ICD-10 OVERVIEW, READINESS AND RESOURCES

Blue Cross Blue Shield of Michigan 2015

*NOTE: The information in this document is not intended to impart legal advice. This overview is intended as an educational tool only and should not be relied upon as legal or compliance advice.
Agenda

✓ ICD-10 Overview
  ▪ The mandate
  ▪ The benefits of ICD-10
  ▪ Similarities and differences

✓ Top 10 Diagnoses for all Professional Providers
  ▪ Top diagnostic codes

✓ Great information…but now what?

✓ Preparation steps

✓ BCBSM readiness

✓ Provider testing

✓ Appendix
The ICD-10 Mandate

- The ICD-10 implementation is scheduled for Oct. 1, 2015. On claims with that date of service, all HIPAA-covered health care entities must begin using ICD-10 codes in place of the ICD-9 codes.

- Claims with non-compliant codes will be rejected.

- Delivered in two parts
  - ICD-10-CM (for all providers in all health care settings)
  - ICD-10-PCS (for hospital claims and inpatient hospital procedures)

- Does not affect CPT or HCPCS codes and usage.
ICD-10 world adoption

Where are we today?

- WHO ICD-9 1979
- WHO ICD-10 1990
- UK ICD-10 1995
- Sweden ICD-10 1997
- Australia ICD-10 AM 1998
- Germany ICD-10-GM 2000
- Canada ICD-10-CA 2001
- Korea ICD-10 2008
- HHS US ICD-10 Delay Announced 2012
- USA ICD-10 2015
The benefits of ICD-10-CM

- More clinically relevant than ICD-9-CM
- Better reflection of clinical severity and complexity
- More accurate representation of provider performance
- Less ambiguous code choices
- Support for medical necessity
- Validation for reported evaluation and management codes
- Less misinterpretation by auditors, attorneys and other 3rd parties
Additional benefits of ICD-10-CM

• Improved efficiencies and lowered administrative costs:
  – Fewer rejected and improper reimbursement of claims
  – Decreased demand for submission of medical record documentation
  – Increased use of automated tools to facilitate coding process
The similarities to ICD-9-CM

- Many conventions have the same meaning.
- Nonspecific codes still exist (unspecified or NOS).
- Codes are looked up the same way: look up term in alphabetic index then verify in tabular list
  - Critical to verify codes in the tabular list as many codes will be incomplete and end with a dash in the alphabetic index
  - Tabular portion of the book contains the coding conventions and 7th character tables.
- Codes are invalid if they are incomplete.
- Adherence to the official coding guidelines is required under HIPAA.
The differences between ICD-9 and ICD-10

- Main differences include:
  - Volume 17,849 ICD-9 vs. 141,797 ICD-10 codes
    - ICD-10
      - 69,823 CM and 71,974 PCS
  - Structure
  - New features

- Differences between the code sets make ICD-10 look like an entirely different coding language.

- Certain diseases reclassified to reflect current medical knowledge.

- Injuries grouped by anatomical site instead of by category of injury.
ICD-10-CM differences

- Combination codes for some conditions and associated symptoms
- Code titles are more complete
- Specificity and detail significantly expanded
- Laterality
- Expansion of some codes
  - Injuries
  - Diabetes
  - Alcohol and substance abuse
  - Post-op complications
Structural differences – ICD-10-CM

- Alpha (Except U)
- 2 Always Numeric
- 3-7 Numeric or Alpha
- Added code extensions (7th character) for obstetrics, injuries, and external causes of injury
- Category
- Etiology, anatomic site, severity
- 3 - 7 Characters
TopTen
Diagnoses for Professional Providers
Top Ten Most Frequently Reported ICD-9-CM Diagnosis Codes for all Professional Claims

<table>
<thead>
<tr>
<th></th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>250.00</td>
<td>Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled</td>
</tr>
<tr>
<td>2</td>
<td>724.2</td>
<td>Lumbago</td>
</tr>
<tr>
<td>3</td>
<td>V76.12</td>
<td>Other screening mammogram</td>
</tr>
<tr>
<td>4</td>
<td>839.20</td>
<td>Closed dislocation, lumbar vertebra</td>
</tr>
<tr>
<td>5</td>
<td>V20.2</td>
<td>Routine infant or child health check</td>
</tr>
<tr>
<td>6</td>
<td>739.3</td>
<td>Nonallopathic lesions, lumbar region</td>
</tr>
<tr>
<td>7</td>
<td>739.1</td>
<td>Nonallopathic lesions, cervical region</td>
</tr>
<tr>
<td>8</td>
<td>401.9</td>
<td>Unspecified essential hypertension</td>
</tr>
<tr>
<td>9</td>
<td>786.50</td>
<td>Chest pain, unspecified</td>
</tr>
<tr>
<td>10</td>
<td>V70.0</td>
<td>Routine general medical examination at a health care facility</td>
</tr>
</tbody>
</table>

