

Second Edition

**The Clinical Documentation
Improvement Specialist's
Guide to ICD-10**

Jennifer Avery, CCS, CPC-H, CPC, CPC-I,
AHIMA-Approved ICD-10-CM/PCS Trainer

Cheryl Ericson, MS, RN, CCDS, CDIP,
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Contents

About the Authors	ix
Introduction	xi
Chapter 1: ICD-10-CM/PCS Primer.....	1
Benefits and Goals of ICD-10-CM/PCS	3
History and intent.....	3
ICD-10-CM/PCS benefits	4
American Applications.....	6
Code applications for payment purposes.....	7
DRGs.....	8
APR-DRGs.....	9
Medicare Severity DRGs.....	10
ICD-10-CM/PCS Compliance Dates	12
CDI Program Influence and Effect	14
Chapter 2: Coding Structure	19
The Alphabetic Index and Tabular List	21
ICD-10-CM Structure.....	23
Character definitions.....	24

CONTENTS

Identifying 7th character.....	24
Placeholder use.....	25
Incorporation of alpha characters.....	26
ICD-10-PCS Structure.....	27
Character definitions.....	31
Chapter 3: Documentation and Coding Guidelines	35
Coding Clinic.....	37
Assigning the Principal Diagnosis	38
Signs and symptoms as PDX	39
Additional Diagnoses	39
Combination codes	41
Includes notes.....	43
Excludes notes.....	44
Acute and chronic conditions.....	44
Manifestations	46
Use additional code.....	48
Multiple codes for a single condition.....	48
Not otherwise specified/not elsewhere classified.....	49
Chapter 4: Programmatic and Query Concerns.....	53
Query Requirements	55
Government guidance	56
Association advice.....	57
Leading queries.....	58
Yes/No queries	60
Drafting CDI and Query Policies	61
Mission and focus	62

CONTENTS

Staffing considerations	63
Query escalation process.....	65
Reconciliation processes	66
Query retention.....	67
Self assessment of CDI effectiveness.....	67
Chapter 5: Clinical Indicators for Coding	73
Acute Myocardial Infarction	75
Altered Mental Status	79
Encephalopathy.....	81
Glasgow Coma Scale.....	84
Anemia in Neoplastic Disease	87
Common causes of anemia in cancer patients.....	87
Anemia as adverse effect of therapy	89
Atherosclerotic Heart Disease	90
Diabetes	93
Fractures	96
Heart Failure.....	99
Right heart failure.....	100
Left-side heart failure.....	100
Systolic and diastolic.....	101
Additional classifications.....	103
Hypertension.....	104
Injuries.....	104
Adding the 7th.....	107
Burns.....	108
Malnutrition	108
Pneumonia	112

CONTENTS

Pneumonia types.....	112
Aspiration pneumonia.....	115
Ventilator-associated pneumonia.....	116
Poisoning, Adverse Effects, and Underdosing.....	117
Underdosing.....	117
Adverse effects and poisoning.....	118
Renal Failure.....	118
Acute renal disease.....	119
Chronic kidney disease.....	120
CKD associated with transplants.....	122
CKD with other conditions.....	122
Hypertensive CKD.....	122
Hypertensive heart and CKD.....	123
Respiratory System Diagnoses.....	123
Hypoxemia.....	125
Sepsis	127
Sequencing of severe sepsis.....	131
Sepsis and severe sepsis with a localized infection.....	131
Sepsis due to a postprocedural infection.....	131
Sepsis and severe sepsis associated with a noninfectious process (condition).....	132
Wound Diagnoses	133
Pressure ulcers.....	133
Nonpressure chronic ulcers.....	134

CONTENTS

Chapter 6: Engaging Support 139

Involvement at Implementation.....	142
Physician advisor insight.....	142
Query reviews.....	144
Query targets for ICD-10-CM/PCS.....	145
CDI/Coder Training Timelines.....	147
Additional educational efforts.....	150

