The following content is from www.roadto10.org

ICD-10 Basics

About ICD-10

The ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets on October 1, 2015. ICD-10 consists of two parts:

- ICD-10-CM diagnosis coding which is for use in all U.S. health care settings.
- ICD-10-PCS inpatient procedure coding which is for use in U.S. hospital settings.

ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by the Health Insurance Portability Accountability Act (HIPAA), not just those who submit Medicare or Medicaid claims:

- Claims for services provided on or after the compliance date should be submitted with ICD-10 diagnosis codes.
- Claims for services provided prior to the compliance date should be submitted with ICD-9 diagnosis codes.

The change to ICD-10 does not affect CPT coding for outpatient procedures.

ICD-10 allows us to speak the same language as the people that are going to be telling our story – for outcomes, for data assessment, and for billing. It's incredibly important to have the severity of disease we are managing accurately portrayed. **Mark Bieniarz, M.D. Cardiologist**

ICD-10-CM Code Structure

ICD-10 diagnosis codes have between 3 and 7 characters:

- Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of any or all of the 4th, 5th, and 6th characters. Digits 4-6 provide greater detail of etiology, anatomical site, and severity. A code using only the first three digits is to be used only if it is not further subdivided.

- A code is invalid if it has not been coded to the full number of characters required. This does not mean that all ICD-10 codes must have 7 characters. The 7th character is only used in certain chapters to provide data about the characteristic of the encounter. Examples of where the 7th character can be used include injuries and fractures, as illustrated in the following tables:

Injuries and External Causes	
Value	Description
A	Initial encounter
D	Subsequent encounter
S	Sequela

Fractures	
Value	Description
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

- A dummy placeholder of "X" is used with certain codes to allow for future expansion and/or to fill out empty characters when a code contains fewer than 6 characters and a 7th character applies. When a placeholder character applies, it must be used in order for the code to be considered valid.

- See next page for specific examples of ICD-10 diagnosis codes. The use of combination codes, increased specificity, and the "X" placeholder is illustrated:

ICD-10 Code Structure – continued

Code	Description
Combination Codes	
I25.110	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
Increased Specificity	
S72.044G	Non-displaced fracture of base of neck of right femur, subsequent encounter for closed fracture with delayed healing
Laterality	
C50.511	Malignant neoplasm of lower-outer quadrant of right female breast
C50.512	Malignant neoplasm of lower-outer quadrant of left female breast
"X" Placeholder	
H40.11X2	Primary open-angle glaucoma, moderate stage

ICD-10-CM Indexes

A comprehensive listing of 2015 diagnosis codes can be found in the ICD-10-CM Index to Diseases and Injuries (alphabetical) and ICD-10-CM Tabular List of Diseases and Injuries which can be accessed from the following links:

- **2015 ICD-10-CM Index to Diseases and Injuries**
- **2015 ICD-10-CM Tabular List of Diseases and Injuries**

A summary of the chapters found in the Tabular List has been provided below:

Chapter	Code Range	Estimated # of Codes	Description
1	A00-B99	1,056	Certain infectious and parasitic diseases
2	C00-D49	1,620	Neoplasms
3	D50-D89	238	Diseases of the blood and blood-forming organs and certain disorders involving t immune mechanism
4	E00-E89	675	Endocrine, nutritional and metabolic diseases
5	F01-F99	724	Mental, Behavioral and Neurodevelopmental disorders
6	G00-G99	591	Diseases of the nervous system
7	H00-H59	2,452	Diseases of the eye and adnexa
8	H60-H95	642	Diseases of the ear and mastoid process

