WARBIRD
CONSULTING PARTNERS

Diagnosis Coding

ICD-10 CM Code Assignment

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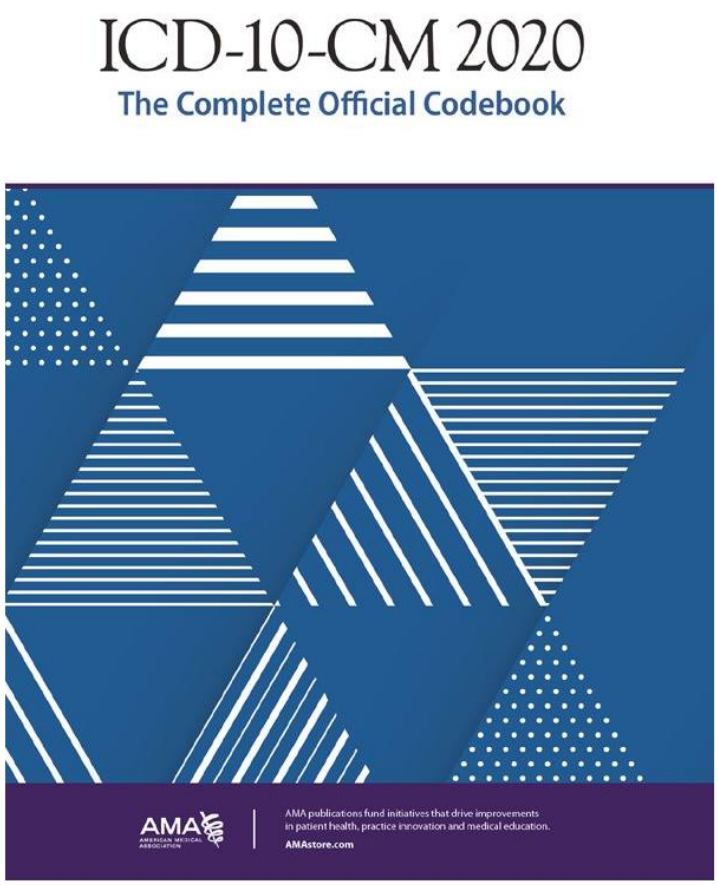
HEALTHCARE EDUCATION FOUNDATION OF WEST VIRGINIA