Appendix

A: Sample Query Policy and Procedure	153
B: Sample Query Forms.....	159
C: Sample ICD-10-PCS Query Opportunities	167
D: Sample ICD-10 Implementation Timeline.....	171

Online Downloads

2013 <i>Draft Official Guidelines for Coding and Reporting</i>	
2010 CDI Program ICD-10 Implementation Benchmarking Report	
2013 CDI Program ICD-10 Implementation Benchmarking Report	
ICD-10-PCS Guidelines <i>Briefings on Coding Compliance Strategies</i> , February 2011	
Article: “Recap of <i>Coding Clinic</i> , 4th Quarter 2012”	
White Paper: “ICD-10-PCS Introduces Procedure Guidelines and Coder Confusion”	



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Ericson's speaking credits in the field of CDI include multiple presentations at the ACDIS national conference, the AHIMA's coding conference and national meeting, and the 2011 Medicare RAC Summit. Additional speaking credits include webinars for the University HealthSystem Consortium and HCPro on topics including physician queries, ICD-10, quality measures, and understanding the mortality index.



Introduction

The United Kingdom began using the ICD-10 code set back in 1995. Although numerous countries have made the switch, the United States had numerous setbacks when it came to implementation. The latest of these came in 2012 when Centers for Medicare & Medicaid Services (CMS) delayed the so-called “go-live” date from October 1, 2013, to October 1, 2014. Various publications, literature, and pronouncements from the agency insist, however, that there will be no more delays.

Facilities with clinical documentation improvement (CDI) programs already in place will be better prepared for the transition. CDI specialists (presumably) will already have provided information about the query process and have educated physicians about needed documentation for coding, quality, and other important measures. Well-established CDI programs already have query policies and processes. Many programs also have regular team meetings across departments to identify documentation improvement targets.

Those facilities that do not have CDI programs in place should seriously consider the potential benefits and costs of doing so. The ICD-9 Clinical Modification (CM) code set contained 24,000 codes. ICD-10-CM/ Procedure Coding System (PCS) contains more than 150,000. As we will discuss throughout *The Clinical Documentation Improvement Specialist’s Guide to ICD-10*, Second Edition, with this increase in codes come additional specificity—specificity which the treating physician must document within the patient’s medical record. Along with the new code sets come additional coding guidelines governing code sequencing, definitions for which diagnosis may be considered integral to another, and rules for coding the cause-and-effect relationship of a disease.

Physicians do not need to become coders; neither do CDI specialists. But CDI staff do need to understand the basic rules and coding conventions of ICD-10-CM/PCS to help capture the documentation needed for code assignment and chart completion.

INTRODUCTION

The time for ICD-10-CM/PCS preparation is now. Many facilities put their educational efforts on hold following the CMS implementation delay. Those that continued their efforts no doubt are already better prepared than their counterparts.

Facilities without CDI programs in place should start one. Those with programs should review their policies and procedures with an eye toward ICD-10-CM/PCS documentation improvement efforts. CDI specialists should begin learning about the new code set and requirements. This book offers a foundation, but additional resources should be obtained through newsletters, blogs, and industry guidance. CDI and coding staff should participate in facility planning and make sure that documentation improvement efforts are identified.

October 1, 2014, may seem like a long time from now. It isn't. Armed with the right information, however, CDI programs can use this time to proactively capture the appropriate documentation needed for a successful transition.

We wish you the best in your endeavors!

CHAPTER 1

ICD-10-CM/PCS Primer

ICD-10-CM/PCS Primer

Benefits and Goals of ICD-10-CM/PCS

On August 24, 2012, the U.S. Department of Health and Human Services (HHS) announced a one-year delay in its required implementation of the ICD-10 Clinical Modification (CM) and Procedural Classification System (PCS). It set a new deadline for October 1, 2014.¹

By most implementation timelines, facilities should have been well into their ICD-10-CM/PCS transitions by 2012. By many accounts, few actually were. According to a website poll from the Association of Clinical Documentation Improvement Specialists (ACDIS), 52% of respondents indicated they were relieved to have the one-year extension; 24% indicated that no one in their facility had received ICD-10-CM/PCS training.²

