ICD-9-CM Coding: Does your coding of diagnoses ensure proper payment?

Hospice & Palliative Care Assoc. of Michigan
Palliative Care Reimbursement Seminar
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PRESENTED BY
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Agenda

- ICD-9: Why are we talking about this now?
- Purpose of ICD
- CMS on ICD-9 coding
- Coding Concepts & Guidelines
- An Intro to ICD -10
Objectives

1. Discuss determination of terminal diagnoses for patients entering hospice care including patients who present as debility, unspecified or adult failure to thrive
2. Discuss accurate ICD-9 coding of hospice diagnoses per the ICD-coding guidelines
3. Review ICD-10 coding principles, timeline for implementation and provider preparation

The why:
2014 Hospice Wage Index rule

CMS on Coding Requirements

- "All of a patient’s coexisting or additional diagnoses” related to the terminal illness or related conditions should be reported on the hospice claims
- 72% of hospice claims report only one diagnosis
CMS on Hospital vs. Hospice Diagnoses

• “In analyzing frequently reported principal hospice diagnoses, data analysis revealed differences between reported principal hospice diagnoses and reported principal hospital diagnoses in patients who elected hospice within 3 days of discharge from the hospital. In analyzing data on cancer diagnoses of Medicare hospice beneficiaries for 2009 through 2011, Table 3 below shows that beneficiaries with a hospital-reported principal cancer diagnosis that elected hospice within three days of hospital discharge did not always have a hospice-reported principal cancer diagnosis.”

Table 3: Principal Diagnoses and Incidence of Diagnoses from Hospitalizations within Three Days Prior to Hospice Entry, FY 2009-2011

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>% of Total Hospital Diagnoses</th>
<th>% of Total Hospice Diagnoses</th>
<th>% of Total Diagnoses That Also Became Principal Hospice Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>140.3</td>
<td>51.4%</td>
<td>31.3%</td>
<td>80.7%</td>
</tr>
<tr>
<td>140.9</td>
<td>91.5%</td>
<td>8.2%</td>
<td>78.9%</td>
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<td>140.4</td>
<td>5.6%</td>
<td>4.0%</td>
<td>83.4%</td>
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<td>140.5</td>
<td>4.9%</td>
<td>4.9%</td>
<td>83.8%</td>
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<td>140.6</td>
<td>5.1%</td>
<td>6.4%</td>
<td>83.9%</td>
</tr>
<tr>
<td>140.7</td>
<td>1.7%</td>
<td>1.5%</td>
<td>83.7%</td>
</tr>
<tr>
<td>140.8</td>
<td>0.3%</td>
<td>0.0%</td>
<td>82.0%</td>
</tr>
</tbody>
</table>

Notes: FY 2009-2010 Hospice claims matched with hospital inpatient claims where no more than three days passed between hospital discharge and hospice admission.

CMS on Hospital vs. Hospice Diagnoses

• “Although ICD-9-CM Coding Guidelines specify that the circumstances of an inpatient hospital admission diagnosis are to be used in determining the selection of a principal diagnosis, this guideline is not always being adhered to for the selection of the principal hospice diagnosis following a hospice beneficiary’s inpatient hospitalization.

☆☆ It is unclear as to why there is this discrepancy in the hospital/hospice diagnosis patterns as ICD-9-CM Coding Guidelines are specific regarding principal diagnosis selection.”
CMS on Debility and Adult Failure to Thrive

- "There have also been noted changes in the diagnosis patterns among Medicare hospice enrollees, with a growing percentage of beneficiaries with non-cancer diagnoses.
- Specifically, there were notable increases between 2002 and 2007 in neurologically based diagnoses, including various dementia diagnoses. Additionally, there have been significant increases in the use of non-specific, symptom-classified diagnoses, such as "debility" and "adult failure to thrive."
- In FY 2012, both "debility" and "adult failure to thrive" were in the top five claims-reported hospice diagnoses and were the first and third most common hospice diagnoses, respectively.*

Alzheimer’s and Other Dementias

- Diagnoses in coding classification “Mental, Behavioral, and Neurodevelopmental Disorders”
  - Not allowable as a principal diagnosis per ICD-9-CM coding guidelines
- Diagnoses in ICD-9-CM coding classification “Diseases of the Nervous System and Sense Organs”
  - Can be used as principal diagnoses per ICD-9-CM coding guidelines

To Make Matters Worse

- Hospice providers have listed the following as the primary terminal conditions*:
  - tuberculin reaction,
  - strep throat,
  - family history of breast disease, and
  - prickly heat,
  - just to name a few of the most outrageous.

