ICD-10 Post-Implementation: Coding Basics Revisited

Leah Nguyen Intro

I am Leah Nguyen from the Provider Communications Group here at CMS. I would like to welcome you to today's MLN Connects video on the International Classification of Diseases, 10th Edition or ICD-10. Now that ICD-10 is here, let's revisit the basics and learn more about the unique characteristics and features of this new coding system. At the end of the video, we will provide websites with links to resources mentioned in the presentation. This video is not intended to serve as a substitute for comprehensive coder training necessary for proficient ICD-10 coding.

Our special guest speakers today are Sue Bowman, Senior Director, Coding Policy and Compliance for the American Health Information Management Association, and Nelly Leon-Chisen, Director of Coding and Classification at the American Hospital Association.

Leah
There seems to be some confusion about the definition of a valid code. Sue, can you explain what a valid code is?

Sue

In the simplest terms, a valid code is one that has the full number of characters required for that code. For ICD-10-CM diagnosis codes, some may be 3, 4, 5, 6 or 7 characters long. A 3-character category code is not a valid code if it has a further 4-, 5-, or 6-character breakdown. If a 7th character applies, codes missing a 7th character are invalid. For ICD-10-PCS procedure codes, which apply ONLY to hospitals reporting inpatient procedures, all codes require 7 characters to be valid.

A complete list of ICD-10-CM valid codes is available on the CMS website. This list should assist providers who are unsure as to whether additional characters are needed for a code to be valid.

There are many helpful ways to identify whether a code is valid or invalid. Coding, billing and claims editing programs may have flags to identify invalid codes missing additional characters. As you verify code numbers in the Tabular list, code books may identify invalid using a variety of formats. Each publisher may use a different format, such as color coding, flags, special symbols or hyphens. It's important to become familiar with the format used by the particular code book or program you may be using.

Sue

It's important to note that the process for determining the correct diagnosis code is same as in ICD-9-CM. First, you look up the diagnostic term in the Alphabetic Index, and then you verify the code number in Tabular List.

Leah
It's great to know that the coding process in ICD-10-CM is one that ICD-9-CM coders are familiar with. In addition to following the index entries and instructions in the coding system, Nelly, are there other resources to help coding professionals select the proper codes?

Nelly
Yes, there are official coding guidelines available for both ICD-10-CM and ICD-10-PCS on the CMS and CDC websites. These guidelines accompany and complement code set conventions and provide additional instructions. Providers must use these guidelines in conjunction with the code set in order to ensure accurate coding. More importantly, adherence to the official coding guidelines in all healthcare settings is required under the Health Insurance Portability and Accountability Act or HIPAA.

Leah
Can you provide some examples of the type of instructions the guidelines provide?

Nelly

Sure. One good example of the guidelines involves hemiplegia and hemiparesis.

ICD-10-CM codes for hemiplegia/hemiparesis and monoplegia specify dominant and nondominant sides. The guidelines provide instruction for these codes when the documentation reflects which side of the body is affected but not whether it is the dominant or non-dominant side. In those instances, code selection is guided by the following:

- If the right side is affected, code as dominant.
- If the left side is affected, code as non-dominant.

Another example of a guideline is when a patient has bilateral glaucoma and each eye is documented as having a different type of glaucoma or a different stage. The instructions are to assign the appropriate code for EACH eye separately rather than the code for bilateral glaucoma.

Nelly
A third example of a guideline is when a patient is admitted for complications of pregnancy during one trimester and remains in the hospital into a subsequent trimester. A provider may need to determine which trimester the code should reflect. The guideline instructs that the trimester for the antepartum complication code should be assigned on the basis of the trimester when the complication developed, not the trimester at discharge.

Leah:

One of the expanded features of ICD-10-CM is the addition of laterality. Can you discuss that?

Nelly

Laterality has been added in ICD-10-CM to allow better identification of anatomic site. Many codes distinguish which side of the body is affected—right, left or bilateral. That's a pretty straightforward concept that most providers understand. One question that came up recently was how to handle bilateral conditions when only one side is treated. If a condition is bilateral but only one side is the focus of treatment during the current encounter, the bilateral code should be assigned. For example, for a patient with bilateral age-related nuclear cataracts and only had one eye treated during the current encounter for cataract surgery, code H25.13, which is the bilateral code, should be assigned.

For hospital outpatients and physician reporting, the CPT code modifier will capture the treated side. For hospital inpatient reporting, the ICD-10-PCS code will capture the treated side.

