

Once you understand the basic structure of ICD-10,
you'll be able to capture the details needed to assign a correct code.

Getting Ready for ICD-10: How It Will Affect Your Documentation

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CD-10 is coming. The scheduled date of arrival is Oct. 1, 2014, and there does not appear to be any potential for further delays. Although many organizations are preparing for the transition, it may still be too early for practicing physicians to try to become familiar with all the nuances of the new coding system. Until you're regularly using ICD-10, you probably won't retain what you've learned.

However, to be prepared, physicians do need to understand the following: 1) the basic changes inherent in the ICD-10 system and 2) how those changes drive the need for additional documentation details.

I have reviewed thousands of medical records over the past several years as a managed care medical director and clinical improvement consultant. This experience has led me to conclude that the overwhelming majority of current medical records, whether handwritten, dictated, or electronic, do not contain the necessary documentation to support the increased coding specificity required to properly use the ICD-10 system. That's the bad news.

The good news is that with a little effort you can get ready for what's coming, and this article will help.

An overview of the changes

The basic structure and coding rules inherent in ICD-10 may not be your idea of compelling reading, but bear with me. This brief overview will help you understand why your documentation will become more important under ICD-10.

Basic ICD-10 structure. An ICD-10 code consists of between three and seven characters. The first character is alpha. The second character is numeric. The third character is typically numeric, but the most recent updates to ICD-10 include some alpha characters in this position. These first three characters represent the category. For example, diabetes mellitus falls in the E00-E89 category of "Endocrine, nutritional and metabolic diseases."

The fourth through seventh characters of an ICD-10 code appear after the decimal point and are either alpha or numeric. These characters reference etiology, anatomic site, and severity. Character seven is called an "extension." Most of the exponential increase in the number of diagnostic codes under ICD-10 is related to these additional characters, as shown below:

H10 Conjunctivitis,
H10.0 Mucopurulent conjunctivitis,
H10.01 Acute follicular conjunctivitis,
H10.013 Acute follicular conjunctivitis, bilateral.

In this example, the first three characters (H10) describe conjunctivitis. The fourth and fifth characters describe the type of infection, and the sixth character describes the bilateral nature. Incidentally, if the conjunctivitis was the result of an external cause, you would have

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to add another code to identify that external cause.

Although it would be easier if the purpose of the fourth, fifth, and sixth characters remained the same from category to category, that is not the case. The use of these characters varies by category, as shown below:

- H54 Blindness and low vision,
- H54.1 Blindness, one eye, low vision other eye,
- H54.11 Blindness, right eye, low vision left eye,
- H54.12 Blindness, left eye, low vision right eye,
- H54.2 Low vision, both eyes,
- H54.4 Blindness, one eye,
- H54.41 Blindness, right eye, normal vision left eye,
- H54.42 Blindness, left eye, normal vision right eye.

Both of these code sets (H10 and H54) have options for the use of nonspecific codes. The H10 code set includes codes for “other acute conjunctivitis” and “unspecified acute conjunctivitis.” The H54 code set

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includes codes for “unqualified visual loss.”

The seventh character (the extension) is mostly found in two chapters of ICD-10. In the “Injury, Poisoning and Other Consequences of External Causes” chapter, it is used to describe the episode of care (A = initial, D =