Laurie Daigle
ldaigle@warbirdcp.com

ICD-10

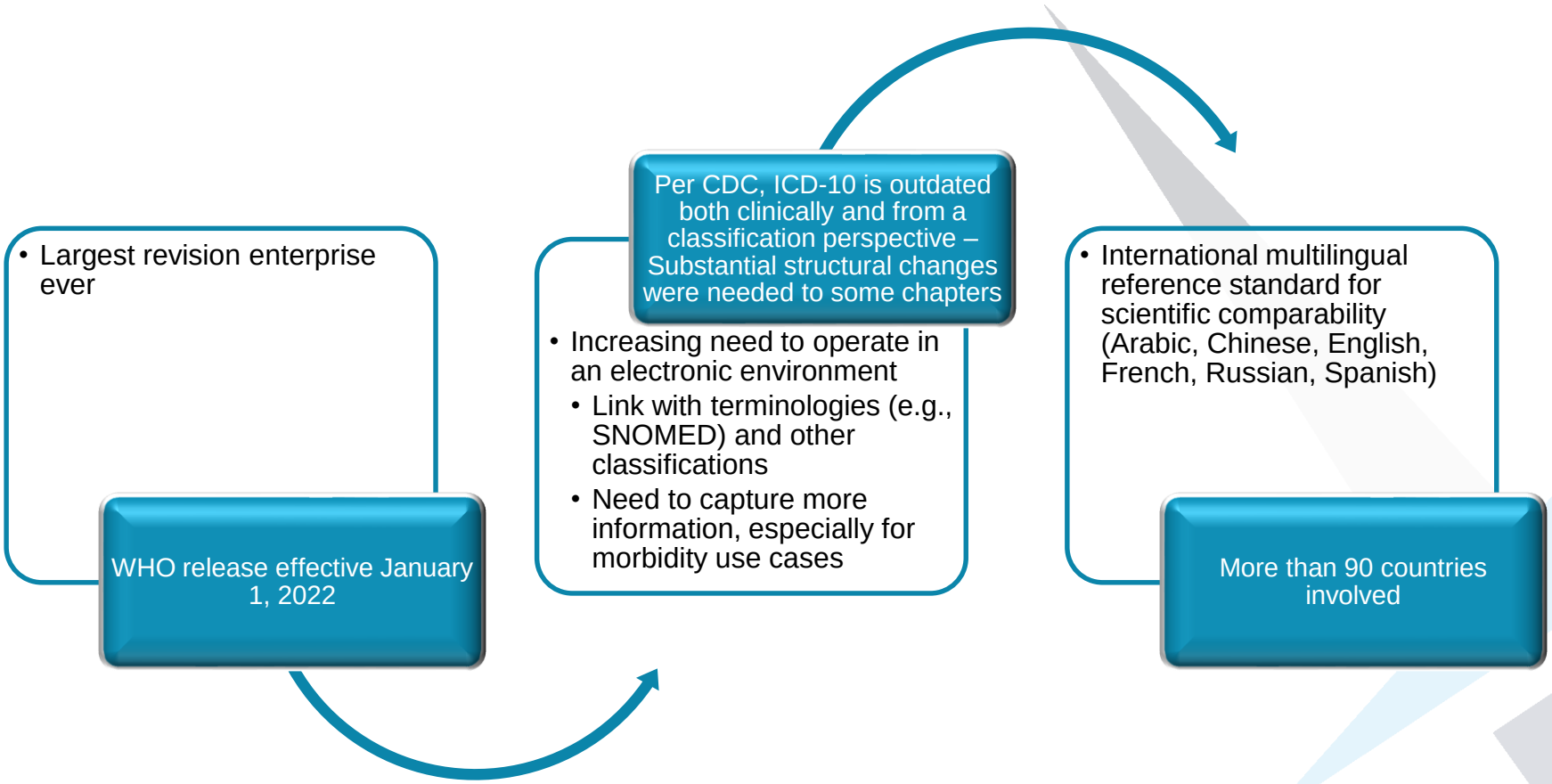
- Explain the purpose of ICD-10
- Describe ICD-10 Code Structure
- Define Annotation and terminology
- Educate proper code assignment

ICD-10



- International code set established by the World Health Organization
- 72,184 diagnosis codes in 2020, defining or explaining
  - Diseases
  - Signs and symptoms
  - Abnormal findings
  - Complaints
  - Social circumstances
  - External causes of injury or diseases

ICD-11

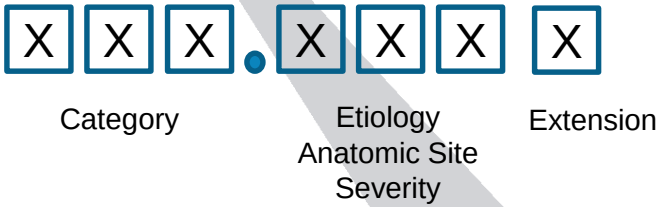

• Largest revision enterprise ever
WHO release effective January 1, 2022
Per CDC, ICD-10 is outdated both clinically and from a classification perspective – Substantial structural changes were needed to some chapters
• Increasing need to operate in an electronic environment
• Link with terminologies (e.g., SNOMED) and other classifications
• Need to capture more information, especially for morbidity use cases
• International multilingual reference standard for scientific comparability (Arabic, Chinese, English, French, Russian, Spanish)
More than 90 countries involved

ICD-10

Chapter	Blocks	Title
I	A00–B99	Certain infectious and parasitic diseases
II	C00–D48	Neoplasms
III	D50–D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
IV	E00–E90	Endocrine, nutritional and metabolic diseases
V	F00–F99	Mental and behavioral disorders
VI	G00–G99	Diseases of the nervous system
VII	H00–H59	Diseases of the eye and adnexa
VIII	H60–H95	Diseases of the ear and mastoid process
IX	I00–I99	Diseases of the circulatory system
X	J00–J99	Diseases of the respiratory system
XI	K00–K93	Diseases of the digestive system
XII	L00–L99	Diseases of the skin and subcutaneous tissue
XIII	M00–M99	Diseases of the musculoskeletal system and connective tissue
XIV	N00–N99	Diseases of the genitourinary system
XV	O00–O99	Pregnancy, childbirth and the puerperium
XVI	P00–P96	Certain conditions originating in the perinatal period
XVII	Q00–Q99	Congenital malformations, deformations and chromosomal abnormalities
XVIII	R00–R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
XIX	S00–T98	Injury, poisoning and certain other consequences of external causes
XX	V01–Y98	External causes of morbidity and mortality
XXI	Z00–Z99	Factors influencing health status and contact with health services
XXII	U00–U99	Codes for special purposes

