ICD-10: Overview Training and Implementation Strategies for Providers

About the Presenters...

Leann R. Ottomeyer, RN, CTN, CPC
Administrator

Medicare-Certified Outpatient Rehabilitation Facility (ORF)
“The Gold Standard”

Ottomeyer Clinics, PLLC

✔ What is a Medicare Certified Outpatient Rehab Facility?
✔ Multi-specialty practice: 3 Chiropractors, 1 Medical Doctor, 1 Family Nurse Practitioner, 1 Physical Therapist, 1 Physical Therapy Assistant, 1 Certified Traditional Naturopath, 1 Massage Therapist
✔ Integrated approach to all aspects of patient care: from primary-care providers to pain management to convenience clinic model
✔ Efficient, affordable access to health-care
✔ Goal: to deliver optimal, integrated health-care to everyone
Learning Objectives

- Understand important ICD-10 guidelines
- Review basic ICD-10 coding structure
- Learn about “SNOMED” codes
- Review case studies for proper coding techniques
- Discuss implementation strategies

Are you ready?

What is ICD-10?
Developed by the World Health Organization as the 10th revision of the “International Classification of Diseases”

- Used internationally since 1995
- Each country is responsible for developing its own adaptations for ICD-10
- United Kingdom (1995)
- Australia (1998)
- Germany (2000)
- Canada (2001)
What is ICD-10?

- ICD-10 was adapted in the United States by the National Center for Health and Statistics to report morbidity and mortality.
- There are 2 code sets:
  - ICD-10-CM
  - ICD-10-PCS

What is ICD-10?

- U.S. has used ICD-10 since 1999 to report mortality data on death certificates
  - Ready for national use in 1994
  - Public comments 1997-1998
  - Tested in 2003 by AHA and AHIMA
  - Final rule published in 2009
  - Postponed in 2012 and 2014

ICD-10 vs. ICD-9

ICD-10 (~68,000 codes)  ICD-9 (~14,000 codes)
Why do we have diagnosis codes?

- HIPAA requirement
- Establish medical necessity
- Process claims
- Translate written terminology into common language
- Provide data for statistical analysis
- Identify fraud, set health care policy, measure quality

Why can't we keep using ICD-9?

- ICD-9 is not descriptive enough
- Many sections are full and cannot be expanded
- Not able to accurately reflect advances in medical technology
Why can't we keep using ICD-9?

- Will not meet the health care changes of the future
- The rest of the modern world is using ICD-10

_The international community is already preparing to switch to ICD-11._

ICD-9 vs. ICD-10

- Both use a tabular list divided into chapters based on body system or condition
- Both use a similar hierarchy
- Both maintain an index with main terms and sub-terms

ICD-9 vs. ICD-10

- Must code to the highest level of specificity
- ICD-10 is mandated under HIPAA
- Both code sets are used in conjunction with current CPT and HCPCS codes to report condition and procedure
ICD-9 vs. ICD-10

- ICD-9 has 17 chapters, ICD-10 has 21 chapters
- “External Causes of Morbidity and Mortality” and “Factors Influencing Health Status” are not considered supplemental classifications and are now Chapters 20 and 21 in ICD-10
- ICD-10 codes are alphanumeric to allow for more specificity

ICD-10

- ICD-10 includes laterality
- ICD-10 requires identification of:
  - “Initial encounter”
  - “Subsequent Encounter”
  - “Sequela”
- ICD-10 requires use of many combination codes when similar disease processes are encountered together

ICD-10 Excludes Codes

There are 2 types of codes that indicate that codes are excluded and independent from each other

- *Excludes1*: is used when 2 conditions cannot occur together or “NOT CODED HERE”!
  - These codes are mutually exclusive and will be rejected if submitted together on a claim
ICD-10

Excludes Codes

- **Excludes2**: indicates “NOT INCLUDED HERE”. These codes indicate the condition excluded is not part of the condition represented by the code. This indicates the patient may have multiple conditions occurring at the same time
  - Can be coded with the other condition listed

An Example of Excludes Codes

**M25.3 Other instability of joint**

- **Excludes1**
  - Instability of joint secondary to old ligament injury (M24.2-)
  - Instability of joint secondary to removal of joint prosthesis (M96.8-)
- **Excludes2**
  - Spinal instabilities (M53.2-)

Laterality in ICD-10 Coding

- Laterality is one of the most significant changes for musculoskeletal coding in ICD-10

- Many codes differentiate right, left, bilateral or unspecified
Laterality in ICD-10

- M25.311 Other instability, RIGHT shoulder
- M25.312 Other instability, LEFT shoulder
- M25.319 Other instability, UNSPECIFIED shoulder

Sequela Codes

- A sequela is a residual effect after the acute phase of an illness or injury has ended.
- These residual effects are always directly produced by the condition.