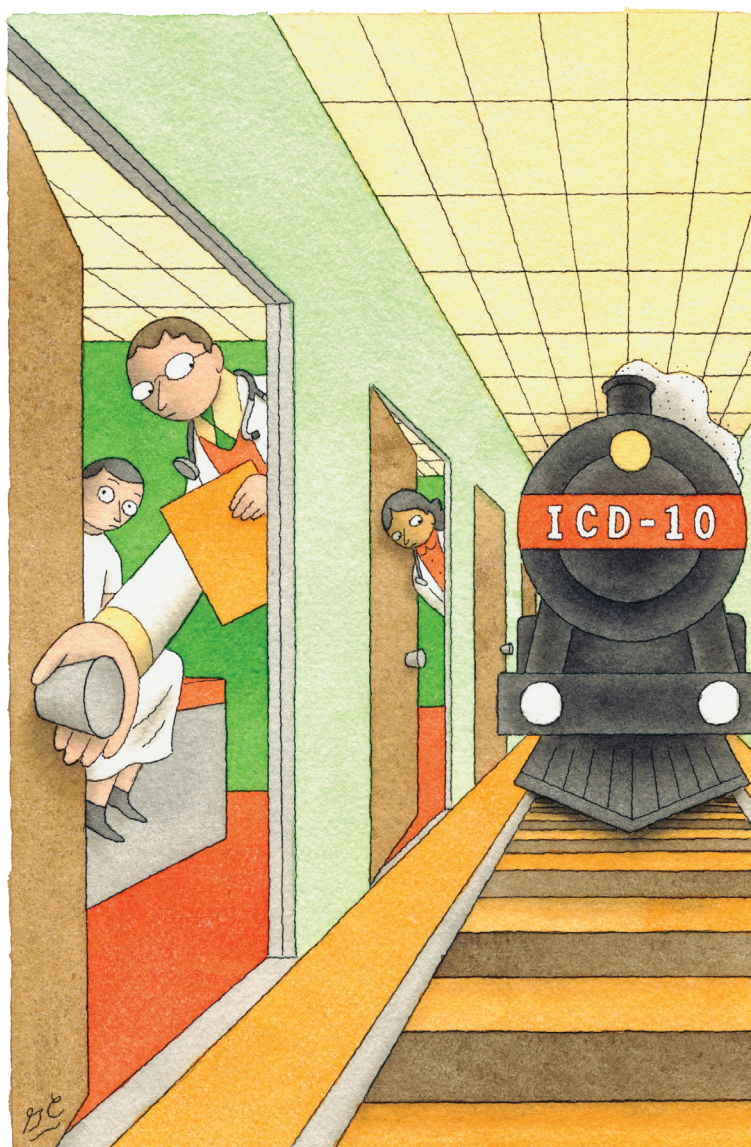
subsequent, and S = sequela). Fractures have even more options for the seventh character depending on whether they involve the Gustilo-Anderson classifications. (Explaining just the basics of fracture coding would take an entire article.) In the “Pregnancy, Childbirth and Puerperium” chapter, the seventh character is used to provide information about the fetus (1 = one fetus, 2-5 = two through five fetuses, and 9 = more than five fetuses).

If the base code is fewer than six characters but the code requires a seventh character, you would fill in the empty spaces with an x (e.g., S03.4xxA).

General coding rules. Common terminology is an important concept in ICD-10. In my experience, the following concepts are frequently misapplied even in ICD-9:

- “With unspecified complications” is a red flag for failure of the provider to document the complications,
- “With other specified complications” means the complication is specified but not contained in the ICD-10 manual,
- “Not otherwise specified (NOS)” is the equivalent of “unspecified.”

While it is tempting to use these non-specific codes, perhaps including them on a superbill, physicians need to be aware of the risks inherent in doing so. I am aware of ongoing discussions among payers to focus audit efforts on providers who frequently use non-specific codes. If you are using an electronic system that provides codes for you to choose from, be aware that the system may include an ICD-9 to ICD-10 translator and limit your options to the more generic four- or



DOCUMENTING DIABETES MELLITUS UNDER ICD-10

In ICD-10, diabetes mellitus falls into five major categories. Three of these categories are rarely encountered in family medicine:

- E08, "Diabetes due to underlying condition," is never used as a primary diagnosis. This category is reserved for individuals who develop diabetes mellitus as the result of an underlying condition such as malignancy, malnutrition, and pancreatitis.
- E09, "Drug or chemical induced diabetes mellitus," will not be encountered often in primary care. When it is, the provider would first code the poisoning due to a drug or toxin, use additional codes for adverse effects when applicable, and use the fourth through seventh characters to list complications.
- E13, "Other specified diabetes mellitus," is another category that is rarely used in primary care. This category includes diabetes mellitus due to genetic defects of beta-cell function and insulin action. It also includes postprocedural diabetes mellitus including postpancreatectomy diabetes mellitus.