ICD-10

- First 3 characters represent category
  - May be a complete code
- Next 3 characters provide detail on disease, condition, location, severity etc. Extra characters may be populated with X.
- Seventh character characterizes
  - Episode of care
    - Initial
    - Subsequent
    - Sequela – Late effect
      - Complications
      - Conditions produced after the acute phase has ended
  - Type of fracture
  - Fracture care
  - Complication of pregnancy



ICD-10

- Maternity
- Sequencing priority
  - O00–O08, Pregnancy with abortive outcome
  - O09, Supervision of high-risk pregnancy
  - O10–O16, Edema, proteinuria, and hypertensive disorders in pregnancy, childbirth, and the puerperium
  - O20–O29, Other maternal disorders predominantly related to pregnancy
  - O30–O48, Maternal care related to the fetus and amniotic cavity and possible delivery problems
  - O60–O77, Complications of labor and delivery
  - O80, O82, Encounter for delivery
  - O85–O92, Complications predominantly related to the puerperium
  - O94–O9A, Other obstetric conditions, not elsewhere classified
- Trimester specified by 5th or 6th character
- 7th character specifies number of fetuses
  - 0 - Not applicable or unspecified
  - 1 - Fetus 1
  - 2 - Fetus 2
  - 3 - Fetus 3
  - 4 - Fetus 4
  - 5 - Fetus 5
  - 9 – Other Fetus

ICD-10

7th Character	Episode of Care
A	Initial
D	Subsequent
S	Sequela

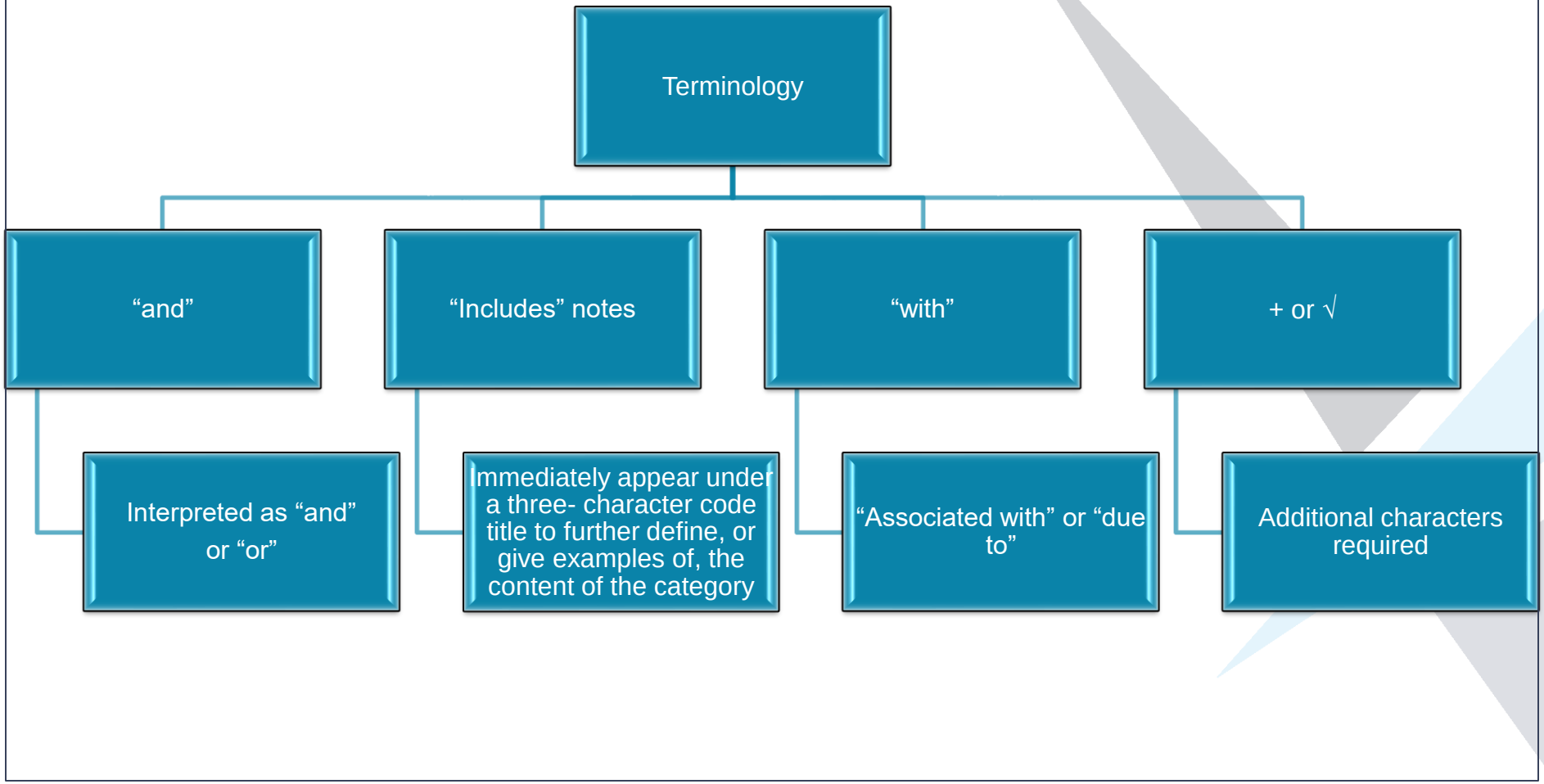
7th Character	Episode of Care-Fracture Extension
A	Initial encounter for closed fracture
B	Initial encounter for open fracture
D	Subsequent encounter for fracture with routine healing
G	Subsequent encounter for fracture with delayed healing
K	Subsequent encounter for fracture with nonunion
P	Subsequent encounter for fracture with malunion
S	Sequela