ICD-9 vs. ICD-10 Code Structure
Let's break down a code...

M25.311

- M refers to “Diseases of the Musculoskeletal System and Connective Tissue”
- 25 refers to “Other joint disorder, not elsewhere classified”
- .3-- refers to “other instability of joint”
- .-1- refers to “shoulder”
- .--1 refers to “right” side

*M25.311 Other instability of joint, right shoulder*

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Important Coding Guidelines

- Always choose the code with the highest level of specificity
- Codes can be 3, 4, 5, 6, or 7 characters.
  - Only pick a 3 character code if there is not an appropriate 4 character code
- Claims WILL be denied for lack of specificity

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Important Coding Guidelines

- Know your payer guidelines
- Only choose signs and symptoms codes when there no definitive diagnosis (R00 to R99)
- If a particular sign or symptom is typically associated with a known diagnosis, do not include the sign or symptom code
  - ex. Sciatica implies hip pain
Important Coding Guidelines

- Do not code for diagnoses that are “probable”, “suspected”, “likely” or “questionable”
- Do not code conditions that no longer exist
- Signs or symptoms that are not typically associated with a condition are okay to code
  - ex. Cervical Strain and Numbness in Hand

Important Coding Guidelines

- Code all conditions that coexist at the time of the visit—but only if they effect patient care.
- Always list acute conditions before chronic conditions
- Include laterality if given in the Alphabetic Index

Important Coding Guidelines

7th Character (Encounters)

- A = Initial Encounter: patient is receiving active care during the first visit to a new provider
- D = Subsequent Encounter: routine care during the healing / recovery phase, such as aftercare and follow-up
- S = Sequela: complications or conditions which are a direct result of a previous condition
  (ex. DDD which develops 5 years after lumbar spine)
Important Coding Guidelines

7th Character Rules
- Some categories in ICD-10 require a 7th character.
- The 7th character must always be used.
- If the code that requires a 7th character is not a 6 character code, then use an “x” placeholder.

Important Coding Guidelines

Dummy Placeholders
- ICD-10-CM utilizes a placeholder “X”
- “X” is used as a 5th or 6th character placeholder when a 7th character is required for codes that are less than 6 characters in length
- A code may require more than one dummy placeholder

Example
T18.2xxA Foreign body in stomach, initial encounter

Code Specifically
- It is very tempting to code for every possible complaint the patient gives
- Signs and symptoms codes are only acceptable when a definitive diagnosis has not been made. (723.1 Cervicalgia)
- Only code for the most relevant conditions and BE SPECIFIC!!!
Code Specifically

- ICD-10 requires specificity (the code sequenced first on the medical records explains “why” the patient was seen.)
- Some “claim-readable” software will only read the 1st code listed on the claim—make it count!
- Always code acute before chronic

Examples of ICD-10

- S02.0xxA Fracture of vault of skull, initial encounter for closed fracture
- T17.828 Food in other parts of respiratory tract, causing other injury
- T81.19xS Other postprocedural shock, sequela (note “x” placeholder)
- S73.111 Iliofemoral ligament sprain of right hip
- Y93.6A Activity, physical games generally associated with school recess, summer camp and children

How Do I Choose the Right Codes?

Payer guidelines dictate which codes to use, but you can follow a general guideline:
1. Neurological
2. Structural
3. Functional
4. Soft Tissue
5. External Causes
   
   Note the order of these codes...
Ch. 6: Diseases of Nervous System (G00-G99)

Dominant / Non-dominant Side: codes related to hemiplegia and hemiparesis require specificity of the dominant side.
- Right dominant side (6th character = 1)
- Right non-dominant side (6th character = 3)
- Left dominant side (6th character = 2)
- Left non-dominant side (6th character = 4)
- G81.002 Flacid hemiplegia affecting left dominant side

Ch. 6: Diseases of Nervous System (G00-G99)

