

Transitioning to ICD-10

What Every PA Should Know

MOST EVERYONE has heard something about ICD-10-CM, but why the change, and what is it really about? There are a number of reasons for the move to ICD-10-CM. One is that ICD-9-CM is out of date and out of space. Another is that the change is necessary to fully implement health information technology (HIT). ICD-10-CM has the potential to reveal more information about quality of care so the data can be used in a meaningful way to understand outcomes, track complications and contribute to the development of clinical decision-making algorithms.

ICD-10-CM has been the international standard for a number of years. In fact, the United States remains the only country in the industrialized world that has not yet implemented ICD-10 or a clinical modification (CM) of ICD-10. Vital statistics offices in the U.S. have used ICD-10 for mortality coding since 1999. Therefore, implementing ICD-10-CM will allow data to be compared internationally and between mortality and morbidity data in the United States.

A key change in ICD-10-CM is that all codes are alphanumeric and some may be up to seven characters in length. The first character is always alphabetized, and the second is always a number. Characters 3 through 7 can be alpha or numeric and may even have a dummy placeholder “x.” The placeholder allows for potential code expansion. To illustrate, labor and delivery complicated by cord around neck, without compression, is coded O69.81x2. The first character is the letter

“O” (not the number zero), the sixth character is a placeholder and the seventh digit indicates which fetus is affected. Failure to note the placeholder “x” or the seventh digit results in an invalid code and likely a denied claim.

There are 21 chapters in ICD-10-CM versus the current 17 chapters in ICD-9-CM. The chapters are divided into “blocks” containing three character categories that form the foundation of the code. Each chapter begins with a summary of the blocks that provides an overview of the categories within the chapter. For example, the chapter on endocrine, nutritional

and metabolic diseases contains a block E08-E13 for diabetes mellitus and a separate block E15-E16 for “other disorders of glucose regulation and pancreatic internal secretion.”

The move to ICD-10 updates clinical terminology and expands the number of diagnosis codes from about 14,000 to 69,000. While this seems like a huge increase, some new codes represent the change to full code titles rather than references to common fourth and fifth digits as is required in ICD-9. However, ICD-10 does include a number of new codes and significant additional clinical information. For example, many injuries will be classified not only by site but also by laterality or other specific characteristics. In ICD-10 the initial treatment of a displaced, type II compound, comminuted fracture of the right radial shaft is coded as S52.351B. The fifth digit denotes a comminuted fracture of the radial shaft, the sixth digit identifies it as displaced and on the right, and the seventh digit identifies the episode of care and the fracture type based on the Gustillo open fracture classification. Based on this example alone, it’s clear that you may need to increase the specificity of your clinical documentation in order to support the most appropriate ICD-10 code!

Although ICD-10 represents a significant change, efforts are being made to ease the transition. Recent changes in ICD-9 have been made in consideration of the move to ICD-10. The last regular update to ICD-9-CM codes was Oct. 1, 2011. There will be no changes to ICD-9-CM or ICD-10-CM until Oct. 1, 2014, except to correct errors or identify new diseases. In addition, CMS has made available general equivalency mapping (GEM) to assist in the conversion from ICD-9 to ICD-10 codes. The scheduled implementation date for ICD-10-CM is not until Oct. 1, 2013, but now is the time to start evaluating your documentation and preparing for the change. **PA**

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