7th Character	Episode of Care Category S52
A	Initial encounter for closed fracture
B	Initial encounter for open fracture, type I or II
C	Initial encounter for open fracture, type IIIA, IIIB or IIIC
D	Subsequent encounter for closed fracture with routine healing
E	Subsequent encounter for open fracture, type I or II, with routine healing
F	Subsequent encounter for open fracture, type IIIA, IIIB or IIIC, with routine healing
G	Subsequent encounter for closed fracture with delayed healing
H	Subsequent encounter for open fracture, type I or II, with delayed healing
J	Subsequent encounter for open fracture, type IIIA, IIIB or IIIC, with delayed healing
K	Subsequent encounter for closed fracture with nonunion
M	Subsequent encounter for open fracture, type I or II, with nonunion
N	Subsequent encounter for open fracture, type IIIA, IIIB or IIIC, with nonunion
P	Subsequent encounter for closed fracture with malunion
Q	Subsequent encounter for open fracture, type I or II, with malunion
R	Subsequent encounter for open fracture, type IIIA, IIIB or IIIC, with malunion
S	Sequela

ICD-10

- Index to disease and injury contains
  - Table of drugs and chemicals
  - Neoplasm table
- Table of external causes of injury
- Z codes in chapter 21 *Factors Influencing Health Status and Contact with Health Services*

ICD-10


Terminology
“and”
“Includes” notes
“with”
+ or √
Interpreted as “and” or “or”
Immediately appear under a three- character code title to further define, or give examples of, the content of the category
“Associated with” or “due to”
Additional characters required

Additional Annotations

- [ ] Brackets
  - Used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases
  - Used in the Alphabetic Index to identify manifestation codes
  - Sequence second
- ( ) Parentheses - Used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned
- : Colon is used in the Tabular List after an incomplete term that needs one or more of the modifiers following the colon to make it assignable to a given category

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- Non-essential modifiers – Additional words in a code description that do not effect code assignment
- Subentry – Additional information that determines correct assignment of additional characters

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Excludes1 - Pure excludes note

- NOT CODED HERE!”
- Indicates that the code excluded should never be used at the same time as the code above the Excludes1 note
- Used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition

Excludes2

- “Not included here”
- Indicates that the condition excluded is not part of the condition represented by the code
- Both conditions may occur at the same time
- Acceptable to use both the code and the excluded code together, when appropriate

Code First

- Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology
  - Sequence underlying condition (etiology) first and manifestation second
  - If manifestation codes have in the code title, “in diseases classified elsewhere” are never permitted to be first listed or principal diagnosis codes
    - Use in conjunction with underlying condition
    - Code underlying condition first
- “use additional code” – Two codes required to fully describe a single condition that affects multiple body systems
  - Sequencing should be etiology/manifestation