Complete / Incomplete: quadriplegia and paraplegia require documentation related to the severity of the spinal cord injury and the level of injury.
- Complete (5th character = odd number 1,3,5)
- Incomplete (5th character = even number 2,4)
- G82.53 Quadriplegia, C5-C7 complete

Ch. 6: Diseases of Nervous System (G00-G99)

Pain—G89
- These codes are often interpreted by the payers as psychosomatic conditions, so use a functional or neurological code if the condition exists.
- Do not use a pain code if the definitive diagnosis implies pain. (i.e. open ankle fracture does not require a pain code, it is implied)
Ch. 6: Diseases of Nervous System (G00-G99)

- Headaches
  - G43 Migraines
  - G44 Other headache syndromes

Migraines G43._ _ _
There are 44 codes for Migraines
Documentation must include the following:
- With or without aura
- Intractable vs Not Intractable
- With or Without Status Migrainosus
- Persistent or Chronic
- With or Without Vomiting
- With or Without Hemiplegic, Cyclical, Ophthalmoplegic, etc

Migraines G43._ _ _
- Use additional code for adverse effect, if applicable, to identify drug (T36-T50 with fifth or sixth character 5)
  - Exclude1
    - headache NOS (R51)
    - lower half migraine (G44.00)
  - Exclude2
    - headaches syndromes (G44.-)
G43.111 Migraine with aura, intractable, with status migrainosus
If the musculoskeletal condition has an *external cause*, such as an accident, then the musculoskeletal code MUST be followed by an *External Cause* code from Chapter 20.

It is correct to code *both* the injury and the activity that caused it.

- M76.61 Achilles tendinitis, right leg
- Y93.02 Activity, running

**Site and Laterality—Required for most codes**

- “Site” represents the bone, joint or muscle involved.
- If multiple sites are involved, and a multiple site code is available, use it.
  - You don’t have to list each site with a multiple site code.
- If multiple sites are involved and there is no code to indicate it, then you should provide a code for each site affected that you are treating.

**Acute Traumatic vs. Chronic or Recurrent**

- Any current acute injury should be coded from Chapter 19 (Injury, Poisoning and Certain other Consequences of External Causes). S00-S99
- Any chronic or recurring condition should be coded from Chapter 13 (Diseases of M.S. System) M00-M99
- If a condition is a late effect (sequela) of a previous condition, you should also include a code for “Personal History of...” Z77-Z99
Ch. 18: Guidelines for Symptoms, Signs and Abnormal Clinical Findings (R00-R99)

Use of Symptom Codes

- Appropriate when a related definitive diagnosis has not been established.
- Only code a sign or symptom that does not typically occur with a definitive diagnosis.
  - e.g. Femur Fracture
    (Pain? Swelling? Nausea?)
- If a combination code contains the sign / symptom, do not list it separately.

Ch. 19: Guidelines for Injury, Poisoning, and Certain Other External Causes (S00-T88)

When an injury is involved in the diagnosis, follow these rules:

1. Code Injury First (Sprain of right wrist)
2. Code Type of Injury (Fall on level ground)
3. Place of Occurrence (On tennis court)
4. Activity Code (While playing a recreational sport)
5. External Cause Code (Earthquake)
6. Where at Working at Time of Injury (if appropriate)

Ch. 19: Guidelines for Injury, Poisoning, and Certain Other External Causes (S00-T88)

Always code most serious injury first.

Watch for timing of care

A = initial encounter
D = subsequent encounter
S = sequela (late effects)
Sprain / Strain Codes have changed!!

- With ICD-10 you MUST code sprain and strain separately!
  - Choose “Strain” if the muscle fibers have torn from overstretching
    - e.g. “Pulled muscle”
  - Choose “Sprain” when the ligaments and tendons are involved.
  - In almost all circumstances, you will need to code for both “sprain” and “strain.”

I just want to code a subluxation!

Subluxation and/or Dislocation of Vertebras Rules of Coding:

- Subluxation vs. Dislocation
- Initial, Subsequent, or Sequela
- Must indicate the vertebral level

Examples:
- S33.130D Subluxation of L3/L4 lumbar vertebra, subsequent encounter
- S33.131D Dislocation of L3/L4 lumbar vertebra, subsequent encounter

Where Do I Find the Subluxation Codes?

- Cervical: 28 codes
  - S13.100_ to S13.181_
- Thoracic: 35 codes
  - S23.1_ to S23.171_
- Lumbar: 20 codes
  - S33.1_ to S33.39xx_

Pay attention to the dummy placeholder and the 7th character requirements for these codes!!
How Do I Choose the Right Codes?