*Terri Deutsch, CMS health insurance specialist,
Federation of American Hospitals meeting, 2007
The take-away:

- Imperative that hospice providers follow ICD-9-CM coding guidelines and sequencing rules for all diagnoses
- Pay particular attention to FTT, dementia and nonspecific coding
- Code the most definitive, contributory terminal illness in the principal diagnosis field
  - with all other related conditions in the additional diagnoses fields for hospice claims reporting

ICD-9 Coding: Concepts & Guidelines

ICD-9 Purpose and Applications

- Facilitate the collection of disease trends for comparison of mortality and morbidity data from different countries and specific populations.
- Establish healthcare quality and guidelines
- Government resource allocation
- Medical necessity for treatment
- Research - clinical trials
- Reimbursement
ICD-9 Coding: CMS Rules

**Note**: research for this presentation revealed the CMS Manual information on the following slides to be nothing new.

Ch. 23 Claims Processing Manual

“Proper coding is necessary on Medicare claims because codes are generally used to assist in determining coverage and payment amounts.”

Ch. 23 Claims Processing Manual

Rules for reporting diagnosis codes on the claim are:
- Use the ICD-9-CM code that describes the patient’s diagnosis, symptom, complaint, condition or problem. Do not code suspected diagnosis.
- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
- Assign codes to the highest level of specificity. Use the fourth and fifth digits where applicable.
- Code a chronic condition as often as applicable to the patient’s treatment.
- Code all documented conditions that coexist at the time of the visit that require or affect patient care or treatment. (Do not code conditions that no longer exist.)
Ch. 11 Hospice Claims Processing Manual

- “The full ICD-9-CM diagnosis code is required. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient’s admission. Use full ICD-9-CM diagnoses codes including all five digits where applicable.”

ICD-9 and Hospice

- Ch. 11, Hospice Claims Processing Manual
  - Principal Dx Code: “The hospice enters diagnosis coding as required by ICD-9-CM Coding Guidelines. Hospices may not report V-codes as the primary diagnosis on hospice claims. The principal diagnosis code describes the terminal illness of the hospice patient and V-codes do not describe terminal conditions.”
  - And on “Other” Dx Codes: “The hospice enters diagnosis coding as required by ICD-9-CM Coding Guidelines.”

Ch. 23 Claims Processing Manual

Interestingly, this Chapter lists specific requirements for ICD-9 coding for physicians, DMEPOS, hospitals, etc. but not a word on terminal illness diagnosis coding for hospices. And, the words “prognosis” or “prognostication” were not found in any CMS manual on ICD coding.
“Other Diagnosis” – ICD-9 Official Guidelines

- For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
  - clinical evaluation; or
  - therapeutic treatment; or
  - diagnostic procedures; or
  - extended length of hospital stay; or
  - increased nursing care and/or monitoring.

“Other Diagnosis”

Might these not be an excellent proactive way to “paint a picture” as to why two hospice patients with the same terminal illness have much different levels of care on the UB-04 hospice claims submitted this month?

ICD-9: 10 Steps to Correct Coding

Step 1: Identify the reason for the visit (e.g., sign, symptom, diagnosis, condition to be coded).
- Physicians describe the patient’s condition using terminology that includes specific diagnoses as well as symptoms, problems or reasons for the encounter. If symptoms are present but a definitive diagnosis has not yet been determined, code the symptoms. Do not code conditions that are referred to as “rule out,” “suspected,” “probable” or “questionable.”
Step 2: Always consult the Alphabetic Index, Volume 2, before turning to the Tabular List.
The most critical rule is to begin a code search in the index. Never turn first to the Tabular List (Volume 1), as this will lead to coding errors and less specificity in code assignments. To prevent coding errors, use both the Alphabetic Index and the Tabular List when locating and assigning a code.