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√ 4th **A41 Other Sepsis**

Code first:
postprocedural streptococcal sepsis (T81.4-) (T81.4-T81.4XXS)
streptococcal sepsis during labor (O75.3) (O75.3)
streptococcal sepsis following abortion or ectopic or molar pregnancy (O03-O07, O08.0) (O03-O07.4, O08.0)
streptococcal sepsis following immunization (T88.0) (T88.0-T88.0XXS)
streptococcal sepsis following infusion, transfusion or therapeutic injection (T80.2-) (T80.2-T80.29XS)

EXCLUDES 1

bacteremia NOS (R78.81) (R78.81)
neonatal (P36.-) (P36-P36.9)
puerperal sepsis (O85) (O85)
streptococcal sepsis (A40.-) (A40-A40.9)

EXCLUDES 2

sepsis (due to) (in) actinomycotic (A42.7) (A42.7)
sepsis (due to) (in) anthrax (A22.7) (A22.7)
sepsis (due to) (in) candidal (B37.7) (B37.7)
sepsis (due to) (in) Erysipelothrix (A26.7) (A26.7)
sepsis (due to) (in) extraintestinal yersiniosis (A28.2)
sepsis (due to) (in) gonococcal (A54.86) (A54.86)
sepsis (due to) (in) herpesviral (B00.7) (B00.7)
sepsis (due to) (in) listerial (A32.7) (A32.7)
sepsis (due to) (in) melioidosis (A24.1) (A24.1)
sepsis (due to) (in) meningococcal (A39.2-A39.4)
sepsis (due to) (in) plague (A20.7) (A20.7)
sepsis (due to) (in) tularemia (A21.7)
toxic shock syndrome (A48.3) (A48.3)

ICD-10

A30 – Leprosy [Hansen's Disease]

INCLUDES Includes infection due to Mycobacterium

EXCLUDES 1 Sequela of Leprosy (B92)

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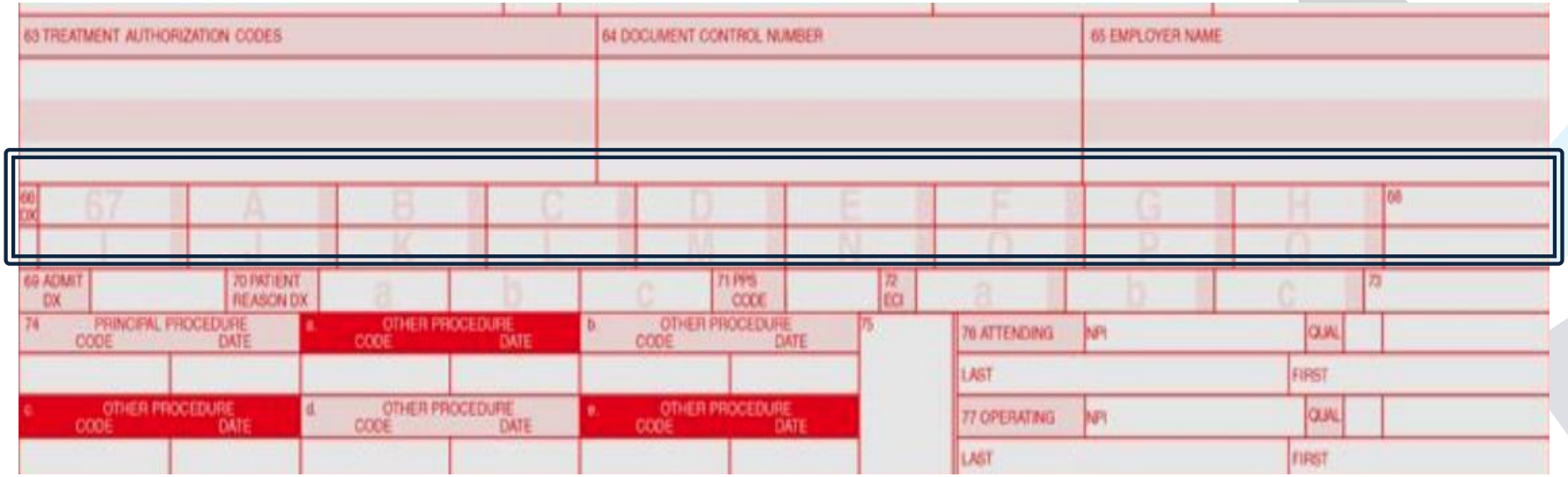
- The provider's statement that the patient has a condition is sufficient to assign an ICD-10
  - Not based on clinical criteria used by the provider to establish the diagnosis
- Signs and Symptoms
  - Should not be reported if routinely associated with a confirmed diagnosis
  - Should be reported, if present if not routinely associated with any diagnosed condition
  - Should be reported when a related definitive diagnosis has not been established
- If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