Payer guidelines dictate which codes to use, but you can follow a general guideline:

1. Neurological
2. Structural
3. Functional
4. Soft Tissue
5. External Causes

Note the order of these codes...

How Do I Code for Injuries?

1. Injury is always First
2. Type of Accident
3. Place of Occurrence
4. Activity Code
5. External Cause Code
6. Where was patient at time of injury?

Coding for Injuries

1. What was the injury? (sprain, strain, herniation, etc)
2. What type of accident? (MVA, fall from ladder, etc)
3. Where did it happen? (playground, driver of car, etc)
4. What was patient doing? (driving, playing tennis, etc)
5. External causes (hint: Chapter 20: V-codes)
6. Where was patient working at time of injury?
Examples of ICD-10 Codes

1. Tongue tied: Q38.1
2. Loss of voice: R49.1
3. Patient follow-up visit for history of falls: Z91.81
4. Functional Quadriplegia: R53.2
5. Patient has Type 1 diabetes without complications: E10.9
6. 40-year old patient with morbid obesity with a BMI of 47.6: E66.01 and Z68.42
7. Concussion and edema of cervical spinal cord, initial encounter: S14.0xxA

SNOMED Codes

- SNOMED is a systematically-organized, computer process-able collection of medical terms
- It provides codes, terms, synonyms and definitions used in clinical documentation and reporting
- Considered to be the most comprehensive, multilingual clinical health care terminology in the world

The primary purpose is to encode the meanings that are used in health information and to support the effective clinical recording of data with the aim of improving patient care.

SNOMED Codes

Consists of 4 primary core components

- Concept Codes—numerical codes that identify clinical terms, primitive or defined hierarchies
- Descriptions—textual description of concept codes
- Relationships—relationships between concept codes that have a related meaning
- Reference Sets—used to group concepts or descriptions into sets, including reference sets and cross-maps to other classification standards
How does SNOMED impact a clinical practice?

Meaningful Use:

- SNOMED codes are part of Stage 2 Meaningful Use implementation
- Stage 2 Meaningful Use requires unique electronic medical record systems to communicate with each other

How does SNOMED impact a clinical practice?

- Since EMR systems must share data and understand the context, SNOMED codes link sets of data with diagnoses and context to convey and the relationship between the condition, cause / effect, etiology and complicating factors
- All providers planning to attest for Stage 2 Meaningful Use are required to use these codes

What Do SNOMED Codes Look Like?
Case Studies

A 38-year old female was the front-seat passenger in a side-impact motor vehicle accident to the rear driver quarter panel of an SUV. She had immediate left-sided neck pain and headache upon impact with no loss of consciousness. She was evaluated by EMS at the scene but refused transportation to the ED for further evaluation. Three days later, she presents to Dr. Wonderful for treatment. She reports headaches, stiffness, neck pain, arm pain and left-sided low back pain.

Clinical findings: decreased range of motion, palpable pain, positive orthopedic findings for left-sided cervical and lumbar pathology, myelopathic weakness, decreased cervical and lumbar deep tendon reflexes.

What ICD-10 codes would you assign to this patient?

M54.12—cervical radiculopathy
M54.42—sciatica with lumbago (combo code)
M62.81—muscle weakness, generalized
M62.83—muscle spasm, back (diminished ROM)
V43.52x—car driver in traffic accident with other car

Don't Panic!
How Does Documentation Change?

- The AAPC estimates that documentation time may increase by 15%.
- The AAPC believes that 65% of physician notes are not specific enough.

Details not required for ICD-9:
- Laterality
- Side of dominance
- Trimesters
- Stages of healing
- Timing of encounter for care

How Does Documentation Change?

Medical documentation must support the “how”, “what”, “why”, “where” and “when” of the problem.
- How did the problem happen?
- What are the functional changes?
- Why does the pain/symptom exist?
- Where did the problem arise?
- Where is it located in the body?
- When did the treatment/problem start?

New Patient Examination Criteria

99201-99205

3 Components which drive E/M level
1. History
2. Exam
3. Medical Decision Making

Each component is divided into several sub-components which are necessary to support the level of E/M exam performed.
Defensible Documentation

- Review documentation requirements for New and Established Patient Exams
- Discuss documentation requirements for proper reimbursement
- Be prepared for documentation requirements for ICD-10

“If you don't document it, you didn't do it.”