History and intent

The ICD code set is the global standard for reporting and categorizing diseases, health-related conditions, and external causes of disease and injury. Originally adopted by the International Statistical Institute at a meeting in Chicago in 1893, it was the first International List of Causes of Death (then called the Bertillon Classification of Causes of Death, after the chairman of that committee Jacques Bertillon, Chief of Statistical Services of the City of Paris).³

Committee members generally intended to revise the list every 10 years and, for the most part, did so at conferences in 1929, 1938, and 1948. At the International Health Conference in 1946, participating governments turned over maintenance of the list to the World Health Organization (WHO), which continued

CHAPTER 1

to craft updates in 1955, 1965, and 1975, with ICD-9 published in 1977. Although the ICD-10 was expected in 1989, publication was postponed.

“It had been realized that the great expansion in the use of the ICD necessitated a thorough rethinking of its structure and an effort to devise a stable and flexible classification system,” according to the history of ICD-10 from the WHO.⁴

Since the ICD-9 implementation, it became increasingly difficult to integrate new codes to accurately describe contemporary diseases, groundbreaking medical procedures, and other new technology. Although ICD-9 is used throughout the world, the United States created its own version, ICD-9-CM, and adapted it for reimbursement use as well. The United States is the only country to use the ICD system as part of its healthcare reimbursement, which accounts (in part) for the delay in implementing the 10th revision.

ICD-9-CM contained 24,000 codes. ICD-10-CM/PCS contains more than 150,000. (Chapter 2 discusses the differences in structure and format of the new code set.)

The 43rd World Health Assembly endorsed the ICD-10 in May 1990, and member states began implementation of the new codes in 1994.

ICD-10 IMPLEMENTATION DATES

- United Kingdom: 1995
- France: 1997
- Australia: 1998
- Germany: 2000
- Canada: 2001

The WHO is currently crafting the 11th revision, which it expects to release in 2015.

ICD-10-CM/PCS benefits

As one might suspect, additional codes provide additional specificity, frequently called “granularity,” to describe the condition and care of a given patient. Capturing such data, theoretically, can more accurately illustrate disease trends, lead to changes in the way healthcare is provided, and even help with clinical research.

ICD-10-CM/PCS PRIMER

Along with the “improved capture of healthcare information and more accurate reimbursement,” the American Hospital Association (AHA) lists the following benefits associated with the transition to ICD-10-CM/PCS:

- *Improved ability to measure healthcare services, including quality and safety data*
- *Augmented sensitivity when refining grouping and reimbursement methodologies*
- *Expanded ability to conduct public health surveillance*
- *Decreased need to include supporting documentation with claims*
- *Strengthened ability to distinguish advances in medicine and medical technology*
- *Enhanced detail on socioeconomic conditions, family relationships, ambulatory care conditions, problems related to lifestyle, and the results of screening tests*
- *Increased use of administrative data to evaluate medical processes and outcomes, to conduct bio-surveillance, and to support value-based purchasing initiatives*⁵

If ICD-10-CM/PCS is used to its full potential, it will provide greater detail and a more accurate depiction of patient severity. This level of detail is expected to provide more information about the relationship between a provider’s performance and the patient’s condition. And this, most believe, should enhance the ability to measure quality.

Of course, many agree that it is difficult to measure the quality of care. If the relevant diagnostic or procedural code includes multiple conditions, it becomes even more difficult to evaluate a provider’s performance in addressing risk factors and effectively treating a patient’s condition. For example, if two conditions with different treatment protocols are assigned to the same code, how can we evaluate the provider’s performance in treating one of these two conditions? The specificity available in ICD-10-CM/PCS should minimize the occurrence of these types of situations.

Capturing “severity” can also be an issue. For example, if we know that a patient has a pressure ulcer, but we do not know whether it involves only skin or extends to the bone, we will not be able to measure the effectiveness of a wound management program. Likewise, we cannot measure the cost of treating pressure

CHAPTER 1

ulcers without specific clinical data—and it is obviously much more difficult, and more expensive, to treat a deep ulcer than it is to treat a superficial one. Cases like this illustrate the benefits of moving to the more specific code set of ICD-10-CM/PCS.

