ICD-10-CM and the Emergency Physician

ICD-10-CM Workgroup, Committee on Nomenclature and Coding

General Considerations

The International Classification of Diseases in the international model for tracking morbidity and mortality statistics and the HIPAA standard for reporting diagnoses in the United States. The current version was released by the World Health Organization (WHO) in 1975 and the US clinical modification (ICD-9-CM) adopted in 1979. WHO issued the 10th edition in 1994. US mortality statistics have been reported in this version since 1999. The US version, ICD-10-CM, will be used for reporting diagnoses for all encounter starting October 1, 2014.

The expansion to just over 68,000 unique diagnosis codes in ICD-10-CM (I-10), made in collaboration with medical specialty societies, allows for greater specificity and granularity in coding. In turn, this will permit greater precision in diagnostic terminology, improved support for medical necessity, and enhanced ability to measure quality metrics. Approximately 95% of the new codes will backtrack to a single ICD-9-CM (I-9) code.

As in I-9, the clinician will continue to select the diagnosis code that shows the "…the highest degree of certainty for that encounter/visit… " and report with the "…highest number of characters available" (ICD-10-CM Official Guidelines for Coding and Reporting). As opposed to I-9, I-10 can have a combination of up to 7 alpha and numeric characters. A code may have a 4 or 5 character stem but require a 7th character to fully explain the encounter. In these circumstances the entire 7 characters must be reported. The V and E-code chapters have been eliminated.

The 7th character will be important in many ED encounters. It will show whether this was the initial visit for active care for a problem ("A") or subsequent visit for aftercare for the condition ("D"). For example,

a patient is seen for laceration due to an animal bite of the scalp and then is brought back to the ED 2 days later to check for signs of wound infection. The initial visit would be reported with code S01.05xA and the re-check with code S01.05xD. If the patient came back to the ED because of complications related to healing, such as an infected wound, then the visit would be reported as a sequela to the initial injury using "S" as the 7th character (S01.05xS). The stem code for open bite wound of the scalp is S01.05, however since a 7th character must be reported, the letter "x" is used as a placeholder in the 6th character space. The 7th character will also identify initial visits for closed vs. open fracture ("A", "B") or if the patient is being seen because of delayed healing or non-union of the fracture ("G", "K").

Laterality

One of the major changes seen with I-10 is "laterality". Some codes will indicate whether the condition occurs on the left or right side, or is bilateral. The clinician, for example, would be able to show if there was a sudden loss of vision in the left eye (H53.132), an acute STEMI involving the right coronary artery (I21.11), or bilateral pulmonary contusions (S27.322). Using an "unspecified site" code may result in delayed or denied payment by third-party payors.

Combination Codes

I-10 converts multiple codes from I-9 into single combination codes. A combination code is a single code that is 1) the merger of two I-9 codes, 2) a diagnosis with an associated secondary manifestation, or 3) a diagnosis with an associated complication. This will not only help with improved specificity but will also take up less lines of code on the HFCA 1500 reporting form. An example of two merged codes would be "severe sepsis" (995.92) and "septic shock" (785.52) in I-9 that appear as the single code "severe sepsis with septic shock" (R65.21) in I-10. The associated manifestation of dementia in Alzheimer's is shown by the codes 331.0 and 294.1 in I-9 and the single code G30.1 in I-10. In I-9 the complication of a foot ulcer

in a patient with poorly controlled Type 2 diabetes is reported using codes 250.82 and 707.15, while in I-10 the same information is related with the single code E11.621.

Urosepsis

Just as in I-9, in I-10 there is not a specific code for "urosepsis". By Coding Guidelines, the term "urosepsis" along is directed to urinary tract infection (N39.0). The physician must be very clear in the documentation to indicate that a patient who is septic due to a urinary tract infection. Instead of using the term "urosepsis" the physician should indicate that the patient has sepsis from a urinary tract infection. The causative organism should also be documented, if known. For example, a patient is septic from an E. coli UTI would be coded A41.51, Sepsis due to Escherichia coli [E. coli]. If the physician indicated the infection was due to an indwelling catheter then T83.51, Infection and inflammatory reaction due to indwelling urinary catheter would also be coded.

Pregnancy

Many conditions related to pregnancy in I-10 will have specific codes based on trimester. It is therefore imperative that the trimester or number of weeks be documented in the record. Trimesters are counted from the first day of the last menstrual period, as follows.