Step 3: Locate the main entry term.
The Alphabetic Index is arranged by condition. Conditions may be expressed as nouns, adjectives and eponyms. Some conditions have multiple entries under their synonyms. Main terms are identified using boldface type.

Step 4: Read and interpret any notes listed with the main term.
Notes are identified using italicized type.

Step 5: Review entries for modifiers.
Nonessential modifiers are in parentheses. These parenthetical terms are supplementary words or explanatory information that may either be present or absent in the diagnostic statement and do not affect code assignment.
**ICD-9: 10 Steps to Correct Coding**

### Step 6: Interpret abbreviations, cross-references, symbols and brackets.

- Cross-references used are "see," "see category," or "see also." The abbreviation NEC may follow main terms or subterms. NEC (not elsewhere classified) indicates that there is no specific code for the condition even though the medical documentation may be very specific. The √ box indicates the code requires an additional digit. If the appropriate digits are not found in the index, in a box beneath the main term, you MUST refer to the Tabular List. Italicized brackets [ ], are used to enclose a second code number that must be used with the code immediately preceding it and in that sequence.

### Step 7: Choose a tentative code and locate it in the Tabular List.

- Be guided by any inclusion or exclusion terms, notes or other instructions, such as "code first" and "use additional code," that would direct the use of a different or additional code from that selected in the index for a particular diagnosis, condition or disease.

### Step 8: Determine whether the code is at the highest level of specificity.

- Assign three-digit codes (category codes) if there are no four-digit codes within the code category. Assign four-digit codes (subcategory codes) if there are no five-digit codes for that category. Assign five-digit codes (fifth-digit subclassification codes) for those categories where they are available.
ICD-9: 10 Steps to Correct Coding

Step 9: Consult the color coding and reimbursement prompts, including the age and sex edits.
- Consult the official ICD-9-CM guidelines for coding and reporting, and refer to the AHA’s Coding Clinic for ICD-9-CM for coding guidelines governing the use of specific codes.

Step 10: Assign the code.

Some Additional Conventions

Manifestation Codes
- A manifestation code is not allowed to be reported as a first-listed diagnosis because each describes a manifestation of some other underlying disease, not the disease itself. This is referred to as mandatory multiple coding of etiology and manifestation.
  - Code the underlying disease first.
- A Code first underlying disease instructional note will appear with underlying disease codes identified.
**Some Additional Conventions**

**Late Effects**
- A late effect is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury.

Coding of late effects generally requires two codes sequenced in the following order: The condition or nature of the late effect is sequenced first. The late effect code is sequenced second.

**Unspecified Code**
- Use these codes when the neither the diagnostic statement nor the documentation provides enough information to assign a more specified diagnosis code. These codes may be stated as “Unspecified” or “Not otherwise specified (NOS).”

Note: Do not assign these codes when a more specific diagnosis has been determined.

**Palmetto GBA Article (09/24/2010)**

Going Beyond Diagnosis: ICD-9-CM 799.3 Debility, Unspecified:

“The guidelines encouraged hospice providers to document how multiple conditions were contributing to the beneficiary’s medical prognosis of ‘six months or less.’ this was to be accomplished by specifically identifying the impairments, activity limitations, and disability associated with the principal diagnosis identified by the hospice provider (i.e., the condition that was impacting most acutely on the beneficiary’s clinical course).”
Description of ESRD Case

- ICD-9-CM
  - 585.6 - End stage renal disease

- Comorbid Conditions
  - 290.41 Vascular dementia with delirium
  - 787.2 Dysphagia
  - 507.0 Pneumonitis due to solids and liquids
  - 396.2 Mitral valve insufficiency and aortic stenosis
  - 441.4 Aortic aneurysm – Abdominal, without rupture
  - 414.9 Chronic ischemic heart disease, unspecified

Will CMS be asking for additional claims information in the future?

**Answer:** Yes. Given the recent growth in the Medicare hospice benefit as well as the recommendations from the Medicare Payment Advisory Commission (MEDPAC) and others, CMS will continue to evaluate the need for additional information on the hospice claim. Any additional requirements will be issued through program transmittals.