The two categories common in family medicine are E10, "Type 1 diabetes mellitus," and E11, "Type 2 diabetes mellitus." To document these conditions for ICD-10 coding, a provider would need to take the following steps:

1. Specify Type 1 or Type 2.

Type 1 diabetes mellitus includes:

- Brittle diabetes mellitus,
- Diabetes mellitus due to autoimmune process,
- Diabetes mellitus due to immune mediated pancreatic islet beta-cell destruction,
- Idiopathic diabetes mellitus,
- Juvenile onset diabetes mellitus,
- Ketosis-prone diabetes mellitus.

Type 2 diabetes mellitus includes:

- Diabetes mellitus due to insulin secretory defect,
- Diabetes not otherwise specified,
- Insulin resistant diabetes mellitus.

2. Document the degree of control.

ICD-10 eliminates any reference to controlled and not controlled. However, the codes shown below include "with hypoglycemia" and "with hyperglycemia."

Although your patient may have Type 2 diabetes mellitus without complications (E11.9), the patient may have elevated blood sugars or an elevated A1C. In this situation, it might be more accurate to code Type 2 diabetes mellitus with hyper-

glycemia (E11.65). ICD-10 does not currently define hyperglycemia, but it considers hyperglycemia to be a complication of diabetes, which is why code E11.65 is found in the E11.6 code family for "Type 2 diabetes mellitus with other specified complications." Of course, diabetes with a complication code carries a relatively higher illness burden than diabetes without a complication code.

Unfortunately, until the final version of ICD-10 is published, it is unknown whether the term "hyperglycemia" will be defined.

3. Specify insulin use.

The primary codes for diabetes mellitus do not include whether the individual is using insulin. Therefore, you must use a second ICD-10 code: Z79.4, "Long term (current) insulin use."

Unfortunately, "long term" does not necessarily mean long term. The "long term use" code for any drug is appropriate once that drug has been started. If you prescribe insulin for the first time at an office visit, it is appropriate to add the Z79.4 code to the base diabetes mellitus code you are using.

4. Specify complications to a very specific degree.

The additional characters in the diabetes codes are essentially the same for both Type 1 (E10) and Type 2 (E11). The list of Type 2 codes, below, shows the degree of specificity required. It is important to note the specific wording of each diagnosis code. For instance, if your patient has diabetes mellitus and chronic kidney disease, you need to specify cause and effect for the condition to be properly coded.

E11.0 Type 2 diabetes mellitus with hyperosmolarity
E11.00 ... without nonketotic hyperglycemic
hyperosmolar coma
E11.01 ... with coma
E11.2 Type 2 diabetes mellitus with kidney complications
E11.21 ... with diabetic nephropathy
E11.22 ... with diabetic chronic kidney disease
E11.29 ... with other diabetic kidney complication
E11.3 Type 2 diabetes mellitus with ophthalmic
complications
E11.31 ... with unspecified diabetic retinopathy
E11.311 ... with macular edema
E11.319 ... without macular edema
E11.32 ... with mild nonproliferative diabetic
retinopathy
E11.321 ... with macular edema