Leah

We've heard that another new feature in ICD-10-CM is the use of the 7th character. Sue, can you explain how the 7th characters work?

Sue

The 7th character is used in the Musculoskeletal, Obstetrics, Injuries, External Causes chapters. It is important to keep in mind that the 7th character is not used in all ICD-10-CM chapters. The 7th character has different meanings and different values depending on the section where it is being used. When the 7th character does apply, it must always be used in the 7th character position. As we noted earlier, when the 7th character applies, codes for which a 7th character applies are invalid if the 7th character is missing.

Sue

Let's review some of the important concepts related to the 7th characters along with examples. For the musculoskeletal, injuries and external causes of morbidity chapters, the most common 7th characters are for initial encounter, subsequent encounter, and sequelae. The 7th characters for initial and subsequent encounter are much more frequently used than "sequelae," since sequelae is limited to late effects of an injury or condition, such as a scar or contracture, or paralysis following a spinal cord injury.

The 7th character for initial encounter is used as long as the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and continuing treatment by the same or a different physician.

Sue

For the 7th character selection of "initial encounter," the key is whether or not the patient is still receiving active treatment. If you're familiar with CPT, it's important to note that "Initial" in this context has an entirely different meaning than in CPT in a couple of different ways. First, disregard the word "initial" – this 7th character may be used for multiple healthcare encounters as long as the patient is still receiving active treatment for the condition described by the code.

Second, whether or not the patient is seeing a new provider is irrelevant to the determination of the 7th character. It doesn't matter if the provider is the same individual, in the same practice or the same specialty – the 7th character for initial encounter is based solely on whether active treatment for the condition is still being provided. So unlike CPT, the 7th character is based on the perspective of the patient's condition and whether active treatment is provided for that condition.

An important guideline for consideration is that for complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem. An example would be a code for infection due to hip prosthesis. If the patient is receiving active treatment for the condition described in the code, which in this example is the infection, the 7th character for initial encounter is assigned. You might think this scenario is a subsequent encounter because the hip prosthesis was placed previously. However, you need to remember that 7th character assignment is based on whether or not the condition described by the code is being actively treated. Since infection is the condition described by the code in this example and the infection is being actively treated, the 7th character for initial encounter should be assigned.

Leah
Can you explain how malunions and nonunions should be handled?

Sue
The 7th characters that specify malunion or nonunion only describe subsequent encounters, not initial encounters, because they presume the fracture was previously evaluated and treated before the malunion or nonunion developed. However, there are occasions when a patient may not seek treatment at the time of the original injury and his first presentation for medical care is for a malunion or nonunion. As explained in the official ICD-10-CM coding guidelines, for malunions and nonunions when the patient delayed seeking treatment for the fracture, the appropriate 7th character for initial encounter should be assigned, rather than the malunion or nonunion "subsequent encounter" 7th characters.

Sue
Situations where the 7th character for initial encounter would apply include:

- Diagnosis and assessment of acute injury and definitive treatment (e.g., suture repair, fracture reduction)
- Malunions/Nonunions when patient delayed seeking treatment for fracture
- Referral to orthopedist for injury evaluation and treatment plan development

- Antibiotic therapy for postoperative infection
- Wound vac treatment of wound dehiscence

Leah
That's interesting information regarding "initial encounters." Nelly, can you tell us about "subsequent encounters"?

Nelly

The 7th character for subsequent encounters is assigned after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

For aftercare of injuries, the acute injury code with the appropriate 7th character for subsequent encounter should be assigned rather than the aftercare "Z" codes which are reserved for non-injury related conditions.

Fracture malunions and nonunions are assigned the appropriate 7th character for subsequent encounter for malunion or nonunion (unless the patient delayed seeking fracture treatment).

Nelly

Here are several examples where the 7th character for "subsequent encounter" would be applied, including
- Rehab therapy encounters (e.g., physical therapy, occupational therapy)
- Follow-up x-rays to check healing status of fracture
- Suture removal
- Cast or splint adjustment, change, or removal
- Removal of external or internal fixation device
- Medication adjustment
- Follow-up visits to assess healing status (regardless of whether the follow-up is with the same or a different provider)
- Dressing changes

Other aftercare and follow up visits following treatment of the injury or condition

Nelly

Lastly, we have the 7th character "S," for sequela, which is used for the residual effect or conditions that arise as a direct result of an acute condition. A typical example is scar formation after a burn.