* The following slides will display the corresponding ICD-10-CM codes.
# Top Ten Most Frequently Reported Diagnosis Codes for all Professional Claims

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Description</th>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.00</td>
<td>Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled</td>
<td>E11.9</td>
<td>Type 2 diabetes mellitus without complications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>E13.9</td>
<td>Other specified diabetes mellitus without complications</td>
</tr>
<tr>
<td>724.2</td>
<td>Lumbago</td>
<td>M54.5</td>
<td>Low back pain</td>
</tr>
<tr>
<td>V76.12</td>
<td>Other screening mammogram</td>
<td>Z12.31</td>
<td>Encounter for screening mammogram for malignant neoplasm of breast</td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td>ICD-10-CM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
| 839.20 – Closed dislocation, lumbar vertebra | M99.13 - Subluxation complex (vertebral) of lumbar region  
S33.0xxA - Traumatic rupture of lumbar intervertebral disc, initial encounter  
S33.100A- Subluxation of unspecified lumbar vertebra, initial encounter  
S33.101A- Dislocation of unspecified lumbar vertebra, initial encounter  
S33.110A- Subluxation of L1/L2 lumbar vertebra, initial encounter  
S33.111A- Dislocation of L1/L2 lumbar vertebra, initial encounter  
S33.120A- Subluxation of L2/L3 lumbar vertebra, initial encounter  
S33.121A- Dislocation of L2/L3 lumbar vertebra, initial encounter  
S33.130A- Subluxation of L3/L4 lumbar vertebra, initial encounter  
S33.131A- Dislocation of L3/L4 lumbar vertebra, initial encounter  
S33.140A- Subluxation of L4/L5 lumbar vertebra, initial encounter  
S33.141A- Dislocation of L4/L5 lumbar vertebra, initial encounter |
<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>V20.2 – Routine infant or child</td>
<td>Z00.121 – Encounter for routine child health examination with abnormal</td>
</tr>
<tr>
<td>health check</td>
<td>findings</td>
</tr>
<tr>
<td>739.3 – Nonallopathic lesions,</td>
<td>Z00.129 – Encounter for routine child health examination without abnormal</td>
</tr>
<tr>
<td>lumbar region</td>
<td>findings</td>
</tr>
<tr>
<td>739.1 – Nonallopathic lesions,</td>
<td>M99.03 – Segmental and somatic dysfunction of lumbar region</td>
</tr>
<tr>
<td>cervical region</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M99.01 – Segmental and somatic dysfunction of cervical region</td>
</tr>
</tbody>
</table>
Top Ten Most Frequently Reported Diagnosis Codes for all Professional Claims Cont’d

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>401.9 – Unspecified essential hypertension</td>
<td>I10 – Essential (primary) hypertension</td>
</tr>
<tr>
<td>786.50 – chest pain, unspecified</td>
<td>R07.9 – chest pain, unspecified</td>
</tr>
<tr>
<td>V70.0 – Routine general medical examination at a health care facility</td>
<td>Z00.00 – Encounter for general adult medical examination without abnormal findings</td>
</tr>
<tr>
<td></td>
<td>Z00.01 – Encounter for general adult medical examination with abnormal findings</td>
</tr>
</tbody>
</table>
From an industry perspective
Important points from an industry perspective

• ICD-10 most likely will increase the need for certified coders
  – This is due to the increased detail in the code set, especially during the initial months of the transition

• Entities must take into consideration external factors (such as impacts of Health Care Reform and requirements of Medicare and Medicaid) when planning for ICD-10

• A maintenance process must be in place as part of a long-term solution to enable processing of codes
  – How do you update the codes today?
  – With increased volume, that process will likely have to change
Everyone has different views of ICD-10

• **Clinician Perspective:** ICD-10 is understanding the increased level of detail needed in the medical record documentation.

• **Coder Perspective:** Training is required to understand the additional detail in the codes.

• **Payer Perspective:** Make sure that our systems can take the submitted codes and pay claims/apply benefits appropriately.

*The best way to understand the impact of the ICD-10 code set is to see it in action…*
Why appropriate coding is important

• Ensuring appropriate benefit application and/or payment (if applicable)
• Helps to reduce the possibility of requests for medical records
• Could help reduce the instances of medical record reviews
• Proper coding now will help your practice or facility deal with the increased detail needed for:
  – quality measures
  – government programs (such as risk adjustment)
  – incentive programs and ACOs
Medical records – A call for detail

Because of ICD-10 specificity, provider documentation must change to meet the new level of detail. For example…

Diagnoses:

• Obesity must be specified in ICD-10 if due to excess calories or if drug induced.
• Angina Pectoris is further classified as unstable angina, angina pectoris with documented spasm or other forms of angina pectoris.
• Asthma is specified as mild intermittent, mild persistent, moderate persistent and severe persistent.
• Tobacco dependence in ICD-9 becomes Nicotine dependence in ICD-10.
• The type of nicotine dependence must be documented for coding purposes.
Preparation steps
Next steps to prepare for ICD-10*