Components of History

There are 4 components included:

1. Chief Complaint
2. History of Present Illness
3. Review of Systems
4. Past, Family and Social History (PFSH)

1. Note: ROS and PFSH from an earlier encounter are permissible, as long as provider references them and reviews them with no changes. Document this!

History of Present Illness

HPI is a chronological description of the problem:

1. Location—anatomical site
2. Quality—characteristics, how it feels or looks
3. Severity—how bad is it and is it changing?
4. Duration—how long has it been a problem?
5. Timing—i.e. Constant, intermittent, in AM....
6. Context—what was patient doing to cause it?
7. Modifying Factors—what makes it better or worse?
8. Associated Signs and Symptoms—secondary complaints
Review of Systems (ROS)

A complete review of systems can be obtained through a combination of questions asked directly by the physician and/or support staff and patient intake tools. All systems reviewed must be documented and referenced in by the provider.

- Constitutional (signs and sx)
- Eyes
- Ears, Nose and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic / Lymphatic
- Allergic / Immunologic

Past, Family, and Social History (PFSH)

- Past History includes: childhood diseases, past illnesses, operations, injuries, treatments and medications.
- Social History includes: age appropriate activities, caffeine and alcohol consumption, tobacco use, etc.
- Family History includes: medical events or hereditary illnesses

Examination

There are 2 options for a multi-level physical examination.

- 1995 CMS Diagnostic Guidelines
- 1997 CMS Diagnostic Guidelines

It does not matter which format you use, just be consistent.
Examination

If using 1995 DG guidelines:
1. Problem-Focused—generally one body area and/or organ system exam
2. Expanded Problem-Focused—limited 2-7 body area and/or organ systems
3. Detailed—an extended 2-7 body area and/or organ systems
4. Comprehensive—8 organ systems (no body areas)

Examination

If using 1997 DG guidelines:
1. Problem-Focused—1 to 5 bullet elements
2. Expanded Problem-Focused—6 or more bullet elements
3. Detailed—2 or more bullet elements each of 6 body areas OR at least 12 bullet elements
4. Comprehensive—2 or more bullet elements from each of 9 areas

Medical Decision Making

MDM is measured by:
- Number of diagnoses and treatment options
- Amount and complexity of data reviewed by the provider
- Risk to the patient or probability of patient's condition deteriorating on this visit or the next
PART Exam for Medicare Standards

- Medicare requires a subluxation to be documented each visit for medical necessity.
- Use a PART exam format, meeting at least 2 of 4 PART criteria.

Pain/tenderness evaluated: include location, quality, intensity

Asymmetry/misalignment: identified on a segmental level

Range of motion abnormality: changes in active, passive, and accessory joint movements resulting in changes in segmental mobility

Tissue—changes in characteristics of associated soft tissues (skin, fascia, muscle, and/or ligament)

Medical Necessity

- Medicare will only cover claims that meet the criteria for medical necessity.
- AT modifier (Active Treatment)
- Remember the Medicare Coding Tree!!

To demonstrate a subluxation by exam, 2 of 4 components of PART must be documented and 1 must be:

- Asymmetry/misalignment: identified on a segmental level

How Do I Choose the Right Codes?

Payer guidelines dictate which codes to use, but you can follow a general guideline:

1. Neurological or Injury
2. Structural
3. Functional
4. Soft Tissue
5. External Causes

Note the order of these codes...
Mrs. Nelson has been a regular patient for 5 years. She is on a maintenance program and sees you twice a month for her chronic low back pain. She added to your schedule this afternoon. When you see her, it is obvious that she is experiencing neck stiffness since her head is rotated toward her left shoulder and she cannot look straight ahead. She reports that she had been sick in bed for 3 days with a cold. Last night she took a decongestant and something to help her sleep. She believes she slept in the same position, on her right side, all night long. When she woke up this morning, she could not turn her head all the way to the right. You perform a problem-focused exam and treat her today.

Code this for both ICD-10 and CPT codes.

Is this a maintenance visit?

M43.6—torticollis

(why not G24.3?)