ICD-9 and Palliative Care

- Code for the diagnosis, condition, problem, or other reason for encounter/visit
  - List first the ICD-9-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.
  - 1500 Claim – up to 8 ICD-9 codes
Question Received by NHPCO....

- “There is some discussion as to how CMS wants hospice to code for Dementia. Do we code it Vascular Dementia if the patient has vascular dementia secondary to CVA? Or do we code it with the CVA diagnosis? The dementia will be the cause of death, however the dementia in this case is secondary to the CVA.”

- Here’s the easy question:
  o Should the cause of death drive the diagnosis code?

The Answer

- 290 Dementias
  o Code first the associated neurological condition
    Excludes
      dementia due to alcohol (331.0-331.2)
      dementia due to drugs (295.83)
      dementia not classified as senile, presenile, or arteriosclerotic (294.10-
      294.11)
      psychoses classified to 295-298 occurring in the senium without dementia or delirium (295.0-298.8)
      senility with mental changes of nonpsychotic severity (310.1)
      transient organic psychotic conditions (293.0-293.9)
  
  So, code the underlying neurological condition as primary

The Answer, cont’d

- 290.4 Vascular dementia
  o Multi-infarct dementia or psychosis
  o Use additional code to identify cerebral atherosclerosis (437.0)
  
  Excludes
  o suspected cases with no clear evidence of arteriosclerosis (290.0)

1) Have to code to the 5th digit
2) Must code the underlying vascular condition
The Answer, cont’d

That 5th digit....

- 290.40 Vascular dementia, uncomplicated
  - Arteriosclerotic dementia:
    - NOS
    - Simple type
- 290.41 Vascular dementia with delirium
  - Arteriosclerotic dementia with acute confusional state
- 290.42 Vascular dementia with delusions
  - Arteriosclerotic dementia, paranoid type
- 290.43 Vascular dementia with depressed mood
  - Arteriosclerotic dementia, depressed type

“The Answer, cont’d

“Use additional code to identify cerebral atherosclerosis (437.0)”

437  Other and ill-defined cerebrovascular disease

- 437.0 Cerebral atherosclerosis
  - Atheroma of cerebral arteries
  - Cerebral arteriosclerosis
- 437.1 Other generalized ischemic cerebrovascular disease
  - Acute cerebrovascular insufficiency NOS
  - Cerebral ischemia (chronic)
  - 437.2 Hypertensive encephalopathy

The Answer, cont’d

- 437.3 Cerebral aneurysm, nonruptured
  - Internal carotid artery, intracranial portion
  - Internal carotid artery NOS
- 437.4 Cerebral arteritis
- 437.5 Moyamoya disease
- 437.6 Nonpyogenic thrombosis of intracranial venous sinus
- 437.7 Transient global amnesia
- 437.8 Other
- 437.9 Unspecified
  - Cerebrovascular disease or lesion NOS
Final Answer

Not enough information to code correctly!

What we do know:
1. If you read the guidelines you can code correctly but
2. Only if you have sufficient documentation

Question Received by NHPCO....

• “If the patient’s H&P states brain “mass,” but we have no pathology report, can we use brain Ca as a diagnosis? Based on everything we’ve heard we should not and we have not. We’re getting so many referrals for patients who have not had a biopsy because of their age, physical status or their desire not to pursue the diagnostic testing. We’ve been using debility and coding “mass” secondary but we’re concerned about using debility so often.”

NOTE: Question received 2 days prior to publication of the 2014 Wage Index rule!

The Answer

• 799.3 Unspecified debility
• 784.2 Swelling, mass, or lump in head and neck
• Instructional notes: "... (780-799)-This section includes symptoms, signs, abnormal results of laboratory or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded. The conditions and signs or symptoms included in categories 780-796 consist of: (a) cases for which no more specific diagnosis can be made even after all facts bearing on the case have been investigated; (b) signs or symptoms existing at the time of initial encounter that proved to be transient and whose causes could not be determined; (c) provisional diagnoses in a patient who failed to return for further investigation or care; (d) cases referred elsewhere for investigation or treatment before the diagnosis was made; (e) cases in which a more precise diagnosis was not available for any other reason,..."
How does ‘debility’ look in ICD10?