E11.329 ... without macular edema
 E11.33 ... with moderate nonproliferative diabetic retinopathy
 E11.331 ... with macular edema
 E11.339 ... without macular edema
 E11.34 ... with severe nonproliferative diabetic retinopathy
 E11.341 ... with macular edema
 E11.349 ... without macular edema
 E11.35 ... with proliferative retinopathy
 E11.351 ... with macular edema
 E11.359 ... without macular edema
 E11.36 ... with diabetic cataract
 E11.39 ... with other diabetic ophthalmic complication
 E11.4 Type 2 diabetes mellitus with neurologic complications
 E11.40 ... with diabetic neuropathy, unspecified
 E11.41 ... with diabetic mononeuropathy
 E11.42 ... with diabetic polyneuropathy
 E11.43 ... with diabetic autonomic (poly) neuropathy
 E11.44 ... with diabetic amyotrophy
 E11.49 ... with other diabetic neurological complications
 E11.5 Type 2 diabetes mellitus with circulatory complications
 E11.51 ... with diabetic peripheral angiopathy without gangrene
 E11.52 ... with diabetic peripheral angiopathy with gangrene
 E11.59 ... with other circulatory complications
 E11.6 Type 2 diabetes mellitus with other specified complications
 E11.61 ... with diabetic arthropathy
 E11.610 ... with diabetic neuropathic arthropathy
 E11.618 ... with other diabetic arthropathy
 E11.62... with skin complications
 E11.620 ... with diabetic dermatitis
 E11.621 ... with foot ulcer
 E11.622 ... with other skin ulcer
 E11.628 ... with other skin complications
 E11.63 ... with oral complications
 E11.630 ... with periodontal disease
 E11.638 ... with other oral complications

E11.64 ... with hypoglycemia
 E11.641 ... with coma
 E11.649 ... without coma
 E11.65... with hyperglycemia
 E11.69... with other specified complications
 E11.8 Type 2 diabetes mellitus with unspecified complications
 E11.9 Type 2 diabetes mellitus without complications

As you can see from these examples, there are numerous codes that document the type of diabetes, the severity of the condition, and the complications of the disease. Adding to the difficulty, when the patient has multiple complications, correct coding requires you to document and code each complication separately.

The good news is that, in family medicine, there are a limited number of ICD-10 codes that will describe the majority of your patients with Type 2 diabetes:

E11.9	Type 2 diabetes mellitus without complications
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
Z79.4	Long term (current) insulin use

While it may be tempting to list these seven codes on your superbill and think that's sufficient, it is important that you remember to thoroughly document each patient's specific condition so that coders may accurately code those patients with additional complications that aren't listed on your superbill.

It is also important to remember to code all additional diagnoses. As family physicians, we know that our patients who have diabetes often also have hypertension, hyperlipidemia, and obesity and may use tobacco products. Each of these additional issues requires separate coding. These additional diagnostic codes may have almost as many combinations as found in the diabetes mellitus codes.



Although the idea of having the number of diagnostic codes expand exponentially is scary, you can handle it.

■ Increased specificity is the over-arching theme in ICD-10.

■ It does not require that you code patients' existing conditions that are not relevant to the current service.

■ You'll want to pay careful attention to ICD-10's "code first," "use additional," "includes," and "excludes" instructions.

five-character ICD-10 codes. It will be important for you to ensure that the most specific code supported by the medical record is used for claim submission.

You are not required to code conditions that exist but are not relevant to the reason for the provided services. For instance, if providing care for a patient with diabetes mellitus, it is relevant to document the smoking status of the patient. If providing care for a patient with an acute ankle sprain, smoking status is likely not relevant.

Here are a few more common coding conventions you need to understand:

- "Code first" means the code is not an acceptable primary diagnosis code and another code should be in the first position,
- "Use additional" means certain situations require an additional diagnostic code,
- "Includes" and "excludes" are parenthetical commentary regarding similarly worded diagnoses that either fall within the code or are excluded from the code.

The need for better documentation

Coding in family physicians' offices generally takes place through one of three formats depending on the size of the practice and the use of electronic health records (EHRs). Solo and small practices often rely on a so-called superbill that contains a list of the most common diagnosis codes for the physician to check. Practices that use EHRs often incorporate an automatic billing system that translates the information from the record onto a CMS-1500 billing form. Larger practices often use coders to abstract the medical record and add diagnosis codes to claim forms.