Determine impact
- Learn about the ICD-10 code set
- Identify all places within your organization that use ICD-9 codes and understand the impact of the transition
- Determine strengths and weaknesses in medical record documentation

Identify training needs
- Staff review and refresh medical terminology
- Plan for coder training (6-9 months prior to implementation)

Reach out to others
- Talk to business partners about ICD-10 readiness (payers, vendors, billing services, etc.)
- Be sure to discuss testing capabilities

*Information from CMS’ MLN Matters, SE1019 and Basics for Medical Practices (source cms.gov/icd-10 website)
More ICD-10 readiness tactics

• Start recoding the superbill and determine the documentation required to code accurately
  – Diabetes: Type 1 or 2, due to underlying condition, drug/chemical induced
  – Manifestations now included in chapter, but some will need an additional code
  – Do you need to expand the superbill based on physician activities?

• Start with the CMS GEMs
  – They will get you in the ball park
  – The GEMs list all possible code combinations

• Budget for time and costs related to ICD-10 implementation
  • Expenses include system changes, resource materials, and training, costs for potential software updates, and reprinting of superbills.
Here’s how to get started
Key industry websites for helpful resources

• Centers for Medicare and Medicaid Services (CMS):
  www.cms.gov/icd10/

• CMS sponsored "Road to ICD-10" website for small-medium physician practices including information by specialty: Build your action plan and jump start your transition to ICD-10. It’s simple and FREE. Visit the CMS tool at: www.roadto10.org/

• American Academy of Professional Coders (AAPC):
  www.aapc.com/icd-10/
  – Specialty crosswalks contain the top 50 ICD-9 codes and the corresponding ICD-10 codes and is especially useful for the most commonly identified diagnosis codes. Download a .pdf for any of the specialties you choose.
  – A .pdf copy is available from AAPC by going to this website link: http://www.aapc.com/ICD-10/crosswalks/pdf-documents.aspx
ICD-10 Implementation Resources

CMS.gov ICD-10 links: provider resources, medical practices basics and Quick Start Guide:
- http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

American Hospital Association - AHA.org website link:

Specialized training resources (extra cost): American Health Information Association – AHIMA.org and American Association Professional Coders – AAPC.com links:
- http://www.aapc.com/icd-10/

Coding and Documentation Tips - AHIMA.org and Californiahia.org links:
- http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049431.hcsp?dDocName=bok1_049431#c
- http://www.californiahia.org/icd-10-cmpcs

American Medical Association – AMA.org website links:

BCBSM website – BCBSM.com and provider readiness mailbox links:
- icd-10providerreadiness@bcbsm.com

CMS MLN Matters #SE1325 – Institutional Services Split Claims Billing Instructions for Medicare Fee-For-Service Claims that span the ICD-10 Implementation Date:

CMS MLN ICD-10-CM/PCS Myths and Facts:

Michigan Department Community Health - ICD 10 Awareness and Training
- http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42552_42696-256928--,00.html

American Academy of Family Physicians AAFP

American Academy of Pediatrics AAP

Check with your professional and medical associations about ICD-10 readiness.
BCBSM readiness
Steps we are taking to minimize the risk of disruption

- Outreach and communications
- Internal training of staff
- Extensive testing plan
Past and present major activities at BCBSM

2009 - 2010
Strategy, planning and mapping methodology

2011
Technical changes, mapping the codes and financial neutrality

2012-2013
Technical coding, neutrality, testing provider readiness, business readiness

2014
External testing, internal re-testing, provider readiness

2015
External testing, internal readiness, provider readiness and Implementation
Introduction: ICD-10 Michigan Mondays

• Purpose of the calls: To inform and educate about the ICD-10 transition

• Upcoming calls – Third Monday of the month, 1-2 p.m.:
  - July 20, August 17, September 21

• Also, as part of a five payer collaborative, webinars focused on specific specialties conducted every other Thursday from noon-1pm

• For both Michigan Monday and the specialty webinars, registration links provided in WebDenis

• Sign-up for notifications and materials in advance by sending an email to:
  - icd-10providerreadiness@bcbsm.com
BCBSM collaboration with other payers in 2015