Other examples of sequela are
- Traumatic arthritis following previous gunshot wound

- Quadriplegia due to spinal cord injury
- Auricular chondritis due to previous burns, and
- Chronic respiratory failure following drug overdose

Nelly

It's important to note that complications of surgical treatment of injuries during the healing or recovery phase should be coded with the appropriate complication codes. An example of a complication would be infection. A complication of surgical or medical care for an injury would not be coded with the "sequela" 7th characters.

Leah

This is great background information on the 7th characters. Sue, do you think you can walk me through a few examples of how to appropriately apply the 7th characters?

Sue

I would be happy to. We'll go through the steps with the same patient to provide additional clarity.

First, we have a patient seen in the emergency department after falling down a flight of stairs. The patient is diagnosed with a displaced fracture of the medial malleolus of the right ankle**.**

In step 1, we look up the term in the Alphabetic Index: Fracture, traumatic, ankle, medial malleolus (displaced) and we get code S82.5 DASH, with the DASH indicating that additional characters are needed, which we will find in the Tabular List.

Sue

In step 2, we verify the code in Tabular List. At S82 Fracture of lower leg, including ankle there are a couple of notes to provide guidance. First, there is a note stating that a fracture not indicated as displaced or nondisplaced should be coded to displaced. Second, a fracture not indicated as open or closed should be coded to "closed." There is also a note that instructs that the appropriate 7th character is to be added to all codes from category S82.

Sue

Next, we see S82.5 Fracture of medial malleolus and confirm that we are in the right place, and select S82.51 for Displaced fracture of medial malleolus of right tibia. Depending on the code book used, there may be a symbol or figure to indicate that a placeholder character "x" is needed before assigning the 7th character. In some code books, the publisher has already pre-populated the character "x". This is an initial encounter and the correct code assignment is **S82.51xA.**

Sue

That same patient seen in the emergency department was referred to an orthopedist for further evaluation and treatment. The same ICD-10-CM code is assigned since this is still active treatment.

Sue
Now that same patient is admitted for surgical repair of the fracture and the same code is assigned because this still active treatment.

Sue
When the same patient returns to the orthopedist for follow-up to assess the healing status, a malunion is diagnosed. Now the code has changed and we are using the 7th character for subsequent encounter with malunion. You will notice that the 7th character is "P" rather than "D." Although "D" is the most common 7th character for subsequent encounter, it's not the only one. It's important to check the Tabular List to determine which 7th character value is applicable as they may vary from category to category.

Sue
Following the same patient, now the patient is admitted for surgical treatment of malunion and we have code S82.51xP—the same code that was used for the visit to the orthopedist when the malunion was identified. While surgical treatment is active treatment of the malunion, the 7th characters for malunion and nonunion describe "subsequent encounter," since malunions and nonunions occur subsequent to the original acute fracture. As we noted earlier, the only exception is in the case of delayed treatment, whereby the patient did not seek any care for the fracture at the time of the original injury, and so the first presentation for care is a malunion or nonunion. That is the only circumstance when an "initial encounter" 7th character would be used for a malunion or nonunion.

Sue
After the surgery, the same patient returns to the orthopedist for follow-up to assess the healing status and now the fracture is healing well. The 7th character for this visit is now changed to "D" for subsequent encounter, closed fracture, routine healing, since the malunion is no longer present and the fracture is healing well.

Sue
The same patient has an outpatient physical therapy encounter and you can see that the same code with the 7th character of "D" is assigned.

Sue
Let's now turn to a DIFFERENT patient. The patient was admitted to home health care where antibiotic treatment for a postoperative wound infection continues to be administered; physical therapy is also being provided post left hip fracture.

The 7th character is "A" for initial encounter for the postoperative infection code because antibiotic therapy is active treatment of the infection.

For complication codes, “active treatment” refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem. The subsequent encounter 7th character is used for the fracture code because the patient is receiving physical therapy, which is considered “subsequent care.” The fracture is coded as closed when the documentation does not specify open or closed. It is coded as “routine healing” when the documentation does not mention delayed healing.

Note that the 7th characters for the infection and the fracture do not have to match. The 7th character designation is specific to the condition described by that particular code. In this case, the infection is still receiving active treatment and so the infection code is considered to be an “initial encounter,” whereas physical therapy is being provided for the fracture, which is considered to be “subsequent care.”

Leah
These are very helpful examples. Nelly, can you talk about unspecified codes and clarify what they are and how they should be used?

Nelly

Just as in ICD-9-CM, ICD-10-CM has “unspecified” or “not otherwise specified” codes available. And just as in ICD-9-CM, each healthcare encounter should be coded to the level of certainty known for that encounter**.** There are instances when signs and symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter.