Excludes1: Congenital(sternomastoid) torticollis (Q68.0)

Current injury—see injury, of spine, by body
region

Ocular torticollis (R29.891)
Psychogenic torticollis (F45.8)
Spasmodic torticollis (G24.3)
Torticollis due to birth injury (P15.2)

G24.3 Spasmodic torticollis

Excludes1: Congenital torticollis (Q68.0)

Hysterical torticollis (F44.4)
Ocular torticollis (R29.891)
Psychogenic torticollis (F45.8)
Torticollis NOS (M43.6)
Sara Sunshine was treated for a follow up visit today. She was initially treated last week after she fell down the stairs while carrying a basket of laundry at home. She reports low back stiffness and pain radiating down her leg from her low back into her left foot. She also has numbness and swelling. X-ray studies on the ankle revealed no abnormalities. After a detailed new patient exam, you determined that she has a lumbosacral sprain/strain, left-sided sciatica and a left ankle sprain.

How would you code this visit?

Sara Sunshine was treated for a follow up visit today. She was initially treated last week after she fell down the stairs while carrying a basket of laundry at home. She reports low back stiffness and pain radiating down her leg from her low back into her left foot. She also has numbness and swelling. X-ray studies on the ankle revealed no abnormalities. After a detailed new patient exam, you determined that she has a lumbosacral sprain/strain, left-sided sciatica and a left ankle sprain.

M54.42—sciatica
S33.9xxD—lumbosacral sprain
S39.012D—lumbosacral strain
S93.402D—left ankle sprain
W10.8xxD—fall down stairs
Y93.E—activity, laundry

Ms. Jones presented today for chiropractic care after a car accident yesterday. She is complaining of headaches and neck pain, pain in her arm and down into the mid-back. She states the pain is getting worse. Her cervical range of motion is diminished and she has pain when she lifts her arm.

Assessment: Whiplash injury and arm pain

What's Missing?
A 35-year old female patient presents as a new patient following an auto accident on 12/31/14. A car stopped suddenly in front of the car she was driving on the freeway. She tried to stop but rear-ended the car in front of her. She believes she was traveling at 40 mph at impact but was braking. She refused transportation to the hospital at the scene. She states that “within a few hours”, she started experiencing neck and back pain. The next day, she went to her primary MD who prescribed Darvocet and Flexaril. These medications provided only temporary relief leading her to seek out care at this clinic.

Patient complains of neck pain with associated radicular pain down the back of both arms. The pain is greater on the right side. She states it hurts to raise her right arm above the head. She also notes localized moderate mid- and low back pain and stiffness.


**Coding for Injuries**

1. What was the injury? (sprain, strain, herniation, etc)
2. What type of accident? (MVA, fall from ladder, etc)
3. Where did it happen? (playground, driver of car, etc)
4. What was patient doing? (driving, playing tennis, etc)
5. External causes (hint: Chapter 20: V-codes)
6. Where was patient working at time of injury?

**When an injury is involved in the diagnosis, follow these rules:**

1. Code Injury First (Sprain of right wrist)
2. Code Type of Injury (Fall on level ground)
3. Place of Occurrence (On tennis court)
4. Activity Code (While playing a recreational sport)
5. External Cause Code (Earthquake)
6. Where at Working at Time of Injury (if appropriate)
So.....How Do We Implement This?

EHR Documentation

- As of January 1, 2015—all Minnesota providers are required to have an interoperable electronic health record system in place.
- All healthcare providers that provide services that could be reimbursed by Medical Assistance are required to have interoperable software, whether or not they actually treat and take insurance reimbursement for MA care.
- The provider must have a certified version on an EHR in use.
- http://www.health.state.mn.us/e-health/hitimp/

What is an Inter-Operable Software?

MDH Website:

“What are the interoperability requirements?
Interoperability is the ability of two or more systems or components to exchange information and to use the information that has been exchanged accurately, securely and verifiably, when and where needed.”

This means your software has to talk to mine and my software has to understand what yours said.

http://www.health.state.mn.us/e-health/hitimp/
EHR Documentation

Your EHR Can Help You Achieve ICD-10 Success
- Use of templates
- Prompts
- Greater coding accuracy and productivity
- A good EHR software will offer Computer Assisted Coding (CAC) software
- Reduced compliance risks

EHR Templates

Templates can be a great tool or a great liability, depending on how you use them.