ICD-10

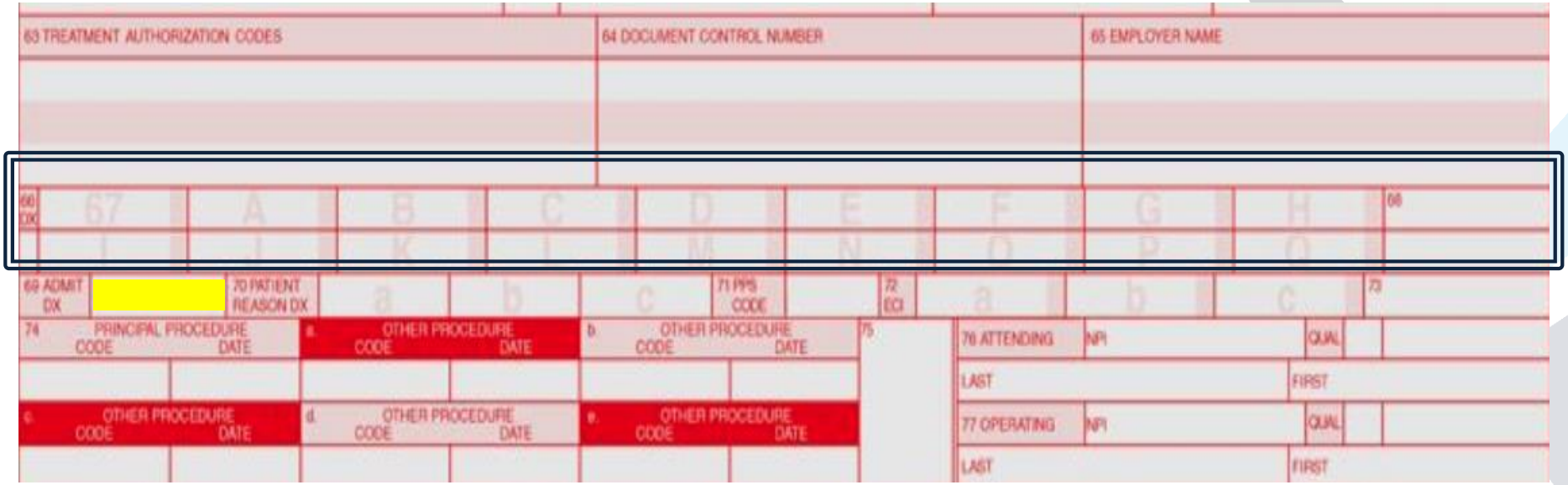
- UP to 24 spaces available on UB beginning with FL67
- Order according to
  - Coding conventions
  - General use guidelines
  - Relevance



Inpatient Coding

ICD-10

- Admitting Diagnosis
  - Form Locator Field 69
  - Condition identified by the physician at the time of the patient's admission
  - Medicare requires for Inpatient only



ICD-10

- Principle Diagnosis
  - Condition chiefly responsible for the patient's admission
  - Always review the entire medical record to establish principal diagnosis
  - Inpatient can code probable, suspected, or other such terms of uncertainty for unconfirmed principal diagnoses
  - Do not codes signs, symptoms, and ill-defined conditions as principal if related definitive diagnosis has been established
  - If two or more conditions equally meet principal reason. Sequence is determined by
    - Circumstances of admission
    - Therapy or treatment provided
    - *Code first* guidelines or indices indicate otherwise
  - Either may be reported as principal if no sequencing guidelines apply