In the first scenario, a one- or two-page superbill will not be enough to capture all the ICD-10 codes needed, so you will have to include specific documentation details to help with code selection that will likely extend beyond the superbill. In the latter scenarios, specific documentation will be required to help either the system or the coder translate a medical record into the most specific and cor-

STEPS YOU CAN TAKE NOW

1. Familiarize yourself with the basic structure of ICD-10.
2. Practice documenting a more complete diagnosis, including details such as site, laterality, complications, and other specific characteristics.
3. Develop more detailed templates to ensure that your documentation will meet coding and billing requirements.
4. If you use a superbill, begin updating it by crosswalking your ICD-9 codes to ICD-10 codes, but be aware that there is not a one-to-one match for each code, and such a list will have limitations. The Centers for Medicare & Medicaid Services offers General Equivalence Mappings (<http://www.cms.gov/Medicare/Coding/ICD10/2014-ICD-10-CM-and-GEMs.html>), which may help with this process.
5. If you use an EHR, ask your vendor about the need for additional documentation elements and find out whether the system can accommodate both code sets in the months before ICD-10 is required, allowing you to start practicing with ICD-10 while you continue billing with ICD-9.

rect ICD-10 code for the services. If the documentation is not specific enough, either the system will not perform properly or the coders will be forced to come back to you requesting additional documentation for them to properly code your claim and obtain reimbursement.

For an example of the level of documentation that will be required to support the new ICD-10 codes, see “Documenting diabetes mellitus under ICD-10” (page 24).

This increased specificity required in documentation may mean that physicians have to document details that seem obvious to them but would not be obvious to those abstracting the record for coding purposes. In fact, some of the documentation may seem silly, but remember that the individual doing the coding can only use what appears in the medical record. Even though your coder may understand what you meant, that will not satisfy an outside auditor or claims payer. In medicine, we often say, “If you didn’t document it, you didn’t do it.” In coding, we often say, “If you didn’t document it, you can’t bill for it.”

One example of this seemingly redundant documentation need is for obese patients. ICD-10 requires that the provider do more than simply document that a patient is obese. ICD-9 uses the code 278.00, “Obesity, unspecified,” but ICD-10 uses E66.0, “Obesity due to excess calories.” At the 2013 AAPC National Meeting, coders were advised not to use E66.0 unless the medical record specifically asserted excess calories as the cause for the obesity. Without that additional documentation, the coders would need to default to E66.9, “Obesity, unspecified.” This would increase the concerns noted above regarding the use of unspecified codes. For individuals using an EHR, this problem could be resolved in the template for documentation. For those providers creating handwritten or dictated records, it might be prudent to get in the habit of adding this additional verbiage to your documentation.

It is important for providers to understand the dramatically increased emphasis on coding that will occur in the near future and how hundreds of millions of dollars will flow through

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Upcoming articles will include the following topics:

- Getting your office prepared for ICD-10,
- Signs and symptoms in ICD-10,
- Preventive services in ICD-10,
- Coding common diagnoses in family medicine.

the Affordable Care Act as a result. If you work in an accountable care organization or other practice setting where the relative illness burden of your personal patients is calculated, more specific coding that leads to higher premium dollars for the payer may result in more dollars flowing to your practice to provide care for those individuals. Coding that does not capture the complete picture of all applicable diagnoses, comorbidities, etc., will result in fewer premium dollars to the payer and potentially fewer claims dollars to the provider.

This transfer of premium dollars based on risk adjustment will be one of the leading drivers for payers to audit providers who are using nonspecific diagnostic codes.

Don’t panic

Yes, ICD-10 is coming and will not be stopped. And although the idea of having the number of diagnostic codes expand exponentially is scary, you can handle it. Many of the new codes are combinations of current ICD-9 codes; many additional codes simply specify right, left, or bilateral; and many other codes are for more complex conditions that are rarely seen in primary care. By learning the basics of the ICD-10 coding system, making some adjustments to your current written or dictated documentation, and ensuring that your EHR system can handle the required increased specificity of documentation, you will be ready to go when ICD-10 arrives. **FPM**

Send comments to fpm@aaafp.org, or add your comments to the article at <http://www.aaafp.org/fpm/2013/1100/p22.html>.

Whether you do your own coding or use an EHR or a professional coder, your documentation will need to become more specific.

If your documentation is not specific enough, your office will not be able to properly code your claim and obtain reimbursement.

Understanding the basic changes in ICD-10 and how those changes drive the need for additional documentation details will improve your readiness for ICD-10.