Getting Ready for ICD-10: Cracking the Code

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ICD 10 is here !!!

• Will be used for Outpatient services October 1, 2014. (NOT BEFORE.)
• 6 fold increase of available Diagnosis codes will allow for more complex and specific detail in diagnosis.
• THIS DOES NOT increase complexity of the procedure during the visits (Diagnosis codes is different from Procedure codes)

Definitions

• *International Classification of Diseases (10th edition), Clinical Modification or “ICD-10-CM”*

versus

*Coding Procedural Terminology or “CPT”*

CPT vs ICD

**CPT**
• Procedure Codes
• How we paid (for Procedures we do)
• Based on Complexity
• RVU linked
• Physician care about this
• “Is the patient covered?”

**ICD**
• Diagnosis Codes
• Describes patient
• Unrelated to physician reimbursement
• But “labels” patient so pts care (future life insurability, “pre-existing conditions”) 
• Diagnosis code should support procedures performed.

Difference between Procedure (CPT) Codes & Diagnosis (ICD) Codes

• Insurances pay us for our Procedures (CPT Codes). NOT DIAGNOSES!!! They still might not recognize all CPT Codes.
• However, Diagnosis Codes support the reasons for the Procedures.
• Payers will all have to collect all ICD codes!

WHY do we have to use these codes?

• It’s the Law!!!
• IT will NOT help improve patient care.
• No physician or Insurer wanted this change
• The CDC people (& other epidemiologists) want to use physicians as data collectors, so THEY can gain information and get more specific patient info! (SORRY!!!)
### History of ICD-10
- ICD-10 (invented here in USA) was endorsed by the 43rd World Health Assembly in May of 1990.
- Came into use in 1994.
- ICD-11 is just around the corner!
- Reality is that this is just a language issue. As physicians we really know & use these terms and categories!

### Delays to date
- Electronic Data submissions standards had to be updated to handle the increased data (5010 standard). Was finally met January 1, 2012.
- 5010 format accommodates 12 diagnosis codes per claim.
- No more delay despite complaints on multiple fronts (mostly PAYERS!)

### Advantages of ICD-10
- More specific & descriptive will allow us to state why many of our patients come to see us. (Rule out allergies because of Family history, or vague past medical history that is uncertain).
- ICD-10 “Z” codes
- Reduces the need for attachments to explain the patient’s condition
- Claims should be processed quicker

### Advantages of ICD-10
- Now we can easily distinguish between CPT codes (always 5 numbers) versus Diagnosis codes (which now always start with a Letter).

### Disadvantages
- No way that a 1 page “superbill” with all diagnosis codes can exist!
- You will have to have sets of diagnosis codes linked together in your systems, which could be brought up easily for each patient.

### Disadvantages
- Definitely will force us to be more specific (when we can).
- Seems that we will be forced to stay away from “Non-specific” (exact etiologies will be detailed).
- Clearly there is going to be semantics and language problems (i.e. There are 2 different ICD-10 codes for “Shortness of Breath” & Dyspnea)
Disadvantages

• Confusion in reading the ICD-10 Code book: “inclusion terms” will list some of the terms to be used, but in a confusing syntax (i.e., Code for ‘history of peanut allergy’ is Z91.010, but the written text states “allergy status, other than to drugs & biological substances, allergy to peanut”???)
• USE of NEC = “other specified”, & NOS=“Unspecified”
• Use of “and” means and/or

Disadvantages - “excludes” notes

• “Excludes 1” indicates that code should NEVER be used at the same time as the listed exceptions in the “excludes 1” note. (i.e., Anaphylactic rx to peanuts, T78.01-, not used with anaphylaxis to nux & seeds, T78.05X)
• “Excludes 2” indicates that the condition excluded IS NOT part of the condition represented by the code, but the patient may also use the second listed code at the same visit. (i.e., Wheezing, R06.2 with asthma codes J45.-)

Disadvantages

• BOTH Chronic & Acute conditions (i.e. Sinusitis) can be used in the same patient encounter. (acute code goes 1st)
• Codes will change from one day to the next (i.e., Contact Dermatitis codes might change from day of first visit, before patch test results, to 4th day after Patch tests are read. Also “specified” L23.-- versus “unspecified” L25.--
• 7th digit = “a” for initial visit or reaction, versus “d” for subsequent visit, & “s” for sequela

Disadvantages

• With/Without: When “with” and “without” are the two options for the final character of a set of codes, the default is always “WITHOUT”
• i.e. Extrinsic or Intrinsic Asthma with Status asthmaticus is J45.902, as opposed to other asthma codes J45.901, J45.909, or J45.998; Same is seen with the mild, moderate, or severe persistent asthma codes

Potential Benefit to Us: 

• Example: Use of Spirometry in our patients with Allergic Rhinitis but no documented asthma. Technically no reason to do spirometry if we only diagnose only “Rhinitis” Codes (J30.XX - J31.0), but if you also code “breathing/coughing” problems (i.e., Dyspnea/Shortness of Breath Codes - R06.XX, or Coughing- R05, or Chest Pain Codes R07.8XX) we should be all right