• Instead of working alone we invited other payers to work with us

• We aren’t quite global

• But we have a much broader audience

• **Participants include:** BCBSM, HAP, Humana, Priority Health, and United Healthcare
ICD-10 Provider Testing Options with BCBSM
<table>
<thead>
<tr>
<th>Testing option</th>
<th>Who it’s for</th>
<th>What it tests</th>
<th>What it will tell you</th>
<th>How to join</th>
</tr>
</thead>
</table>
| Medical scenario (content-based) testing | Professional providers | A medical scenario is presented (by specialty) and the submitter is asked to assign appropriate ICD-10 codes | • What codes were submitted  
• What other health care providers of the same specialty submitted for that scenario | Click on the following link to register: bcbsmicd10providerregistry.highpointsolutions.com |
| Transactional testing             | Clearinghouses | The ability to accept fully compliant 837 transactions with ICD-10 codes | Whether or not a claim with an ICD-10 code was received and passed EDI compliance checks | Send an email to icd-10claimstesting@bcbsm.com |
| DRG shift testing                 | Facilities     | The impact of ICD-10 coding on DRG shifts                                     | • ICD-10 codes submitted (based on a historical ICD-9 claim)  
• Impact of the ICD-10 codes on the DRG assignment | Send an email to icd-10providertesting@bcbsm.com |
| End-to-end testing                | Facilities     | Submission of an 837 within guidelines                                         | 835 response based on the 837 submission                                               | Send an email to icd-10claimstesting@bcbsm.com |

*Unless otherwise noted, all options are currently available and will be available through 10/1/2015.
Professional Testing with BCBSM

• The professional testing tool is available for use now through the ICD-10 implementation date (Oct. 1, 2015).
• Use of this tool is **free of charge**.
• Testing is done through the web; no special software or lengthy test requirements are needed. Once you register, you will receive a personalize link to the testing tool.
• It is “content based” and “specialty specific,” which means that you will be presented with several health care encounters and be asked to code the diagnoses in ICD-10.
• Scenarios are based on specialties (internal medicine, oncology, etc.) and providers must register for each specialty they are interested in testing. Scenarios are groups of 3 narratives with a maximum of 9 narratives.
Professional Testing with BCBSM
Cont’d

• We recommend you have some familiarity with the ICD-10 codes and have a code book or other access to the code set to complete this test.

• BCBSM will provide a peer group report of the codes selected for the same scenarios which can be accessed multiple times as additional providers participate in the testing.

• To register and begin the ICD-10 professional testing process, access the following link: http://bcbsmicd10providerregistry.highpoint-solutions.com
Professional Provider Testing

• Steps for narrative development:
  – We developed a list of codes of interest: high volume, high dollar with potential change of benefit or member liability
  – Determined specialties that would treat that diagnosis
  – Identified claims that would match diagnosis and specialty
  – Wrote narratives to describe an encounter and had them reviewed by physicians of that specialty
  – Piloted the testing product for content and ease of use

• User guide and documentation of the process is available for review
Specialties for testing

- Allergy/Immunology
- Audiologist
- Cardiovascular Disease
- Certified Nurse Midwife
- Chiropractic
- Clinical Psychologist
- Dermatology
- Emergency Medicine
- Endocrinology
- Family Practice
- Gastroenterology
- General Practice
- General Surgeon
- Group Practice
- Hematology
- Hematology-Oncology
- Infectious Disease
- Internal Medicine
- Nephrology
- Neurology
- Nurse Practitioner
- Obstetrics & Gynecology
- Occupational Therapist
- Ophthalmology
- Optometry
- Orthopedic Surgery
- Otolaryngology
- Pediatric Medicine
- Physical Medicine and Rehabilitation
- Physical Therapist
- Plastic and Reconstructive Surgery
- Podiatry
- Psychiatry
- Psychologist
- Pulmonary Disease
- Radiation Oncology
- Rheumatology
- Thoracic Surgery
- Urology
- Vascular Surgery
Family Practice Example – Peer Report

View your response along with your peers.
Questions?

• Professional testing tool link: [http://bcbsmicd10providerregistry.highpointsolutions.com](http://bcbsmicd10providerregistry.highpointsolutions.com)

• Provider testing questions mailbox: [lcd-10providertesting@bcbsm.com](mailto:lcd-10providertesting@bcbsm.com)

• Provider readiness questions mailbox: [lcd-10providerreadiness@bcbsm.com](mailto:lcd-10providerreadiness@bcbsm.com)
Appendix
Professional Provider Testing Tool
Screenshots
ICD-10 Provider Testing Registration

Welcome Blue Cross and Blue Shield of Michigan (BCBSM) Providers

Thank you for agreeing to assist us with ICD-10 Professional Testing. Step one of the process is to register each unique Professional Provider organization. This website will register testers from your organization by capturing the contact name, email, and telephone number for each participant.

Once we process the registration request, the testers will be sent an email with a link to the website to begin their test activity along with a desktop procedure manual.

If you have any questions about the registration process or any other concerns around your ICD-10 readiness, please feel free to contact BCBSM at ICD-10ProviderTesting@BCBSM.com.

Sincerely, The BCBSM ICD-10 Program: Provider Readiness Team

Begin

View Peer Report by Specialty

Registration landing page
Provider Registration Specialty Selection

ICD-10 Provider Testing Registration

Registration
Please select the specialty or specialties that best suit your organization.
Note: Hold down the Ctrl key if selecting multiple specialties.