Pros:
- Collect data that can be reused in other parts of record
- Trigger provider to complete missing components to visit
- Collects and organizes data

Cons:
- Can be used too broadly
- Must be careful to avoid inaccurate information from "routine clicks"
- Can look too canned from visit to visit
- Can result in incomplete coding if not careful

EHR Templates

Details to Include:
- Encounter type (initial, subsequent, sequela, routing healing, delayed healing)
- Laterality
- Severity
- Disease relationships
- Anatomic details
- Etiology
- Symptoms / manifestations of disease process
EHR Templates

- Relationship of condition to procedure
- Post-procedure complication?
- Fracture type
- Dominant / Non-dominant side (hemiplegia and monoplegia cases)
- External cause
- Route of administration
- Traumatic vs. pathologic / chronic
- Specific body part involved

EMR Software

- Stage 2 Meaningful Use software should allow for conversion of ICD-9 codes to ICD-10 and SNOMED
- Your software should also allow for code sets to automatically change based on the date (9/30/15 vs. 10/01/15)
- Your software MUST push both ICD-9 and ICD-10 codes for at least 2 years
- Remember, Personal Injury and Work Comp Payers are only encouraged to switch to ICD-10 format
- But, Minnesota requires that Work Comp Payers are compliant with the ICD-10 conversion

EMR Software

- Accurate data on severity, risk, quality and outcomes depends on complete, accurate coding and documentation
- Non-specific documentation results in non-specific code assignments
- Non-specific code assignments results in denials by third-party payers
- EHR software should assist complete, unique documentation for each patient encounter
Are There Any Tools I Can Use?

- Yes—CAREFULLY
- General Equivalence Mapping (GEM) Tools can simplify your coding, if you understand the limitations
- GEMs tend to point from a specific code to a generalized code or a different code than you started with.
- These coding tools can be okay, as long as you understand how to use them

GEMs

- According to the CMS website, GEMs are a useful tool to create an initial crosswalk, for large sets of codes
- GEMs can be used to “get familiar” with the new codes
- GEMs will NOT be updated by CMS as codes change over time
- Do not depend only on GEMs

GEM Examples

- 739.1 Non-allopathic Lesion of Cervical Spine (all levels)
- Becomes S13.140A Subluxation of C3/C4 cervical vertebrae, initial encounter
- But the GEMS will point this back to 839.03 Closed dislocation, 3rd cervical vertebrae
What Resources I Can Use?

Options for GEMs:

- “Find-a-Code” App for smartphone
- AAPC and AHIMA have created tools to assist with crosswalk
- Update your Electronic Medical Record (EHR) software to ICD-10 compatible
- Proprietary Resources (ChiroCode Institute)

Example of ICD-10 Crosswalk

Nuts and Bolts...

- Understand how the ICD-10 codes are changing and how to use them
- Require your biller/coder to get training to understand and use ICD-10 codes
- Decide who is responsible to implement ICD-10 changes in your practice
- Communicate with that delegated person about a timeline
- Locate all existing documents with ICD-9 codes (fee slips, medical record templates, etc)
Nuts and Bolts...

- Prepare a list of most commonly used ICD-9 codes
- If currently on EMR software, talk to vendor about ICD-10 conversion
  - Determine a timeline of conversion
- After software conversion, begin process to crosswalk ICD-9 codes to ICD-10 equivalents
  - Some EMR systems will have built-in crosswalks
  - Other systems may require you to create a “pick list” of utilized codes

Nuts and Bolts...

- If currently using paper charting, you are now REQUIRED to transition to electronic records
  - Your master forms will need both ICD-9 and ICD-10 codes as you get more familiar with the new code sets
- Create “cheat-sheets” of most commonly used codes
- Maintain current versions of both ICD-9 and ICD-10 coding manuals.
- Make sure you are using the correct version of CMS-1500 claim form.
- Make sure your EHR is “inter-operable”

Pulling It All Together

- Use an Electronic Medical Record (EMR) system that is certified for Stage 2 Meaningful Use.
- Identify the ICD-9 codes most commonly used in your practice and begin to cross-reference them to the appropriate ICD-10 codes
- Beware of mapping tools! They may steer you wrong.
- Get educated on ICD-10 coding conventions
- Identify all the places in your practice flow that need to be updated for ICD-10
What is the grace period for ICD-10 implementation?

CMS has indicated that there is NO grace period beyond the October 1, 2015 deadline.

Be prepared and plan now.

Resources

- CMS.gov/icd10
- Aapc.com/icd10
- Ahima.org/icd10
- DHS.state.mn.us—search for ICD-10
- Local payers websites—search for ICD-10