- 1st trimester – less than 14 weeks, 0 days
- 2nd trimester - 14 weeks 0 days to less than 28 weeks 0 days
- 3rd trimester - 3rd trimester- 28 weeks 0 days until delivery

For example, a woman with a pre-exisiting history of hypertension is evaluated in the emergency department at 13 weeks estimated gestational age. The I-10 code O10.011 (Pre-existing essential hypertension complicating pregnancy, first trimester) would be reported. There are also a new set of codes to show physical, sexual or psychological abuse during pregnancy. For example, a woman in her

second trimester who is brought to the ED following a sexual assault would be reported with the code O9A.412, Sexual abuse complicating pregnancy, second trimester.

Some conditions will have in their definition a time frame. For example, threatened abortion (O20.0) would be used for vaginal bleeding that would be due to a potential miscarriage before 20 weeks of completed gestation.

Just as in I-9, codes from the pregnancy chapter are listed first unless the pregnancy is unrelated or incidental to the visit and it is the provider's responsibility to state the condition being treated is not affecting the pregnancy. If the ED visit is unrelated to the patient's pregnancy, then code Z33.1 (Pregnant state, incidental to encounter) would be reported.

Acute Myocardial Infarction

Physicians documenting the presence of an acute myocardial infarction should be aware that an infarction is considered acute for 4 weeks in I-10. In I-9, the period of acute myocardial infarction is defined as 8 weeks.

How specific will the physician need to be with the coding? In I-10 the physician would be able to differentiate as to which specific coronary was affected in a ST elevation (STEMI) myocardial infarction of anterior wall. Since in the ED the physician is unlikely to have that degree of detail, the correct code would be based on the highest degree of clinical certainty:

- STEMI vs. non-STEMI
- Anterior vs. inferior wall

For a patient with a STEMI of the anterior wall, the physician's documentation should support I21.09 Acute STEMI transmural myocardial infarction of anterior wall. The physician should also document any contributing factors such as tobacco use (Z72.0) or to identify presence of hypertension (I10-I15). As in I-9, the physician should also document if the patient had received tPA at another facility within the previous 24 hours (Z92.82).

Injury, poisoning, and other consequences of external causes

I-10 describes injury, poisoning, and other consequences of external causes in much greater detail than I-9. Codes in the S00 – S99 describe injuries to a specific body area. Codes T07 – T88 covers injuries involving multiple body systems, foreign bodies, burns and environmental related conditions, poisonings and certain other consequences of external causes including trauma, surgical and medical care related complications. There are more unique codes to better describe the type and severity of injury. For example, there are now separate codes to identify puncture wounds and bites from lacerations (which were lumped together in I-9).

Many concepts from the E-code chapter are now incorporated or combined with codes in this chapter.

To facilitate correct selection of injury codes physicians should document the following as clearly as possible:

- Reason for the encouter: initial (first time seen for the problem or a new visit for a recurring condition), subsequent (planned follow-up or aftercare), or due to a sequela of initial injury. Very important for the provider to document was the patient seen for this injury before and if so where?

- The location of the injuries
- Which injury appears the most serious and/or primary
- Associated injuries to blood vessels and nerves, when present
- Presence or absence of foreign body
- Severity, cause, location and estimated involved body surface area of burn(s)
- Duration of loss of consciousness
- Presence of abuse or neglect
- Specify injuries or poisonings that occur as a complication of care.

For example, in a child who has a radius fracture from a fall from a jungle gym, the physician needs to be clear as to:

- What part of the radius is fractured: proximal, shaft, distal
- Type of fracture: torus, Colles', non-displaced
- Which side is affected: left or right
- Episode of care: initial or follow-up visit

So, for a patient who is being seen right after injuring his right forearm and I found to have a radius buckle fracture, the physician documentation should sufficient to support the diagnosis code S52.521A, torus fracture of right distal radius, initial encounter. Documentation of how the child was injured would support the addition of W09.2xxA, Fall on or from jungle gym.

I-10 codes related to poisonings, adverse drug effects, underdosing, and exposure to toxic substances are subdivided by intent. The physician should document whether the event was:

- Accidental
- Intentional self-harm
- An assault
- Of undetermined cause
- An adverse effect of a medication
- Due to underdosing of a prescribed medication (new to I-10).