Organizations can select multiple specialties

Specialties (select all that apply)
- General Practice
- General Surgeon
- Allergy/Immunology
- Otolaryngology
- Cardiovascular disease
- Dermatology
- Family Practice
- Gastroenterology

Submit
# Provider Registration Data Capture

**ICD-10 Provider Testing Registration**

**Registration for Specialty: General Practice**

Please complete the registration information below (* indicates required fields):

<table>
<thead>
<tr>
<th>Organization Name *</th>
<th>Other</th>
<th>XYZ Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address 1</td>
<td>123 Main Street</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>Detroit</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Michigan</td>
<td>Zip: 48226</td>
</tr>
<tr>
<td>County *</td>
<td>Wayne</td>
<td></td>
</tr>
<tr>
<td>Contact First Name *</td>
<td>Jim</td>
<td></td>
</tr>
<tr>
<td>Contact Last Name *</td>
<td>Wigglesworth</td>
<td></td>
</tr>
<tr>
<td>Contact Email Address *</td>
<td><a href="mailto:wrigglesworth@gmail.com">wrigglesworth@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
<td>313-565-1234</td>
<td></td>
</tr>
</tbody>
</table>

Do you have an ICD-10 Coding Book? [ ]

[Submit for Processing]

Contact information is specialty specific
Provider Registration Confirmation

ICD-10 Provider Testing Registration

Specialty General Practice was successfully submitted for processing

Thank you for registering with the BCBSM ICD-10 Provider Testing team. We are processing your information. In the next few days, you should receive an email containing a unique test tool link along with an accompanying user guide to assist you.

Exit   Register Another Specialty/Participant

Select to continue with multi-specialty registration
Family Practice Example – Landing Page

Personalized “landing page” identifying the scenarios available to the provider
ICD-10 Provider Testing

Testing Information:
- Before You Start
- Frequently Asked Questions
- Printing
- First Family Practice
  - Family Practice 1
  - Family Practice 2
  - Family Practice 3

Resource Information:
- Email Us
- CMS Site
- HIMSS Site

Hyperlinks to narratives
Family Practice Example – Print Capability

ICD-10 Provider Testing

1. Patient Information:
   - Age: 62
   - Gender: Male
   - Date Of Service: 10/10/2014
   - Chief Complaint: Pt. c/o headache. Pt. has been monitoring blood pressure at home and it has been elevated.

2. Clinical Information:
   - Height: 70
   - Weight: 165
   - Blood Pressure: 180/85
   - Pulse: 72
   - Respiratory Rate: 16
   - Temp: 98.0

3. Diagnostic Information:
   - Past Medical History: Pt. was diagnosed as hypertensive 5 years ago and has been on Benicar. He initially started on a 5 mg dosage, but one year ago that was increased to the 20 mg dosage daily. Otherwise this is a healthy active male. There have not been any past surgeries or injuries.
   - Office Visit Notes: Blood pressure in the office remains elevated standing, sitting and laying down. No papilledema on eye exam. Will increase dosage to 40mg daily. Counseled pt. on diet, including salt reduction and exercise. Pt. to follow up in 6 weeks to evaluate revised dosage of medication.

4. ICD-10 Codes:
   - List the appropriate ICD-10 diagnosis codes that would represent the key medical concepts presented in the narrative description above.

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td></td>
</tr>
</tbody>
</table>

5. Remarks: Please provide any additional comments or remarks below.

Formatted for printing to allow offline data capture.
Providers can enter one or more ICD-10 Codes
Invalid codes are “logged”
Completion of all narratives activates the button to review narrative responses.
After reviewing responses select the submit button to complete process.
Family Practice Example – Narrative Review Page

After submission, view your peer report, continue to the next scenario, or exit the tool.
Successful completion of the first scenario activates the second scenario and generates your report.
Placeholder “X”

• Addition of dummy placeholder “X” or “x” is used in certain codes to:
  – Allow for future expansion
  – Fill out empty characters when a code contains fewer than 6 characters and a 7th character applies
  – It is not case sensitive

• When placeholder character applies, it must be used in order for the code to be valid.
ICD-10-CM Coding Tip

Placeholder Character “X” in Diagnosis Codes

- ICD-10-CM (diagnosis codes) uses a placeholder character “X”. The “X” is used in certain diagnosis codes to allow for future expansion.
  - Use the “X” to fill out empty characters when a code contains fewer than 6 characters and a 7th character applies.
  - Where the placeholder exists, the “X” must be used to be considered a valid code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S02.2XXA</td>
<td>Fracture of nasal bones, initial encounter for closed fracture</td>
</tr>
<tr>
<td>S97.01XA</td>
<td>Crushing injury of right ankle, initial encounter</td>
</tr>
</tbody>
</table>
ICD-10-CM Coding Tip
Placeholder Character “X” in Diagnosis Codes (Cont’d)

S02.2XXA Fracture of nasal bones, initial encounter for closed fracture

Tabular instructions:

- S02 Fracture of skull and facial bones
- Note: A fracture not indicated as open or closed should be coded to closed
- Code also any associated intracranial injury (S06-)
- The appropriate 7th character is to be added to each code from category S02
  
  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
  S - sequela

Example of how to build the code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S02.2</td>
<td>Fracture of nasal bones</td>
</tr>
</tbody>
</table>

Tabular instructions indicate that the appropriate 7th is to be added to each code from category S02.