9	I00-I99	1,254	Diseases of the circulatory system
10	J00-J99	336	Diseases of the respiratory system
11	K00-K95	706	Diseases of the digestive system
12	L00-L99	769	Diseases of the skin and subcutaneous tissue
13	M00-M99	6,339	Diseases of the musculoskeletal system and connective tissue
14	N00-N99	591	Diseases of the genitourinary system
15	O00-O9A	2,155	Pregnancy, childbirth and the puerperium
16	P00-P96	417	Certain conditions originating in the perinatal period
17	Q00-Q99	790	Congenital malformations, deformations and chromosomal abnormalities
18	R00-R99	639	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
19	S00-T88	39,869	Injury, poisoning and certain other consequences of external causes
20	V00-Y99	6,812	External causes of morbidity
21	Z00-Z99	1,178	Factors influencing health status and contact with health services

External Cause Code Reporting

If you have not been reporting ICD-9-CM external cause codes, you will not be required to report ICD-10-CM codes found in Chapter 20 unless a new State or payer-based requirement about the reporting of these codes is instituted. If such a requirement is instituted, it would be independent of ICD-10-CM implementation.

In the absence of a mandatory reporting requirement, you are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

Native Coding and Unspecified Codes

Native coding means to assign an ICD-10 diagnosis code directly based on clinical documentation. Practices are encouraged to natively code using ICD-10 code reference sources instead of using crosswalks, which should be used for general knowledge. Specific codes reflecting the most appropriate level of certainty known for an encounter should be evaluated first:

- Specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition.
- 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 health condition to assign a more specific code, coding should comply with the payer guidelines for the use of unspecified codes.

What is different with ICD-10?

ICD-9 to ICD-10

More than an update, a leap in how we define care.

Modern History of the Medical Dictionary—ICD-10

The World Health Organization's (WHO) International Classification of Diseases has served the healthcare community for over a century. The United States implemented the current version (ICD-9) in 1979. While most industrialized countries moved to ICD-10 several years ago, the United States is just now transitioning with a final compliance date of October 1, 2015. It's time our Medical Dictionary reflected modern medicine.

By Physicians for Physicians

Under the sponsorship of the WHO, a select group of physicians created the basic ICD-10 structure. Following this, each physician specialty within the United States offered their input on the subset of diagnosis codes required. In most cases, the specialties advocated capturing additional detail based on information that physicians intuitively use in delivering patient care.

These changes enhance current medical documentation standards to capture a greater level of detail in patient care. Accurate analysis of health data will help improve the quality and efficiency of delivering patient care, particularly as electronic sharing and exchange of health records grows.

We still are stuck with a coding system that was put in place 30 years ago or longer. It's time to update it! **Scott Cyrus, D.O. Pediatrics**

The Differences will make a Difference

It is important to understand the major improvements and changes between ICD-9 and ICD-10 diagnosis codes.

ICD-9-CM Diagnosis Codes	ICD-10-CM Diagnosis Codes
No Laterality	Laterality – Right or Left account for >40% of codes
3-5 digits • First digit is alpha (E or V) or numeric • Digits 2-5 are numeric • Decimal is placed after the third character	7 digits • Digit 1 is alpha; Digit 2 is numeric • Digits 3–7 are alpha or numeric • Decimal is placed after the third character
No placeholder characters	"X" placeholders
14,000 codes	69,000 codes to better capture specificity
Limited Severity Parameters	Extensive Severity Parameters
Limited Combination Codes	Extensive Combination Codes to better capture complexity
1 type of Excludes Notes	2 types of Excludes Notes

Other Important Changes to Note in ICD-10-CM:

• **Importance of Anatomy**: Injuries are grouped by anatomical site rather than by type of injury

• **Incorporation of E and V Codes**: The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM

• **New Definitions**: In some instances, new code definitions are provided reflecting modern medical practice (e.g., definition of acute myocardial infarction is now 4 weeks rather than 8 weeks)