ICD-9 CM Versus ICD-10CM

<table>
<thead>
<tr>
<th>ICD-9 CM</th>
<th>ICD-10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 characters</td>
<td>3 - 7 characters</td>
</tr>
<tr>
<td>First character is numeric or alpha (E or V)</td>
<td>Character 1 is alpha (all letters except U are used)</td>
</tr>
<tr>
<td>Characters 2-5 are Numeric</td>
<td>Character 2 is numeric</td>
</tr>
<tr>
<td>Always at least 3 characters</td>
<td>Characters 3-7 are alpha or numeric</td>
</tr>
<tr>
<td>Use of decimal after 3 characters</td>
<td>Use of decimal after 3 characters</td>
</tr>
<tr>
<td>Use of dummy placeholder “x”</td>
<td>Use of dummy placeholder “x”</td>
</tr>
<tr>
<td>Alpha characters are not case-sensitive</td>
<td>Alpha characters are not case-sensitive</td>
</tr>
</tbody>
</table>
ICD-10 CM Character Layout

- 1st Character – name of section
- 2nd Character – body system
- 3rd Character – etiology
- 4th Character – anatomical site
- 5th Character – severity
- 6th Character – device
- 7th Character- qualifier
- (extension) only used in some sections of the system

ICD-10 CM Coding Guidelines

- Code to the highest degree of specificity documented
  - Statistic – 65% of all providers documentation lacks the degree of specificity required for ICD-10CM

ONGOING ISSUE

Document, Document, Document!!!!

- If it’s not recorded, it did not happen!
- If it is illegible – it did not happen!

ICD-10 CM Coding Guidelines

- Locate the term in the alphabetic index
- Verify the code in the tabular list
- Read instructional notations that appear in both alphabetic Index and tabular index
- A dash (-) at the end of an alphabetic index indicates that additional characters are required

ICD 10 Downloadable “book”


Joint Council of AAI has made “cheat sheet” available

Conversion sites between ICD-9 & ICD-10

- [http://www.icd10data.com/Convert](http://www.icd10data.com/Convert)

“Z” Codes will be very helpful

- Encounter for allergy testing (Z01.82)
- Personal history codes for peanut allergy (Z91.010); variety of specific foods (Z91.011-Z91.02); & other things (again definitive separate codes in Z91.0XX)
- Drug Allergy codes: to Penicillin (Z88.0); or other drugs (Z88.1-Z88.9)

Asthma Codes could now change with each visit

- Asthma codes (J45.20-J45.998) is mostly based on Asthma severity score (but also with codes that note acute exacerbation, or status asthmaticus)
- Cough variant asthma with separate code (J45.991)
- Exercise induced asthma (J45.990)

Anaphylaxis

- Will require specific coding. Patient with Personal history of anaphylaxis gets Z87.892 code PLUS the historical agent reported (Z88.-codes or Z91.0-codes for non-foods)
- Hx of anaphylaxis to a food use T78.00Xx (where the 7th digit would be “a” for initial visit; “d” for subsequent visit; or “s” for a sequela from the anaphylaxis).

Shot reactions

- If pt has system reaction to shot first code to use would be T88.6XXa to designate an acute anaphylactic rx given at that initial visit for properly administered drug or medication.
- Plus you would record the code of why you were giving shots for (pollen allergens, or insect venom hypersensitivity, etc).

Respiratory Symptoms & signs

- Confusion in my mind about when to use the codes for “shortness of breath”, versus “dyspnea”
- Marshall Grodofsky’s opinion: Use “shortness of breath” code (R06.02) for patient history of SOB. Orthopnea R06.01 also would be history of SOB with laying down.
- Dyspnea (R06.00) is a finding by physician on physical exam.
Confusion over different Contact Derm Codes

• Two sets of codes from L23.0- L25.9
• L23.- codes “allergic contact dermatitis”
• L25.- codes are “unspecified contact derm”
• What’s the difference?????
• Marshall Grodofsky’s guess is that the L23.- codes are patch test proven, and the L25.- codes are historically suggested. Any other guesses?????

Getting Ready

• Learn the most common “allergy” codes: ie. Asthma codes, Allergic Rhinitis codes, anaphylaxis codes, Food & Drug Allergy codes.
• Start being more specific in how you document NOW! (ie. Classify every visit in pts with asthma by their severity at time of visit. Also document positive specific allergens for the AR at every visit!)

Getting Ready

• Review your own “favorite” ICD-9 codes and start making up your own “cheat sheet” with expanded listing ICD-10 codes.
• I suggest personally editing the “descriptive terms” that can be entered into your Electronic Health record systems making it easier for you to find the codes you want to use when October 1 comes.
• Make sure your systems are ICD-10 compatible NOW.

Do the Best You can

• Remember it is NOT FRAUDULANT to semantically use different terms. (We charge & get paid by CPT Codes- Don’t EVER CHARGE for service you didn’t perform)
• If you think the patient has a diagnosis that you think you adequately documented then I think you should be OK!!!!

Patient Scenarios

Good Luck!