<table>
<thead>
<tr>
<th>Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>S02.2XX</td>
<td>Because the code subcategory has only four characters (S02.2), the placeholder “X” is inserted twice before the 7th character.</td>
</tr>
<tr>
<td>S02.2XXA</td>
<td>The seventh character “A” is added to report this is an initial encounter for closed fracture.</td>
</tr>
</tbody>
</table>
ICD-10-CM Coding Tip
Placeholder Character “X” in Diagnosis Codes (Cont’d)

S97.01XA  Crushing injury of right ankle, initial encounter

Tabular instructions:
–  S97 Crushing injury of ankle and foot
–  Use additional code(s) for all associated injuries

The appropriate 7th character is to be added to each code from category S97
A - initial encounter
D - subsequent encounter
S – sequela

Example of how to build the code

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S97.0</td>
<td>Crushing injury of ankle</td>
</tr>
<tr>
<td>S97.01</td>
<td>Crushing injury of right ankle</td>
</tr>
</tbody>
</table>

Tabular instructions indicate that the appropriate 7th is to be added to each code from category S97

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S97.01X</td>
<td>Because the code subcategory has only five characters (S97.01), the placeholder “X” is inserted once before the 7th character.</td>
</tr>
<tr>
<td>S97.01XA</td>
<td>The seventh character “A” is added to report this is an initial encounter.</td>
</tr>
</tbody>
</table>
7th Character describing encounter

- **Initial encounter**: As long as patient is receiving active treatment for the condition.

- **Subsequent encounter**: After patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

- **Sequela**: Complications or conditions that arise as a direct result of a condition (example is a scar formation after a burn).

- **Note**: For aftercare of an injury, assign acute injury code with 7th character for subsequent encounter.
ICD-10-CM Coding Tip

Injury, poisoning, and certain other consequences of external causes (S00-T88)

7th character

Initial encounter (A), Subsequent encounter (D) and Sequela (S)

• Some ICD-10-CM diagnosis codes use a 7th character. Most of the diagnoses in Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00-T88) have the following 7th character values:
  – Initial encounter (A)
  – Subsequent encounter (D)
  – Sequela (S)
ICD-10-CM Coding Tip
Injury, poisoning, and certain other consequences of external causes (S00-T88)
Initial Encounter, 7th character “A”

• The 7th character “A” is used when the patient is receiving active treatment for the condition.

• Examples of active treatment are:
  – Surgical treatment
  – Emergency department encounter
  – Evaluation and treatment by a new physician

Patient is seen in the emergency department – use the 7th character “A”
The emergency room physician refers the patient to an Otolaryngologist for evaluation and treatment. The patient is evaluated and treated by the Otolaryngologist – use the 7th character “A”
The Otolaryngologist performs surgery on the patient – use the 7th character “A”
ICD-10-CM Coding Tip

Injury, poisoning, and certain other consequences of external causes (S00-T88)

Subsequent Encounter, 7th character “D”

• The 7th character “D” is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

• Examples of subsequent treatment are:
  – Cast change or removal
  – Removal of external or internal fixation device
  – Medication adjustment
  – Other aftercare

Note: The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care. For example, for aftercare of an injury, assign the acute injury code with the 7th character “D” subsequent encounter.
ICD-10-CM Coding Tip
Injury, poisoning, and certain other consequences of external causes (S00-T88)

Sequela, 7th character “S”

- The 7th character “S” is used for complications or conditions that arise as a direct result of a condition, such as a scar formation after a burn; the scars are sequela of the burn. A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated.
- When using the 7th character “S”, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself.
- The specific type of sequela (e.g., scar) is sequenced first, followed by the injury code.
- The “S” is added only to the injury code, not the sequela code.
- See the ICD-10-CM Official Guidelines for coding and reporting for additional information.