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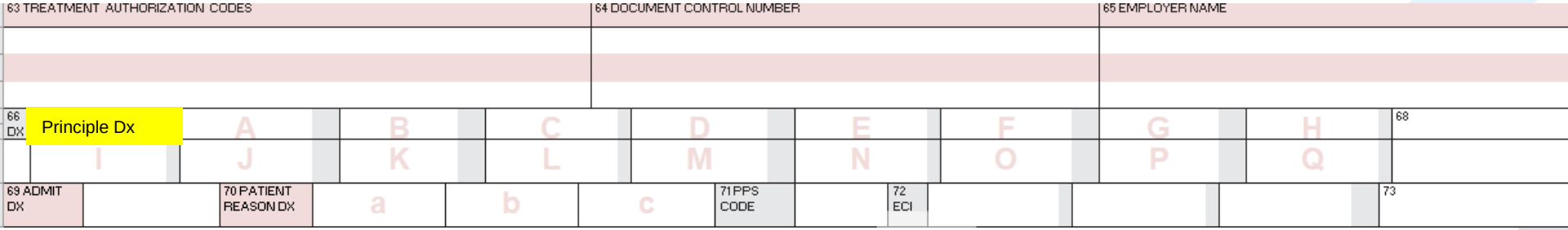
- When a patient is referred to an observation unit for a medical condition that either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition that led to the hospital admission
- Admission after surgery
  - Code complication code where reason for admission is for treatment of a surgical complication
  - Code reason for surgery in absence of complication
  - If admission is unrelated to surgery, code unrelated condition as principal diagnosis



ICD-10

- Uniform Hospital Discharge Data Set (UHDDS)
  - Originally developed for hospital reporting of inpatient data elements
  - Required for reporting Medicare and Medicaid patients
- Definitions and guidelines for selection of principal diagnosis and other (secondary) diagnoses apply to:
  - Acute care short-term hospitals
  - Long-term care hospitals
  - Psychiatric hospitals
  - Home health agencies
  - Rehabilitation facilities
  - Nursing homes and other settings

ICD-10

- According to UHDDS, “Other diagnoses” is interpreted as additional conditions *that affect patient care*
  - *Directly related to admitting injury or illness*
  - *Conditions that coexist at the time of admission*
  - *Develop subsequently*
  - *Hospital acquired*
  - *Affect the treatment received*
  - *Affect length of stay*
  - *Diagnoses that relate to an earlier episode that have no bearing on the current hospital stay should be excluded*

ICD-10

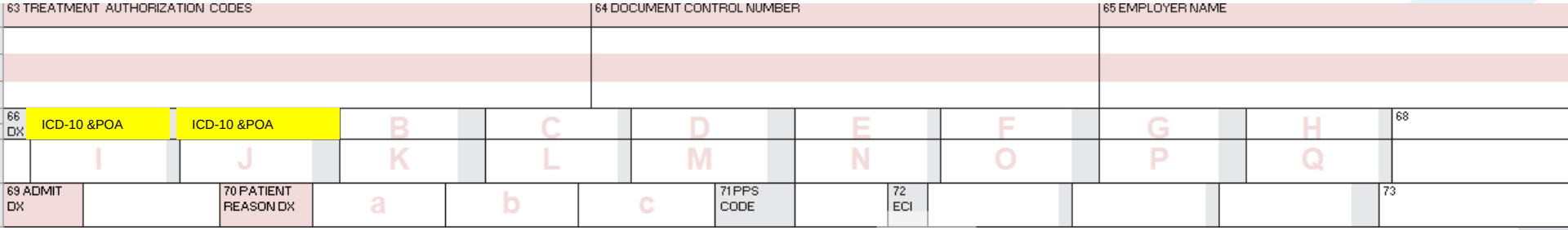
- Present on Admission (POA) guidelines apply to all conditions coded and reported based on Uniform Hospital Discharge Data Set definitions and current official coding guideline
- POA is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA.
- A POA Indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes. CMS does not require a POA Indicator for an external cause of injury code unless it is being reported as an "other diagnosis."