A significant benefit of implementation is improved claims. Because ICD-10-CM/PCS are less ambiguous coding systems and more logically organized than ICD-9-CM, theoretically, there should be fewer erroneous, rejected, and exaggerated claims.

The biggest reason to move to ICD-10-CM/PCS is to obtain and use the better clinical information contained in the new code set. The modern terminology, enhanced severity, and more accurate description of conditions and procedures all provide more accurate and complete information on which to make coverage, payment, and patient management decisions. As CDI professionals know, however, all this additional detail must first be captured by the physician and written in the health record before a code can be applied.

American Applications

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the use of specified code sets for particular types of claims to standardize all healthcare transactions. As such, the ICD code set has become the basis of healthcare payment systems in the United States.⁶ Therefore, all providers in all settings will use ICD-10-CM to report these conditions effective October 1, 2014.

The ICD-9-CM is used to code and classify morbidity data from hospital inpatient and outpatient records, physician offices, and most National Center for Health Statistics (NCHS) surveys. The ICD-9-CM *Official Guidelines for Coding and Reporting* are the official rules for ICD-9-CM and are approved by the four cooperating parties:

- AHA
- American Health Information Management Association (AHIMA)
- Centers for Medicare & Medicaid Services (CMS; formerly known as the Health Care Financing Administration)
- NCHS (authorized by the United States government)

ICD-10-CM/PCS PRIMER

Volumes 1 and 2 of ICD-9-CM are used to report the following conditions:

- Diseases
- Injuries
- Impairments and their manifestations
- Causes of injury, disease, impairment, or other health-related problems

Other code sets are used for other purposes. Most notably Volume 3 of ICD-9-CM, which will be replaced by ICD-10-PCS. This set is used to report procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients.

The Healthcare Common Procedure Coding System (HCPCS) is used for the reporting of medical supplies, orthotic and prosthetic devices, and durable medical equipment, which are typically an outpatient service. A combination of HCPCS and the current procedural terminology (CPT) classification system in its fourth revision (CPT-4) is used for reporting the following: physician services, physical and occupational therapy services, radiological procedures, clinical laboratory tests, other medical diagnostic procedures, hearing and vision services, and transportation services. These codes are also typically associated with an outpatient claim. It is important to remember that a short-term acute care facility, commonly referred to as a hospital, can offer both inpatient and outpatient services. Consequently, CDI staff need to know which type of service is being provided, e.g., inpatient or outpatient, to accurately investigate the record and interpret the coding needs for the claim.

The current set of clinical codes, version ICD-9-CM, has been used in the United States since 1980—more than 30 years. To understand the importance of the code set in healthcare reimbursement, a review of the progression of government payment systems is warranted.

Code applications for payment purposes

In 1965, Medicare reimbursed healthcare based on actual charges. In October 1983, the federal government created the inpatient prospective payment system (IPPS), which changed the payment method to one based on fixed rates. The fixed payment rate was determined by diagnosis-related group (DRG), which

CHAPTER 1

is based on the assignment of ICD-9-CM codes and their sequencing. The change, policymakers hoped, would influence hospital behavior and encourage more cost-efficient management of medical care.

DRGs

Under IPPS, CMS categorized each patient's care into a DRG. The original DRG system, developed by Robert Barclay Fetter and John Devereaux Thompson at Yale University with the support of the CMS, aimed to categorize “like” patients with theoretically “like” treatment/charges based on the patient's principal diagnosis and up to eight secondary diagnoses. Age and discharge status also influenced categorization of the approximately 538 DRGs. Each DRG was designed to contain ICD-9-CM codes that are clinically coherent and have similar hospital resource consumption and length of stay (LOS) patterns.⁷

Certain conditions thought to increase the complexity of the stay were classified as complications and comorbidities (CC). The CCs were identified by their associated ICD-9-CM code. Yale University determined that to qualify as a CC, the diagnosis had to increase the patient's LOS by one day in 75% of the cases reviewed. CMS adopted Yale University's original CC list, which remains fairly unchanged since 1986.