<table>
<thead>
<tr>
<th>Example</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>L90.5</td>
<td>Scar conditions and fibrosis of skin</td>
</tr>
<tr>
<td></td>
<td>T22.212xS</td>
<td>Burn of second degree of left forearm</td>
</tr>
</tbody>
</table>

Use additional external cause code to identify the source, place, and intent of the burn if your office chooses to capture external cause codes.
ICD-10-CM Coding Tip
Additional 7th Characters Used for Fracture Coding

• Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88)
  – Other 7th characters applied in this chapter to certain code categories depending upon site of fracture:

<table>
<thead>
<tr>
<th>Character</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Initial encounter for closed fracture</td>
</tr>
<tr>
<td>B</td>
<td>Initial encounter for open fracture (type I or II or NOS)</td>
</tr>
<tr>
<td>C</td>
<td>Initial encounter for open fracture (type IIIA, IIIB, IIIC)</td>
</tr>
<tr>
<td>D</td>
<td>Subsequent encounter for fracture w/routine healing</td>
</tr>
<tr>
<td>E</td>
<td>Subsequent encounter for open fracture (type I or II w/routine healing)</td>
</tr>
<tr>
<td>F</td>
<td>Subsequent encounter for open fracture (type II,II,II w/routine healing)</td>
</tr>
<tr>
<td>G</td>
<td>Subsequent encounter for fracture w/delayed healing</td>
</tr>
<tr>
<td>H</td>
<td>Subsequent encounter for open fracture (type I or II w/delayed healing)</td>
</tr>
<tr>
<td>J</td>
<td>Subsequent encounter for open fracture (type II,II,II w/delayed healing)</td>
</tr>
<tr>
<td>K</td>
<td>Subsequent encounter for fracture w/nonunion</td>
</tr>
<tr>
<td>M</td>
<td>Subsequent encounter for open fracture (type I, II w/nonunion)</td>
</tr>
<tr>
<td>N</td>
<td>Subsequent encounter for open fracture (type IIIA, IIIB, IIIC w/nonunion)</td>
</tr>
<tr>
<td>P</td>
<td>Subsequent encounter for fracture w/malunion</td>
</tr>
<tr>
<td>Q</td>
<td>Subsequent encounter for open fracture (type I, II w/malunion)</td>
</tr>
<tr>
<td>R</td>
<td>Subsequent encounter for open fracture (type IIIA, IIIB, IIIC w/malunion)</td>
</tr>
</tbody>
</table>
Need for Prophylactic Vaccination and Inoculation against Influenza

• In an effort to aid Health Information Management Coding and Medical Billing Professionals with ICD-10, the following coding tip is provided with an educational intent.

• TIP: In ICD-9, there are individual codes by type or disease for the coding of encounters for prophylactic vaccinations and inoculations. For example, V04.81 – need for prophylactic vaccination and inoculation against influenza. In ICD-10, there is only one code to assign for encounters for vaccinations and inoculations. The type or disease for the vaccination and inoculation is captured by coding the procedure code. ICD-10 coding Note for this code states: Procedure codes are required to identify the types of immunizations given.

• The ICD-10 code for vaccination and inoculation administration is Z23, Encounter for immunization:
  • The procedure code is required to identify the type of immunization or vaccine given
ICD-10-CM Coding Tip
Routine Child Health Examination

• In an effort to aid Health Information Management Coding and Medical Billing Professionals with ICD-10, the following coding tip is provided with an educational intent.

• TIP: In ICD-10, some of the codes for routine health examinations distinguish between “with” and “without” abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded. For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for “without abnormal findings.” When assigning a code for “with abnormal findings,” additional code(s) should be assigned to identify the specific abnormal finding(s).

• In ICD-9 there is only one code for routine child health examination (V20.2), but in ICD-10, there are two codes. These codes are used for children over 28 days old and include development testing. These codes are:

  Z00.121: Encounter for routine child health examination with abnormal findings
  Z00.129: Encounter for routine child health examination without abnormal findings
ICD-10-CM Coding Tip

Z00.121: Encounter for routine child health examination with abnormal findings

- Encounter for development testing of infant or child
- Health check (routine) for child over 28 days old
  - Previously reported as V20.2 - Routine infant or child health check in ICD-9
  - Instructional note to use additional code to identify any abnormal findings
  - Excludes 1 note indicates that Z00.121 cannot be used with the following:
    - Health check for child under 29 days old (Z00.11-)
    - Health supervision of foundling or other healthy infant or child (Z76.1 to Z76.2)
    - Newborn health examination (Z00.11-)
ICD-10-CM Coding Tip
Z00.129: Encounter for routine child health examination without abnormal findings

- Encounter for development testing of infant or child
- Health check (routine) for child over 28 days old
  - Previously reported as V20.2 - Routine infant or child health check in ICD-9
  - Excludes 1 note indicates that Z00.129 cannot be used with the following:
    - Health check for child under 29 days old (Z00.11-)
    - Health supervision of foundling or other healthy infant or child (Z76.1-Z76.2)
    - Newborn health examination (Z00.11-)
ICD-10-CM Coding Tip

Encounter for general adult medical examination

- In an effort to aid Health Information Management Coding and Medical Billing Professionals with ICD-10, the following coding tip is provided with an educational intent.

- **TIP:** In ICD-10, some of the codes for routine health examinations distinguish between “with” and “without” abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded. For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for “without abnormal findings.” When assigning a code for “with abnormal findings,” additional code(s) should be assigned to identify the specific abnormal finding(s).