I-9 used codes 960-979 to describe "poisoning by drugs, medicinal and biological substances." A separate E-code was required to report whether the poisoning occurred accidentally, as a complication of therapeutic use, was intentionally self-inflicted, the consequence of an assault or caused an adverse effect. The corresponding section in I-10 (T36-T50) includes unique combination codes for each of these situations. There is also a code for adverse effects due to underdosing. In documenting encounters involving poisoning, adverse drug effects, or underdosing, the physician should document the specific

adverse effect(s), the name of the substance(s), and whether the encounter is due to accidental administration, therapeutic administration, intentional overdose, or the consequence of an assault.

In the case of a patient who presents with a hypertensive encephalopathy because he has been trying to "stretch out" his ACE-inhibitor high-blood pressure medication because he can't afford the prescription, the physician's documentation should support the coding of:

- I67.4, Hypertension encephalopathy
- I10, Essential (primary) hypertension
- T46.4X6A, Underdosing of angiotensin-converting-enzyme inhibitors
- Z91.120, Patient's intentional underdosing of medication regimen due to financial hardship

The description of external causes is greatly expanded. As in I-9, these causes of morbidity are reported as contributing (secondary) diagnoses The greater level of specificity in these codes means that even the smallest details describing the context of an injury can be used in code selection, e.g. fall from baby stroller (V00.821) vs. fall from motorized mobility scooter (V00.831)

While similar to the information already extracted from the medical record with I-9, coders will be looking in the physician's documentation for details when reporting accidents and injuries regarding place and activity such as the following:

- The size and type of all vehicles, conveyance involved (animal-drawn, pedal cycle, motorcycle, 3-wheeled or 4-wheeled, car, van, pickup, bus, heavy transport, military, railway vehicle, railway train, watercraft, aircraft, special purpose vehicle, ski left, etc.).
- Collisions with fixed or moving objects
- Location of the patient was driver, passenger, pedestrian, in a structure stuck by an object, etc.
- Whether the accident was a traffic or non-traffic accident
- Whether the accident occurred during boarding or alighting from a vehicle
- Activity at time of the injury
- For falls, height, activity, mechanism, any stationary or moving objects struck
- For injuries by objects, the activity and type of object, described in as much detail as is practical

The documentation should also clearly differentiate between acute traumatic vs. old or chronic injuries. When determining the appropriate diagnosis code the physician will need to make sure enough information is documented to support the code selection. For example, in a child who has a radius fracture from a fall from a jungle gym, the physician needs to be clear as to

what part of the radius is fractured: proximal, shaft, distal.

- Type of fracture: torus, Colles', non-displaced
- Which side is affected: left or right
- Episode of care: initial or follow-up visit

So, for a patient who is being seen right after injuring his right forearm and I found to have a radius buckle fracture, the physician documentation should sufficient to support the diagnosis code S52.521A, torus fracture of right distal radius, initial encounter. Documentation of how the child was injured would support the addition of W09.2xxA, Fall on or from jungle gym.

Coma

ICD-10-CM codes R40.21 – R40.24 allow reporting of all three components of the Glasgow coma score (GCS). A 7th digit is required based on the time the score was obtained.

- 0 - unspecified time
- 1 - in the field [EMT or ambulance]
- 2 - at arrival to emergency department
- 3 - at hospital admission
- 4 - 24 hours or more after hospital admission

In the case where EMS had determined the GCS was 8 (without specifics) while they had the patient but the physician determined the GCS was 13 (E3, V4, M6) on arrival to the ED, then the documentation would support the coding of R40.2431 (GCS 3-8 determined in the field) and R40.2132 (eyes open to sound), R40.2242 (confused speech) and R40.2362 (obeys commands) all on arrival to ED.

Summary

ICD-10-CM will bring about many changes to the way information is gathered from the medical record. The physician will be helping the coder, the hospital and themselves with clear, detailed documentation. Use of unspecified codes when more specific code may be available, e.g. laterality, distal vs. proximal, may bring unwelcomed delays in reimbursement from third party payors. A descriptive history of the present illness and attention to exam detail along with a concise summary/review of the encounter for more complex patents may help alleviate some of these issues.

Working early with your physicians, coders, electronic health record vendors and hospital will make the transition easier in the long run.