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>799.3 Unspecified debility</td>
<td>R53 – Malaise &amp; Fatigue</td>
</tr>
<tr>
<td></td>
<td>R53.81 Other malaise</td>
</tr>
<tr>
<td></td>
<td>Chronic debility</td>
</tr>
<tr>
<td></td>
<td>Debility NOS</td>
</tr>
<tr>
<td></td>
<td>General physical deterioration</td>
</tr>
<tr>
<td></td>
<td>Malaise NOS</td>
</tr>
<tr>
<td></td>
<td>Nervous debility</td>
</tr>
</tbody>
</table>

An Intro to ICD-10
- What is all the fuss about
- A little bit on implementation

ICD-10 CM
- New HIPAA standard for coding diagnoses
  - Applies to all covered entities
- 14,025 ICD-9 codes versus 69,000 ICD-10 codes (and growing)
- Should reduce need for extra documentation
- Conducive to EHRs
- Implementation date: 10/01/2015??
ICD-10 Final Rule Issues

- Single implementation date for all users
  - Date of service for ambulatory and physician reporting
  - Date of discharge for inpatient settings
- ICD-9-CM claims for services prior to implementation date will continue to flow through systems for a period of time

ICD-9 is 30 Years Old

- ICD-9 – CM in use since 1979. WHO developed based on medical knowledge at that time.
- Countries using ICD-10
  - UK (1995)
  - France (1997)
  - Australia (1998)
  - Germany (2001)
  - Canada (2001)

A Comparison

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 Digits</td>
<td>3-7 Digits</td>
</tr>
<tr>
<td>1st digit is alpha or numeric</td>
<td>Digit 1 is alpha</td>
</tr>
<tr>
<td>Decimal is used after the 3rd character:</td>
<td>Digit 2 is numeric</td>
</tr>
<tr>
<td>- 496 – Chr airway obstruction</td>
<td>Digits 3-7 can be either</td>
</tr>
<tr>
<td>- 511.9 – unspecified pleural effusion</td>
<td>A decimal is used after the 3rd character:</td>
</tr>
<tr>
<td>- V02.61 – hepatitis B carrier</td>
<td>- 878 – Q fever</td>
</tr>
<tr>
<td></td>
<td>- A69.21 – Meningitis due to Lyme disease</td>
</tr>
<tr>
<td></td>
<td>- S82.13A – Displaced fx of neck of right radius, initial encounter for closed fx</td>
</tr>
</tbody>
</table>
## New Features in ICD-10

### Laterality (left, right, bilateral)
- C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast
- H16.013 – Central corneal ulcer, bilateral
- L89.012 – Pressure ulcer of right elbow, stage II

### Combination codes for certain conditions and common associated symptoms and manifestations
- K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding
- E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
- I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

### Combination codes for poisonings and their associated external cause
- T42.3x2S – Poisoning by barbiturates, intentional self-harm, sequela
- Character ‘x’ is used as a 5th digit placeholder to allow for future expansion and to fill in other empty digits when a code that is less than 6 digits requires a 7th character
- T46.1x5A – Adverse effect of calcium-channel blockers, initial encounter
- T15.02xD – Foreign body in cornea, left eye, subsequent encounter.
New Features in ICD-10

- Two Types of Excludes Notes
  - Excludes 1 – indicates the code excluded should never be used with the code where the note is located (do not report both codes)
    - Q03 – Congenital hydrocephalus
    - Excludes 1: Acquired hydrocephalus (G91.
  - Excludes 2 – Indicates the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time – both codes can be reported to capture both conditions.
    - L27.2 – Dermatitis due to ingested food
    - Excludes 2: Dermatitis due to food in contact with skin (L23.6, L24.6, L25.4)

New Features in ICD-10

- Inclusion of clinical concepts that do not exist in ICD-9, for Example:
  - T45.526D – Underdosing of antithrombotic drugs, subsequent encounter (drug underdosing)
  - Z67.40 – Type O blood, Rh positive (blood type)
  - Y90.6 – Blood alcohol level of 120-199 mg/100 ml (blood alcohol level)