A DRG is determined by the selection of the principal diagnosis—the principal diagnosis is that condition after study which is chiefly responsible for occasioning the admission. The principal diagnosis will fall into one of 27 major diagnostic categories (MDC), 25 of which are grouped by body system. If a surgical procedure occurs, it can change the MDC or just the DRG assignment.

When both the principal diagnosis and surgical procedure are located in the same MDC, the DRG assignment changes from a “medical” DRG to a “surgical” DRG and is typically reimbursed at a higher rate. Once the base DRG is established as medical or surgical, the presence of a CC can increase the reimbursement associated with the DRG, if the DRG is divided into one where payment differs with a CC and without a CC. The basic DRG format also differentiated diagnoses by age with relatively few DRGs qualifying as CC for those where the patient was under age 17. The DRG payment is designed to cover all the hospital resources associated with the care of the patient regardless of the types of services provided and LOS, except in extreme circumstances. At the time, CMS believed hospitals and physicians would have an incentive under this system to better control LOS and costs per case.

APR-DRGs

Since the early 1980s, providers have been requesting an expansion of the payment system to more accurately capture resource consumption, costs, and payments. This is why some providers use the All-Patient-Refined DRG classification system (APR-DRGs) developed by 3M. APR-DRGs are also based on ICD-9-CM codes and will be updated with ICD-10-CM/PCS codes, but unlike the DRG system that classifies according to the presence or absence of a CC, this system differentiates patients along two scales: severity of illness (SOI) and risk of mortality (ROM). It expands CMS' original DRGs by stratifying patients into one of four possible groups within each scale:

- Minor = 1
- Moderate = 2
- Major = 3
- Extreme = 4

The SOI/ROM values relate to distinct patient attributes. The SOI relates to the extent of physiologic decompensation or organ system loss of function that the patient experiences. The ROM relates to the patient's likelihood of dying. Both the SOI and ROM are separately assigned a numeric qualifier ranging from one to four, determined independently by the software program according to the assigned diagnoses codes. The number of diagnoses as well as the grouping of the codes determines the SOI/ROM scores. Depending on the combination of the patient's characteristics and associated diagnoses, the value of a particular diagnosis in regard to the SOI and/or ROM score can change. In other words, the impact of a diagnosis is not constant in the APR-DRG classification system.

The APR-DRG system classifies patients with secondary diagnoses, which may or may not also be classified as a CC in the DRG system, that involve multiple body systems. This classification allows hospitals and medical communities to qualify and quantify the clinical acuity of different patient populations. Two hospitals may have the same volume of a patient type that falls into a particular DRG, but those hospitals may also have vastly different SOI, ROM, and APR-DRG values.⁹

Medicare Severity DRGs

The DRG system of the 1980s did not provide enough variation among patients and associated reimbursement levels. In 2007, CMS developed a new formula to more accurately capture the resources required to treat severely ill patients and better represent severity—the Medicare Severity DRG (MS-DRG) model.

The MS-DRG system is founded on two key points:

1. Complexity: hospital resource consumption that is not related to secondary diagnoses (e.g., the cost of the device)
2. Monotonicity: a trend that should occur between severity level and average costs for certain DRGs (i.e., as severity level rises, the cost of care also rises)

CMS identified several reasons for making the transition to MS-DRGs. The agency said the new system would help it to:

- Compare facilities across a wide range of resources and outcome measures
- Evaluate differences in inpatient mortality rates
- Implement and support critical pathways
- Identify continuous quality improvement
- Internally manage data¹⁰

MS-DRGs also helped to eliminate a perceived bias contained in the original DRG program. Critics claimed the original structure slighted the sickest and most resource-intensive medical patients while rewarding facilities that performed only high-cost and, therefore, well-reimbursed surgical procedures.