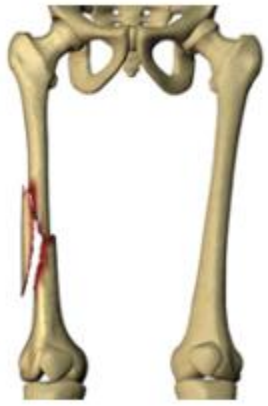
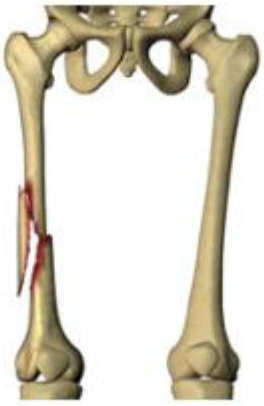
• **Restructuring and Reorganization**: Category restructuring and code reorganization have occurred in a number of ICD-10-CM chapters, resulting in the classification of certain diseases and disorders that are different from ICD-9-CM

• **Reclassification**: Certain diseases have been reclassified to different chapters or sections in order to reflect current medical knowledge

To learn more about ICD-10 and the changes surrounding the transition, please visithttp://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10MythsandFacts.pdf.

Figure One: Femur Fracture Example illustrates the major differences between the ICD-9 and ICD-10 code structure.

Figure One: Femur Fracture Example

ICD-9	ICD-10
	
Before the Compliance Date 821.11 Open fracture of Shaft of Femur **All codes for femur fracture = 16**	***After the Compliance Date*** S72.351C Displaced comminuted fracture of shaft of right femur, initial encounter for open fracture type IIIA, IIIB, or IIIC **All codes for femur fracture = 1530**

How will my practice benefit from ICD-10?

Prepping for the compliance date is critical

ICD-10 will provide an enhanced platform for physician practice. As of October 1, 2015, the ICD-10 coding classification will become the new baseline for clinical data, clinical documentation, claims processing, and public health reporting. Understanding patient encounters and preparing for the transition will be critical to the financial sustainability of each practice.

From proper observation and documentation to improved clinical documentation, progress notes, operative reports, and histories, the benefits of ICD-10 begin with enhanced clinical documentation enabling physicians to better capture patient visit details and lead to better care coordination and health outcomes.

Ultimately, better data paves the way for enhanced quality and greater effectiveness of patient care and safety. While the transition to ICD-10 will require work, it is temporary. The benefits of ICD-10 will impact everything from patient care to each practice's bottom line.

ICD-9 may have been adequate for the past environment, but that's not the environment of the future. ICD-10 is needed to help us paint the picture of the population we are managing in the future payment models. ICD-10 will also allow other physicians and physician extenders to see what took place in the visit.

Maggie Gaglione, M.D.
Internal Medicine and Bariatrics

Why prepare for ICD-10?

Reasons to prepare for ICD-10 can be broken down into four categories:

Clinical

Informs better clinical decisions as better data is documented, collected, and evaluated

Provides new insights into patients and clinical care due to greater specificity, laterality, and more detailed documentation of patient diseases

Enables patient segmentation to improve care for higher acuity patients

Improves design of protocols and clinical pathways for various health conditions

Improves tracking of illnesses and severity over time

Improves public health reporting and helps to track and evaluate the risk of adverse public health events

Drives greater opportunity for research, clinical trials, and epidemiological studies

Operational

Enhances the definition of patient conditions, providing improved matching of professional resources and care teams and increasing communications between providers

Affords more targeted capital investment to meet practice needs through better specificity of patient conditions

Supports practice transition to risk-sharing models with more precise data for patients and populations

Professional

Provides clear objective data for credentialing and privileges

Captures more specific and objective data to support professional Maintenance of Certification reporting across specialties

Improves specificity of measures for quality and efficiency reporting

Aids in the prevention and detection of healthcare fraud and abuse

Provides more specific data to support physician advocacy of health and public health policy

Financial

Allows better documentation of patient complexity and level of care, supporting reimbursement for care provided

Provides objective data for peer comparison and utilization benchmarking

May reduce audit risk exposure by encouraging the use of diagnosis codes with a greater degree of specificity as supported by the clinical documentation