ICD-10

- Hospitals must report POA information for both primary and secondary diagnoses for
  - High cost conditions, high volume conditions or both
  - Result in the assignment of a case to a Diagnosis Related Group (DRG) that has a higher payment when present as a secondary diagnosis; and
  - Could reasonably have been prevented through the application of evidence-based guidelines.
- Section 5001(c) provides that CMS can revise the list of conditions from time to time, if it contains at least two conditions
- CMS will not provide additional payment for cases in which one of the selected conditions was not present on admission

ICD-10

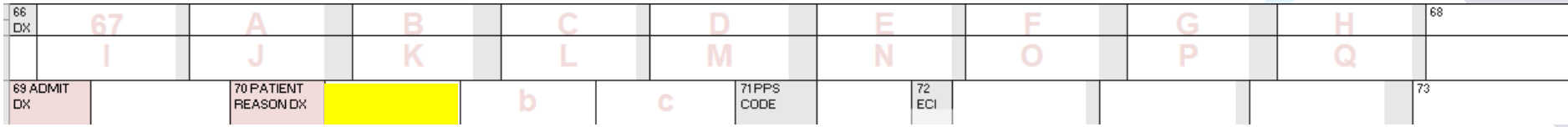
- Eight character on FL 67 assigned to principal and secondary diagnoses for paper and 2300HI for 837I
- Y - Yes (present at the time of inpatient admission)
- N – No (not present at the time of inpatient admission)
- U - Unknown (documentation is insufficient to determine if condition is present at time of inpatient admission)
- W – Clinically undetermined (provider is unable to clinically determine whether condition was present at time of inpatient admission or not)
- Blank – Unreported/Not used – Exempt from POA reporting



Outpatient Coding

ICD-10

- Reason for visit - shown in the medical record to be chiefly responsible for the services provided (Chief Complaint)
  - Do NOT use the ultimately (possibly) more important diagnoses discovered in the visit as the reason for visit
  - Report all documented conditions
  - Report symptoms for conditions not confirmed
- Required by CMS on all TOB 13X and 85X for Admission or Visit codes
  - Priority (Type) of Admission or Visit codes
    - 1 Emergency
    - 2 Urgent
    - 5 Trauma
  - Revenue Codes
    - 045x Emergency Room
    - 0516 Urgent Care Clinic
    - 0762 Observation



ICD-10

- *Per AHA Coding Clinic dated March 24, 2020: Presumptive positive COVID-19 test results should be coded as confirmed.* ***A presumptive positive test result means an individual has tested positive for the virus at a local or state level,*** *but it has not yet been confirmed by the Centers for Disease Control and Prevention (CDC).*
- Per AHA Coding Clinic FAQ dated April 20, 20 – If the provider has confirmed COVID-19 after the test results come back negative how is this coded?
  - "If the provider still documents and confirms COVID-19 even though the test results are negative, or the provider documented disagreement with the test results, assign code U07.1, COVID-19. As stated in the Official Guidelines – "Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider... the providers documentation that the individual has COVID-19 is sufficient."
- Per AHA Coding Clinic FAQ dated April 20, 20 – "Due to the heighten need to capture accurate data on positive COVID-19 cases, we recommend that providers consider developing facility-specific coding guidelines to hold back coding of inpatient admissions and outpatient encounters until the test results for COVID-19 testing are available. This advice is limited to cases related to COVID-19."
- Per AHIMA/AHA – "Z20 codes may be used in patients who are in an area where a disease is epidemic. Therefore, due to the current COVID-19 pandemic, when a patient presents with signs\symptoms associated with COVID-19, code Z20.828 may be assigned without explicit documentation of exposure or suspected exposure to COVID-19."

ICD-10


Report diagnoses at the highest level of specificity for the diagnosis shown to be reason for the outpatient services
Report symptom addressed in provider note, in absence of finding
Do not report suspected or rule out for outpatient
Reading physician must always report finding if applicable

ICD-10

- Report personal history codes
  - Relevant to treatment options
  - Relevant to reason for visit,
  - Support reason for screening services
- Report personal history of cancer, malignant neoplasms (leukemia, lymphoma)
- Personal history of falling
- Report family history
  - Risk factors relevant to visit
  - Screening services

ICD-10

- Report chronic conditions actively being treated
- Report stable conditions
  - Related to current chief complaint
  - Addressed during visit
  - Which affect management decisions
- Do not code treatments that no longer exist

ICD-10

- 2021 Changes
- History and exam no longer required to document and Code Evaluation and Management Services
- May impact diagnosis coding
- Providers will need to be educated to document medical necessity for ordered services

Questions?

Resources

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3435CP.pdf

Contact

Uniquely Qualified

Warbird Consulting Partners, LLC
600 Galleria Pkwy SE, Suite 1400
Atlanta, GA 30339
www.warbirdconsulting.com

John Behn, MPA
jbehn@warbirdcp.com

Laurie Daigle, CPC
ldaigle@warbirdcp.com