New Features in ICD-10

- Significant expansion for a number of codes for:
  - Injuries
  - Diabetes
    - E10.610 – Type 1 DM w/diabetic neuropathic arthropathy
  - Substance abuse
    - F10.182 – Alcohol abuse with alcohol-induced sleep disorder
  - Postoperative complications
    - Displacement of heart valve prosthesis, initial encounter
New Features in ICD-10

- Expansion of and distinction between intraoperative complications and post-procedural disorders.
  - D78.01 – intraoperative hemorrhage and hematoma of spleen complicating a procedure on the spleen
  - D78.21 – post-procedural hemorrhage and hematoma of spleen following a procedure on the spleen.

Structural Differences

- Full code titles
- Laterality – Left v. Right
- Combines common associated conditions
- Clinical concepts that have not been available in ICD-9

Other Changes

- Injuries grouped by anatomical site rather than type of injury
- Certain diseases have been reclassified to different chapters to reflect current medical knowledge
- New code definitions
  - E.g.: definition of an acute MI is now 4 weeks rather than 8 weeks
- Codes corresponding to V and E codes are incorporated into the main classification rather than as supplementary classifications
- Several more...
Some Mapping is Easy...

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>428.9</td>
<td>I50.0</td>
<td>Heart Failure, Unspecified</td>
</tr>
<tr>
<td>Acute Kidney Failure</td>
<td>584.9</td>
<td>N17.9</td>
<td>Acute Kidney Failure, Unspecified</td>
</tr>
<tr>
<td>Intestinal Obstruction</td>
<td>560.9</td>
<td>K56.60</td>
<td>Unspecified Intestinal Obstruction</td>
</tr>
</tbody>
</table>

Others not so much: Lung cancer – 162.9

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>A 1:1 Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>• C34.00 Malignant neoplasm of unspecified main bronchus</td>
<td>• C34.30 Malignant neoplasm of lower lobe, unspecified bronchus or lung</td>
</tr>
<tr>
<td>• C34.01 Malignant neoplasm of right main bronchus</td>
<td>• C34.31 Malignant neoplasm of lower lobe, right bronchus or lung</td>
</tr>
<tr>
<td>• C34.02 Malignant neoplasm of left main bronchus</td>
<td>• C34.32 Malignant neoplasm of lower lobe, left bronchus or lung</td>
</tr>
<tr>
<td>• C34.10 Malignant neoplasm of upper lobe, unspecified bronchus or lung</td>
<td>• C34.80 Malignant neoplasm of overlapping sites of unspecified bronchus and lung</td>
</tr>
<tr>
<td>• C34.11 Malignant neoplasm of upper lobe, right bronchus or lung</td>
<td>• C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung</td>
</tr>
<tr>
<td>• C34.12 Malignant neoplasm of upper lobe, left bronchus or lung</td>
<td></td>
</tr>
<tr>
<td>• C34.2 Malignant neoplasm of middle lobe, bronchus or lung</td>
<td></td>
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ICD-9: CHF - 428

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>CHF</th>
</tr>
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<tbody>
<tr>
<td>• 428.0 Congestive heart failure, unspecified</td>
<td>• 428.22 Chronic systolic heart failure</td>
</tr>
<tr>
<td>• 428.1 Left heart failure</td>
<td>• 428.23 Acute on chronic systolic heart failure</td>
</tr>
<tr>
<td>• 428.20 Systolic heart failure, unspecified</td>
<td>• 428.30 Diastolic heart failure, unspecified</td>
</tr>
<tr>
<td>• 428.21 Acute systolic heart failure</td>
<td>• 428.31 Acute diastolic heart failure</td>
</tr>
<tr>
<td></td>
<td>• 428.32 Chronic diastolic heart failure</td>
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ICD-10 CHF

