ICD-10

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Q. My staff keeps telling me that my documentation will have to change in order for them to properly choose an ICD-10 diagnosis code. Is that true?

A. Documentation practices should not have to change but it will be helpful to understand the granularity of the new codes. There is greater specificity including laterality, temporal factors, contributing factors, symptoms, manifestations, and anatomic location. Thus, if you currently gloss over details in the medical record, you will need to document more specifics in order to support the appropriate code.

You will want to make clear the anatomical location, right or left, whether the condition is acute, chronic, or chronic with an acute exacerbation. Documenting any prior issues regarding the current condition is still important, as well as any additional information regarding the patient's environment (exposed to second hand smoke, tobacco dependence, tobacco use, etc.).

For example, a patient presents with ear pain and a fever. She has suffered bouts with acute purulent otitis media (OM) three times in the past 6 months. The patient is prescribed antibiotics, gets better, but then her condition recurs. The patient's father smokes in the home. Examination reveals a bulging, cloudy, immobile right tympanic membrane with purulent fluid. The left ear is normal. The diagnosis is right recurrent purulent OM. The coder assigns ICD-10 codes H66.004, "Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear" and Z77.22, "Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)."

Keep in mind that external cause codes are not mandatory unless you are subject to a state-based external cause code reporting mandate or these codes are required by a particular payor. However, you are encouraged to report external cause codes because they provide valuable data for injury research and evaluation of injury prevention strategies.

There are hundreds of changes in the fracture code set. For example, a patient presents for a recheck of his distal radial torus fracture of the right arm. Everything is healing well and he will return the following week for possible cast removal. The appropriate ICD-10 code is S52.521D. The first part of the code (S52) represents the fracture of the forearm; the (52) after the decimal represents the torus fracture of lower end of the radius; the (1) represents the right arm; and the (D) reports that the visit is a subsequent visit. If you were billing for this visit today, you would use diagnosis code V54.12, "Aftercare for healing traumatic fracture of lower arm."

Because there are so many changes in the codes, you might want to start by identifying your most-used codes and compare ICD-9 codes to ICD-10 codes. Because ICD-10 is much more granular than ICD-9, you will find that a single ICD-9 code will often map to multiple, more specific ICD-10 codes. Review your documentation to make sure that it includes enough information to select the most specific ICD-10 code available for the encounter.

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CODING Q & A

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You can find ICD-9 to ICD-10 translator tools online. AAPC offers a free tool at http://www.aapc.com/icd-10/codes/index.aspx and you do not have to be a member to use it. However, while the tool is nice to have, it should not be used in lieu of ICD-10 training, a coding book or an online coding program. ■

Q. I heard that insurance companies will deny more claims once we start using ICD-10, especially if an unspecified code is billed. Have you any insight on the subject?

A. It is difficult to be certain what the payors will do. Although there may be a transition period while all payors get onboard with the new technology to handle the new codes, the additional specificity of ICD-10 codes may actually reduce the number of requests for additional information. Along that same line, you will want to make sure your documentation is detailed enough that the coder can assign a specific code or that your EMR prompts you to code more specifically.

One concern of many coders is that payor software systems may produce many inappropriate denials for ICD-10 codes that have not been properly mapped to support CPT and HCPCS codes. I currently warn clients that these denials are likely to be frequent with many payors, and it is likely to take at least 3 to 6 months for payors to correct these issues.

In both ICD-9 and ICD-10, unspecified codes have acceptable uses. Although specific diagnosis codes should be reported when reflected in the medical record, sometimes an unspecified code most accurately reflects the encounter. 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 condition, it is acceptable to report the appropriate unspecified code. For example, in almost all patients diagnosed with pneumonia in the urgent care center, the specific organism has not been identified. In these cases, the most accurate code would be J18.9, "Pneumonia, unspecified organism." ■