“Under the old DRG system (with payments based on broad averages), incentives could lead hospitals to cherry-pick—the practice of treating only the healthiest and most profitable patients,” said CMS Acting Deputy Administrator Herb Kuhn in a press release issued in 2007. Under the latest structure, payments “will be more accurate and [will] better reflect the severity of the patient’s condition.”¹¹

ICD-10-CM/PCS PRIMER

The new system increased the number of DRGs to nearly 750. It also identified three levels of severity for diagnostic categories as follows:

1. MS-DRG with major CC (MCC): the highest severity indicator
2. MS-DRG with CC: a lesser level of severity
3. MS-DRG without CC/MCC: the lowest level of severity and resource consumption

A DRG can be composed of a variety of CC and/or MCC combinations. When patients can be classified into one of two groups within an MS-DRG, this is referred to as a pair or duo. The classification of patients into three groups is called a triplet, trio, or triad. These are DRGs that differentiate patients without a CC or MCC from those with a CC, or from those with an MCC. The presence of multiple CCs does not equal the value of an MCC. This is a key distinction from the APR-DRG system where the presence of multiple conditions can change the weight or value of the SOI and/or ROM scale. In the MS-DRG system a single MCC captured as a secondary diagnosis can affect the severity and the reimbursement of care. In APR-DRG system multiple secondary diagnoses are needed to reach the highest severity and reimbursement levels.

Using statistical methodology, CMS annually reviews the relative weight, or payment factor, of each MS-DRG to ensure it accurately reflects similar resource consumption and LOS patterns. For example, in the 2011 IPPS update, CMS noted one DRG that encompassed the payment for a bone marrow transplant procedure. However, it noted an approximate \$27,000 difference in the cost of an autologous versus allogeneic bone marrow transplant. Therefore, they separated these procedures into two MS-DRGs to provide more accurate reimbursement for each procedure.¹²

TIMELINE OF IPPS PROGRESSION

- 1983–1984: DRG implemented in the United States, increasing the importance of ICD-9 coding for IPPS
- 1990: 3M develops the APR-DRG system¹³
- 1996–2006: ICD-10-CM/PCS implementation starts outside the United States
- 2007: MS-DRG system implemented highlighting the importance of, and need for, greater specificity in coding and documentation

Of course, without precise and accurate provider documentation in the health record describing the patient's conditions that required hospital services, there can be no corresponding ICD code assignment, no related DRG assignment, no accurate reimbursement, and no data analysis leading to improved quality of care or cost savings. As the adage goes: Documentation is everything.

ICD-10-CM/PCS Compliance Dates

On January 16, 2009, the HHS released two final rules related to improved clinical data collection: one for the adoption of the next generation of diagnosis and procedure codes, ICD-10-CM/PCS, and another that updates standards for electronic healthcare and pharmacy transactions, commonly referred to as 5010/DO.¹⁴ The transition to ICD-10-CM/PCS was also mandated in the Patient Protection and Affordable Care Act (section 1104), which passed in 2010.¹⁵

To accommodate the vast array of new codes, computer system applications in almost every healthcare organization in the nation require revision. Previously, healthcare systems used the HIPAA 4010 transaction, which cannot support the format of ICD-10-CM/PCS codes. An ICD-9-CM diagnosis code consists of up to five digits with the possibility of two different letters (E or V) in the first position, but ICD-10-CM codes contain up to seven alphanumeric characters and can incorporate almost any letter in the alphabet. ICD-9-CM procedure codes use up to four digits with a decimal following the second digit, while ICD-10-PCS codes contain seven alphanumeric characters without a decimal. The 5010 claim form allows for accurate capture of these longer, more complex codes.

Additionally, the new 5010/DO electronic claim form allows organizations to report up to 25 diagnosis codes and 25 procedure codes. The increased number of reportable codes can prevent organizations from “losing” codes on a claim, as their billing software may sequence codes like those for palliative care, V66.7, too low on the diagnosis list to be reported under the old format. Capturing such codes affects mortality calculations and provides valuable data.