Specific diagnosis codes should be reported when they are supported by the available documentation and clinical knowledge of the patient’s health condition.

Nelly
“Unspecified” codes are used when the documentation is insufficient to assign a more specific code or the provider doesn’t have sufficient clinical information about the patient’s condition for a more specific code to be assigned. Unspecified codes should be reported when they most accurately reflect what is known about the patient’s condition at the time of that particular encounter.

Nelly

It’s important to note that unspecified codes ARE valid codes, and they are still acceptable. It would be inappropriate to select a specific code that is not supported by the medical record documentation, or to conduct medically unnecessary diagnostic testing, in order to determine a more specific code.

Of course, providers should try to be as specific as possible in their documentation so that the most specific codes can be assigned and the most complete and accurate clinical picture can be

represented. But there are many instances when unspecified codes are the best choice no matter how good the documentation is. The patient's diagnosis may not have been fully clinically determined yet. Or the provider may be capturing clinical conditions being managed by a different provider and so he or she doesn't have all of the specific details about the condition that might be available to the provider managing that condition.

Guidelines regarding unspecified codes being acceptable are part of the *ICD-10-CM Official Guidelines for Coding and Reporting*, which all HIPAA-covered entities must comply with.

Nelly
Here are a few common ICD-9-CM and ICD-10-CM unspecified codes for signs, symptoms and conditions such as anemia, abdominal pain, stroke, angina and COPD.

Nelly

Let's review coding steps by walking through the assignment of an unspecified code for chest pain.

First, look up the term in the Alphabetic Index:

Pain, chest (central) and you can see we get code R07.9.

The next step is to verify the code in the Tabular List. The correct code is R07.9 Chest pain, unspecified.

Leah
Sue, can show us another coding example, maybe for a more specific condition this time?

Sue

Sure – Let's take a look at recurrent bilateral acute serous otitis media.

In step 1, look up the term in the Alphabetic Index: Otitis media and you can see H66.9 dash. However, we have more specific information and we find the subterms "acute, subacute" which sends us to H66.90, but there is further specificity for "serous" which the Index instructs us to see "Otitis, media, nonsuppurative, acute, serous."

Sue
We follow the Index instruction and look up "Otitis, media, nonsuppurative, acute, serous," where we find another subterm for "recurrent" which points us to code H65.0 dash.

Sue

Now we are ready for step 2 to verify the code in the Tabular. Because the dash tells us that we are missing characters, we find that the valid code is H65.06 for Acute serous otitis media, recurrent, bilateral.

Leah
That was great information, demonstrating how straightforward the coding process is. Now could you go over external causes of morbidity codes?

Sue
The first point to keep in mind regarding the external cause codes is that there is no national requirement for mandatory reporting of External Causes of Morbidity ICD-10-CM codes. Reporting of these codes is only required for providers subject to a state-based mandate or a payer requirement.

Sue

However, providers are encouraged to voluntarily report external cause codes because these codes have significant value. There are misconceptions related to external cause codes in ICD-10-CM. These codes provide valuable data for injury research and evaluation of injury prevention strategies. The data are used at the national, state, and local levels to identify high-risk populations, set priorities, and plan and evaluate injury prevention programs and policies. The codes are also potentially useful for evaluating emergency medical services and trauma care systems. The majority of these external cause codes are for ordinary activities that many of us may be engaged in, such as driving.

Improving the availability of, and access to, high-quality external cause data can benefit auto insurance companies, disability insurers, health insurance plans, public payers, healthcare purchasers, employers, businesses, labor unions, schools, and other entities interested in injury prevention and safety issues.

Leah
Now that you and Nelly have covered all of this great information about the use of the new coding system and the coding process, can you explain where code books can be obtained?

Su**e**
There is a free ICD-10-CM code set version from the CDC website. There are also a variety of hard copy books from several publishers as well as other associated tools with helpful hints from commercial vendors. These are available on paper or electronic and even including mobile apps.

Leah
Nelly, can you talk about the Central Office and its role and how to submit questions?

Nelly

Sure. The AHA Central Office is a clearinghouse service housed and supported by the American Hospital Association. This is a long-standing service dating back to 1963, when only hospitals were working with ICD codes. It was established by a Memorandum of Understanding with the Department of Health and Human Services to collaborate and provide free assistance with ICD-9-CM advice. It serves as a triage service providing coding advice based on the established, official sources. Anything that needs additional clarification or has not been addressed before is referred to the agencies responsible for the code set, namely CDC for diagnosis codes and CMS for procedure codes.