- In ICD-9 there is only one code for routine general medical examination at a health care facility (V70.0), but in ICD-10, there are two codes. These codes are used for encounters for adult periodic examinations (annual)(physical) and any associated testing. These codes are:
  
  Z00.00 - Encounter for general adult medical examination *without* abnormal findings  
  Z00.01 - Encounter for general adult medical examination *with* abnormal findings
ICD-10-CM Coding Tip

Z00.00 - Encounter for general adult medical examination without abnormal findings

- Encounter for adult periodic examination (annual) (physical) and any associated laboratory and radiologic examinations
  - Encounter for adult health check-up NOS
  - Previously reported as V70.0 - Routine general medical examination at a health care facility (Health checkup) in ICD-9.
  - Excludes 1 note indicates that Z00.00 cannot be used with the following conditions;
    - Encounter for examination of sign or symptom – code to sign or symptom
    - General health check-up of infant or child (Z00.12)

- Example: A patient is referred to the radiology department for a chest X-ray as part of a routine physical examination. Code Z00.00, Encounter for general adult medical examination, is listed as the reason for the encounter because there are no presenting symptoms and the X-ray was not performed to rule out any suspect disease.
ICD-10-CM Coding Tip

Z00.01 Encounter for general adult medical examination with abnormal findings

- Encounter for adult periodic examination (annual) (physical) and any associated laboratory and radiologic examinations
  - Previously reported as V70.0 - Routine general medical examination at a health care facility (Health checkup) in ICD-9.
  - **Instructional note to use additional code to identify any abnormal findings**
  - Excludes 1 note indicates that Z00.01 cannot be used with the following conditions:
    - Encounter for examination of sign or symptom – code to sign or symptom
    - General health check-up of infant or child (Z00.12)

- Example: A patient is referred to the radiology department for a chest X-ray as part of a routine physical examination, however the physician noted decreased lung sounds on examination. Code Z00.01, Encounter for general adult medical examination with abnormal findings, is listed as the reason for the encounter because there are presenting symptoms and the X-ray was performed to rule out any suspect disease.
ICD-10-CM Coding Tip

Routine Gynecological Examination

In an effort to aid Health Information Management Coding and Medical Billing Professionals with ICD-10, the following coding tip is provided with an educational intent.

TIP: In ICD-10, some of the codes for routine health examinations distinguish between “with” and “without” abnormal findings. Code assignment depends on the information that is known at the time the encounter is being coded. For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for “without abnormal findings.” When assigning a code for “with abnormal findings,” additional code(s) should be assigned to identify the specific abnormal finding(s).

In ICD-9 there is only one code for routine gynecological examination (V72.31), but in ICD-10, there are two codes. These codes are:

• Z01.411 - Encounter for gynecological examination (general)(routine) with abnormal findings
• Z01.419 - Encounter for gynecological examination (general)(routine) without abnormal findings


NOTE: This tip sheet was developed in collaboration with the California Health Information Association, AHIMA Affiliate.
ICD-10-CM Coding Tip

Z01.411 - Encounter for gynecological examination (general)(routine) with abnormal findings

- Encounter for general gynecological examination with or without cervical smear
- Encounter for gynecological examination (general)(routine) NOS
- Encounter for pelvic examination (annual)(periodic)
  - Previously reported as V72.31 - Routine gynecologic examination in ICD-9
  - **Instructional note to use additional code to identify any abnormal findings**
  - Instructional note to use additional code for screening for human papillomavirus, if applicable (Z11.51), screening vaginal pap smear, if applicable (Z12.72) or to identify acquired absence of uterus, if applicable (Z90.71-).
  - Excludes 1 note indicates that Z01.411 can not be used with the following conditions;
    - Gynecologic examinations status-post hysterectomy for malignant condition (Z08)
    - Screening cervical pap smear **not** a part of a routine gynecological examination (Z12.4)
ICD-10-CM Coding Tip

Z01.419 - Encounter for gynecological examination (general)(routine) without abnormal findings

- Encounter for general gynecological examination with or without cervical smear
- Encounter for gynecological examination (general)(routine) NOS
- Encounter for pelvic examination (annual)(periodic)
  - Previously reported as V72.31 - Routine gynecologic examination in ICD-9
  - Instructional note to use additional code for screening for human papillomavirus, if applicable (Z11.51), screening vaginal pap smear, if applicable (Z12.72) or to identify acquired absence of uterus, if applicable (Z90.71-).
  - Excludes 1 note indicates that Z01.419 can not be used with the following conditions;
    - Gynecologic examinations status-post hysterectomy for malignant condition (Z08)
    - Screening cervical pap smear not a part of a routine gynecological examination (Z12.4)

- NOTE: This tip sheet was developed in collaboration with the California Health Information Association, AHIMA Affiliate.