The American National Standards Institute (ANSI), transaction version 5010, and the National Council for Prescription Drug Programs (NCPDP), versions DO and 3.0, were implemented as of January 1, 2012, as adopted by HHS and mandated by the CMS. In addition to accommodating the ICD-10-CM/PCS code set, 5010 includes more than 850 structural, technical, and content changes. The shift affects the following:

ICD-10-CM/PCS PRIMER

- Abstracting systems
- Benefits administration
- Billing and claim systems/software and processing (patient accounting systems)
- Coding and grouping software
- Contracting
- Disease and case management
- External clinical reporting
- Financial reporting
- Medical necessity and advanced beneficiary notification software
- Ordering systems
- Provider profiling and report cards
- Quality management
- Underwriting
- Utilization management

In addition to changes in the electronic claims submission form and changing the coding set to ICD-10-CM/PCS, CMS also implemented many other initiatives to encourage the use of electronic formats for healthcare data, including meaningful use and the Electronic Prescribing Incentive Program (e-Rx). Unfortunately, these technological initiatives and data reporting requirements are costly without federal funding, creating a great burden for some providers. In response to these mandates, various provider groups expressed serious concerns regarding their ability to meet the initially planned 2013 compliance date, most notably the AMA, whose House of Delegates passed policy opposing the implementation in November 2011.

CHAPTER 1

“The implementation of ICD-10 will create significant burdens on the practice of medicine with no direct benefit to individual patients’ care,” said Peter W. Carmel, MD, AMA president, in a press release at the time.¹⁶

In February 2012, at the AMA’s National Advocacy Conference, CMS Acting Administrator Marilyn Tavenner indicated that HHS would consider a delay.¹⁷ A proposed rule was published in April, and the final implementation rule delaying implementation to October 1, 2014, was released in August.

Unfortunately, the implementation delay may negatively affect many organizations that slowed or stopped their ICD-10-CM/PCS implementation efforts due to the uncertainty. Even with the year extension on the implementation deadline, many facilities will need to scramble to prepare. Best practice suggests six months to one year of dual coding (the coding of diagnoses and procedures in both ICD-9-CM and ICD-10-CM/PCS simultaneously in preparation for implementation), which means coders should be proficient using ICD-10-CM/PCS by fall 2013 to spring 2014.

The American Health Information Management Association (AHIMA) and ACDIS both included preparation recommendations as far back as October 2009. According to many timelines, organizations should be planning and engaging in provider education as of 2013. Just as codes were subjected to annual review and changes under ICD-9-CM, annual changes will be made to the code set under ICD-10-CM/PCS. For example, in 2009, there were 68,102 diagnosis codes, and in 2010, there were 69,101 diagnosis codes. Over the course of that year, 1,982 new codes were added and 983 codes were deleted.

However, only minimal revisions to ICD-9-CM will occur for both 2012 and 2013. There were no new diagnosis codes for this year, and only a few procedure codes were added based on new treatments.

CDI Program Influence and Effect

ICD-10-CM/PCS represents both diagnosis and procedure codes, and the changes in diagnoses will affect nearly every business process and system in all healthcare settings. Expect changes in documentation, reimbursement, coverage, insurance plan structures, quality measures, and audits. In addition, those working in healthcare should expect ICD-10-CM/PCS implementation to be a bigger project, nationally speaking, than any other effort undertaken in a long time—bigger even than those associated with the electronic transition at the year 2000 (also colloquially known as Y2K) and HIPAA.