We have been providing advice for ICD-10-CM and ICD-10-PCS since 2012. It's important to note that this service does NOT replace learning how to code, nor was it ever intended to be a coding hotline service for every possible coding question anyone would have. Rather, it was established to provide assistance in developing and providing official advice and interpretation for vague or difficult cases.

Nelly

Coding questions can be submitted via our online service to codingclinicadvisor.com. This is a FREE service, so we ask users to become familiar with the service and review the frequently asked questions section for details. The same process was used for ICD-9-CM questions. Please be sure to go through the steps of locating a code that we have covered in this program, review the Alphabetical Index and the Tabular List instructional notes and be familiar with the Official Coding Guidelines before sending your question.

Be sure to formulate an actual coding question and not just ask us to code your entire superbill or an entire record, validate your code assignment or "what is the code for XYZ." We can only address specific coding problems submitted with supporting medical record documentation. Along with your question specify whether it refers to a certain setting—for example, skilled nursing facility, home health, or acute hospital inpatient. We cannot answer questions on payment or coverage issues, or on the general equivalence maps or GEMs.

Also, we regret that we are not able to support requests for ICD-10-PCS coding advice related to hospital outpatient procedures since ICD-10-PCS is the HIPAA standard for inpatient hospital procedure coding only. In many ways, ICD-10-PCS was not designed to support the coding of most services that are performed by providers in the outpatient setting.

Leah

You mentioned the AHA Coding Clinic; can you tell me more about it?

Nelly

The AHA Coding Clinic is a quarterly publication that has provided ICD-9-CM coding advice for over 30 years. In order to support the field's preparation for ICD-10 implementation, we began providing both ICD-10-CM and ICD-10-PCS coding advice in 2012, at the same time that we

provided ICD-9-CM advice. Since early 2014 Coding Clinic has solely focused on ICD-10 advice. The publication provides practical examples of frequently asked questions from the AHA Central Office clearinghouse service. We provide real life application of the classification rules and guidelines based on questions and documentation sent to us by providers who had already started dual coding and were practicing coding with ICD-10. So Coding Clinic is helping fill in those knowledge gaps on code selection identified by the early adopters, so that all providers get to share in the benefits from the advice where a consensus opinion has been achieved.

Nelly

Coding Clinic is supported by the Editorial Advisory Board which includes the Centers for Medicare & Medicaid Services and the CDC's National Center for Health Statistics. These two federal agencies are the maintainers of the ICD-10 code sets. In addition, Sue and I participate on the Board representing our respective organizations: the American Hospital Association and the American Health Information Management Association. Clinical guidance is provided by physicians representing the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Academy of Pediatrics. We also work with other physician specialties on an ad hoc basis, along with coding experts.

Leah

Should requests to change the ICD-10 codes be sent to the AHA Central Office too?

Nelly

No, although CMS and the CDC participate in the advice provided through the AHA Coding Clinic publication, code set maintenance goes through a different process with the CDC and CMS sharing responsibility. The CDC is responsible for the ICD-10-CM codes and CMS is responsible for the ICD-10-PCS codes. Jointly, they lead the ICD-10 Coordination and Maintenance Committee, or C&M. The committee is responsible for approving coding changes, developing errata, addenda and other modifications. Requests for coding changes are submitted to the committee for discussion at either the spring or fall meeting.

Nelly

The Committee provides a public forum to discuss proposed changes to ICD-10. Tentative agendas for the meetings are posted one month in advance of the scheduled meetings. The meetings are open to the public and held at CMS headquarters in Baltimore. Registration opens approximately one month prior to meeting. The meetings are also broadcast live and are also available on demand.

Proposals are presented at the meeting describing the clinical issues and the disease, procedure or technology. Questions and comments from the public regarding the clinical and coding issues are encouraged both at the meetings and in writing.

No decisions are made at the meetings. Once the comment period has closed, recommendations and comments are carefully reviewed and evaluated,, before final decisions are made.

Final decisions on code revisions are made through a clearance process within the Department of Health and Human Services.

Nelly
Here is some detailed information on submitting code change proposals.

Leah – Closing

Thank you, Nelly and Sue, for this informative presentation. We will leave you with links to excellent resources on the CMS, CDC, AHA, and AHIMA websites.

That is all the time we have, and I would like to thank our special guest speakers, Nelly Leon-Chisen from AHA and Sue Bowman from AHIMA for taking time to share their knowledge of ICD-10 coding. More information on these topics is available on the ICD-10 website at www.cms.gov/icd10. Thank you and have a nice day.