<table>
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<tr>
<th>Just for 428.0</th>
<th>A 1:12 Ratio</th>
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<tr>
<td>I50.1 Left ventricular failure I50.20 Unspecified systolic (congestive) heart failure</td>
<td>I50.32 Chronic diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.21 Acute systolic (congestive) heart failure</td>
<td>I50.33 Acute on chronic diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.22 Chronic systolic (congestive) heart failure</td>
<td>I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.23 Acute on chronic systolic (congestive) heart failure</td>
<td>I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.30 Unspecified diastolic (congestive) heart failure</td>
<td>I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
<tr>
<td>I50.31 Acute diastolic (congestive) heart failure</td>
<td>I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure</td>
</tr>
</tbody>
</table>

Muscular Dystrophy a 1:1 Crosswalk

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>359.0 Congenital hereditary muscular dystrophy</td>
<td>G71.2 Congenital myopathies</td>
</tr>
<tr>
<td>359.1 Hereditary progressive muscular dystrophy</td>
<td>G71.0 Muscular dystrophy</td>
</tr>
<tr>
<td>359.21 Myotonic muscular dystrophy</td>
<td>G71.11 Myotonic muscular dystrophy</td>
</tr>
</tbody>
</table>

Chronic Kidney Disease; End Stage

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>585.6 - End stage renal disease</td>
<td>N18.6 - End stage renal disease</td>
</tr>
</tbody>
</table>
### Cirrhosis

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
</table>
| 571.2 - Alcoholic cirrhosis of liver | K70.30 - Alcoholic cirrhosis of liver without ascites  
K70.31 Alcoholic cirrhosis of liver with ascites |
| 571.5 - Cirrhosis of liver without mention of alcohol | K74.0 Hepatic fibrosis  
K74.60 Unspecified cirrhosis of liver  
K74.69 Other cirrhosis of liver |

### Failure to Thrive

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
</table>
| 783.7 - Adult failure to thrive | R62.7 - Adult failure to thrive  
Code Information:  
- delayed puberty (E30.0)  
- gonadal dysgenesis (Q99.1)  
- hypopituitarism (E23.0) |
|    | Note: Will this even apply in hospice? |

### CMS on Unspecified Codes in ICD10*

* "In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. Each health care encounter should be coded to the level of certainty known for that encounter."

*ICD 903187 April 2013, pg 5*
CMS on Unspecified Codes in ICD10*

- "If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing to determine a more specific code.”

*ICD 903187 April 2013, pg 5

ICD-10 –

What it means from an operational perspective

- Budgeting
  - Resource Books
  - Overtime
  - Education
- Staff will need to be trained
- Physicians will need to be trained
- Software, hardware, form revisions
- Mapping of old and new codes
  - Doctors: Start now!

ICD-10 Things to Think About

- Will your [billing company] [contracted plans] be ready?
- Increased denials during learning curve and to-be-expected glitches
- Need for both ICD-9 and ICD-10 for at least 2 years
  - Working “old” A/R
- Process, policy changes
  - EMR templates will need to incorporate these ICD-10 concepts
  - Progress Note templates will need to incorporate these ICD-10 concepts
Training*

- Begin 3 to 6 months prior to implementation
- Coders
  - 16 hours of training, per AHIMA
  - 40-60 hours, per AAPC
- 8 hours – Administrative and clinical staff
  - Basics on how to code
  - Where will admissions staff find the needed information?
- Additional time for physicians
  - Perhaps 12 hours
  - Understanding the codes
  - Without an understanding, they won’t know what to document
  - How to document to support the codes

*AHIMA, Rand, Nolan, AHIP

Web Resources

- General ICD-10 information
  - [http://www.cdc.gov/hchs/about/major/dvs/icd10des.htm](http://www.cdc.gov/hchs/about/major/dvs/icd10des.htm)
- ICD-10-CM files, information, and General Equivalence Mappings (GEM) between ICD-10-CM and ICD-9-CM
  - [http://www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm](http://www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm)
- CMS Educational Tools
  - [www.cms.gov/ICD10](http://www.cms.gov/ICD10)
- American Academy of Professional Coders
  - [www.aapc.com](http://www.aapc.com)
- American Health Information Management Association
  - [www.ahima.org/icd10/understand.asp](http://www.ahima.org/icd10/understand.asp)

Questions?