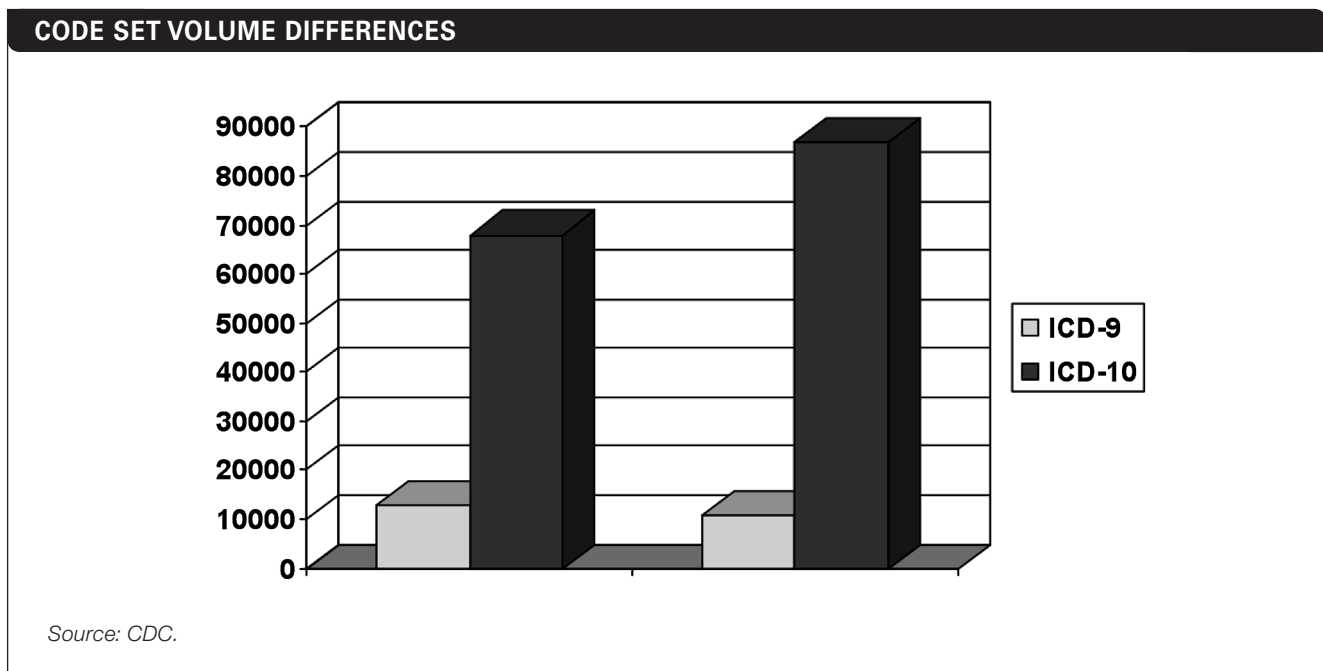
ICD-10-CM/PCS PRIMER

The biggest reason to move to ICD-10-CM/PCS is to obtain and use the better clinical information contained in the new code set. The modern terminology, enhanced severity, and more accurate description of conditions and procedures all provide more accurate and complete information on which to make coverage, payment, and patient management decisions.

As illustrated in Figure 1.1, the fact that the volume of codes is greatly increasing may be difficult to fully comprehend. CDI programs can help alleviate the burden of documentation efforts associated with ICD-10-CM/PCS initiatives if they remember to focus on appropriately detailed documentation in the health record. CDI specialists act as translation and analysis intermediaries who work between the data-driven world of coding professionals and the clinical/analytical world of patient care. Each and every aspect of care provided to a patient in the hospital must be transcribed into a code. Some physicians still do not realize that the words they write in the context of the health record never actually leave the facility—only codes do.

Correct coding and appropriate reimbursement represent a direct reflection of accurate and complete documentation. This will prove ever more important as ICD-10-CM/PCS becomes the new code structure.

FIGURE 1.1



CHAPTER 1

At the time of this publication, facilities should already have begun implementation of CDI efforts to identify current documentation deficiencies and to strengthen the integrity of the health record. To prepare for ICD-10-CM/PCS, these CDI programs must become proficient in the art of crafting physician queries and interrogating the health record. They must search through today's records for clues pointing to significant diseases that may otherwise have gone unnoticed and unreported. CDI professionals must furthermore understand the components of ICD-10-CM/PCS and work with their coder counterparts to target areas that will require additional documentation and/or additional specificity for accurate code assignment.

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