certain structural components are the same in both systems:

- A hierarchal structure that gets more specific with more digits
- Conventions are similar:

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  - Brackets are used in the alphabetical index to represent manifestations
  - NOS means "not otherwise specified"
- Must code to the greater level of specificity
- Must look up a diagnosis in the alphabetical index and then verify it in the tabular list

Differences between ICD-10-CM and ICD-9-CM

ICD-10-CM offers greater specificity and several new features, including:

- Number of characters is expanded from five to seven
- Laterality is added (i.e., left, right)
- Dummy placeholder "x" allows for future expansion and allow for the code to add the seventh character, as needed:
  - Injuries, obstetrics, external causes
- Seventh character identifies encounter episode
- Fractures require knowing open, closed, healing status, and encounter to determine the seventh character
- Combination codes are used better for both the diagnosis and manifestation
- Diabetes section codes are separated by type I or type II
- ICD-9-CM injuries are grouped primarily by type of injury; in ICD-10-CM injuries are grouped primarily by body area
- "Postoperative complications" adds distinction between intraoperative complications and postprocedural disorders

ICD-10 coding updates

Every October, the Centers for Medicare & Medicaid Services (CMS) updates the official authorized addenda, which are then included in the ICD-10 coding manuals. This listing is

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available for download on the CDC website through the National Center for Health Statistics (NCHS). Even though ICD-10-CM is not active for claims management until October 1, 2014, annual updates, addenda, and guidelines have been published.

> *Note: CMS has stated there will be no grace period for the usage of ICD-10-CM. On September 30, 2014, coding will be performed using ICD-9-CM, and on October 1, 2014, all required coding will be performed using ICD-10-CM.*
>
> *This also means that all software programs must be able to convert data from ICD-9 to ICD-10 if necessary. See* www.cms.gov/ICD10/Downloads/Jan122011_ICD10_Call.pdf.

Two departments of the federal government's HHS—CMS and the NCHS—update the *ICD-9-CM Official Guidelines for Coding and Reporting*. The guidelines are approved by four organizations that make up the cooperating parties for ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS. Official questions for coding scenarios are answered in the *AHA Coding Clinic* magazine, which is published quarterly with the approval of the cooperating parties.

Changes and updates to the ICD-10-CM system are reviewed twice a year, in the spring and fall, through the ICD-9-CM Coordination and Maintenance Committee (C&M). The ICD-9-CM C&M is a federal interdepartmental committee composed of representatives from CMS and NCHS.

Suggestions for coding modifications may come from both public and private sectors. The ICD-9-CM C&M plays only an advisory role. The NCHS director makes all final decisions for diagnostic codes, and the CMS administrator has final approval for procedure codes.

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Final decisions that are made after the fall meeting usually take effect October 1 of the following year. An exception to this rule is the implementation of codes capturing new technology. Such new codes may be implemented after April 1.

ICD-11

The final draft of ICD-11 is scheduled for adoption in 2015 by the WHO. The first draft was released in July 2011 for public viewing and comments. Due to the structural differences between ICD-9 and ICD-11, it will be necessary to implement ICD-10 as a transitional step. The ICD-11 beta will not be released until after the ICD-10 compliance date of October 1, 2014.

Chapter Resources

AHA
www.aha.org

AHA Coding Clinic
www.ahacentraloffice.org/ahacentraloffice/index.html

AHIMA
www.ahima.org/icd10

CMS, ICD-10
www.cms.gov/ICD10

CMS
www.cms.gov

ICD-10-CM
www.cdc.gov/nchs/icd/icd10cm.htm

ICD-9-CM Coordination and Maintenance Committee
www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp

ICD-10-CM Official Guidelines for Coding and Reporting
www.cdc.gov/nchs/icd/icd10cm.htm

WHO
www.who.int/classifications/icd/en

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Karen L. Fabrizio, RHIA, CPRA

If ICD-10 implementation is not on your radar, it should be. To remain profitable and compliant under the new coding system, your facility must prepare now for the transition. Author Karen Fabrizio provides you with a three-step plan that takes you from understanding the differences between ICD-9 and ICD-10 to full-scale ICD-10 readiness at your facility with ***ICD-10 Essentials for Long-Term Care:*** *Your Guide to Preparation and Implementation.* You will learn the fundamentals of ICD-10 coding, what you can do today to manage the transition to ICD-10, and how to prepare for the impact on your daily operations.

Complete with a chronological, step-by-step ICD-10 implementation action plan for your entire facility, this book is the perfect primer to get you where you need to be in order to survive and thrive under ICD-10.

In this book, you will be able to:

- Implement simple procedural changes immediately to ease the burden of the transition in future months
- Familiarize your coders with the ICD-10 format to ensure a smooth transition during implementation
- Develop timelines to train clinicians in new documentation requirements
- Achieve leadership buy-in for the necessary budget, policy changes, and infrastructure upgrade to accommodate ICD-10 requirements
- Execute a step-by-step action plan throughout your facility to ensure timely ICD-10 readiness

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