ICD-10 IS COMING

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WHAT IS THE IMPACT ON THERAPY PRACTICES?

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Overview

- Understanding the language of clinical diagnosis
- What is ICD ?
- About ICD-9 CM
- Good Clinical documentation
- Regulatory Impact
- Clinical documentation changes
- Introduction to ICD-10 CM
- Examples

International Classification of Diseases

- What is the International Classification of Diseases?
- How did ICD come about?
- Who is responsible for updating ICD?
- WORLD HEALTH ORGANIZATION (WHO)

Good documentation means …

- Accurate and timely charting
- Key components of medical record s
- Evaluation and Re-evaluation
- Plan of Care
- Treatment and Periodic Assessment
- Status updates
- Objective and measurable goals
- Progress and desired Clinical Outcomes

Beginning of ICD Classification

- François Bossier de Lacroix (1706-1777)
- William Farr (1807-1883) - first medical statistician - classifications and international uniformity of preventable diseases
- Jacques Bertillon (1851-1922) – List of Cause of Death

ICD – Current Version

- We are in ICD- Ninth Version today
- There are approx. 16,500 diagnosis codes
- ICD-9 is set-up as an index
- ICD-9 has 3, 4, 5 digit codes for each disease

Regulatory Impact

- Coverage of therapy services
- Payment for therapy services
- Documentation requirements
- Collection of accurate data
- Submission of accurate data through claims
- Reporting of quality indicators
- Outcomes Measurement

Coverage of Therapy Services

- ACTIVE PARTICIPATION of the clinician in treatment means that the clinician personally furnishes in its entirety at least 1 billable service on at least 1 day of treatment.

Assessment of Status

- ASSESSMENT is separate from evaluation, and is included in services or procedures, (it is not separately payable).
- The term assessment as used in Medicare manuals related to therapy services is distinguished from language in Current Procedural Terminology (CPT) codes that specify assessment, e.g., 97755, Assistive Technology Assessment, which may be payable).

Assessment is not a Re-evaluation

- Assessments shall be provided only by clinicians, because assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s).
- Assessment determines, e.g., changes in the patient's status since the last visit/treatment day and whether the planned procedure or service should be modified.

Plan of Care and Certification

- CERTIFICATION is the physician's/non-physician practitioner's (NPP) approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care.
- Note: State rules may vary – check Scope of Practice.

Complications and Co-morbidities

- COMPLEXITIES are complicating factors that may influence treatment, e.g., they may influence the type, frequency, intensity and/or duration of treatment. Complexities may be represented by diagnoses (ICD-9 codes), by patient factors such as age, severity, acuity, multiple conditions, and motivation, or by the patient's social circumstances such as the support of a significant other or the availability of transportation to therapy.

Initial Evaluation

- EVALUATION is a separately payable comprehensive service provided by a clinician, as defined above, that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting.

Medical vs. Treatment Diagnosis

- A diagnosis (where allowed by state and local law) and description of the specific problem(s) to be evaluated and/or treated. The diagnosis should be specific and as relevant to the problem to be treated as possible.

- In many cases, both a medical diagnosis (obtained from a physician/NPP) and an impairment based treatment diagnosis related to treatment are relevant.

- The **treatment diagnosis may or may not be identified by the therapist**, depending on their scope of practice. **Where a diagnosis is not allowed, use a condition description similar to the appropriate ICD-9 code.**
- For example the medical diagnosis made by the physician is CVA; however, the treatment diagnosis or condition description for PT may be abnormality of gait, for OT, it may be hemiparesis, and for SLP, it may be dysphagia.
- For PT and OT, be sure to include the body part evaluated. Include all conditions and complexities that may impact the treatment. A description might include, for example, the premorbid function, date of onset, and current function;

Re-evaluation

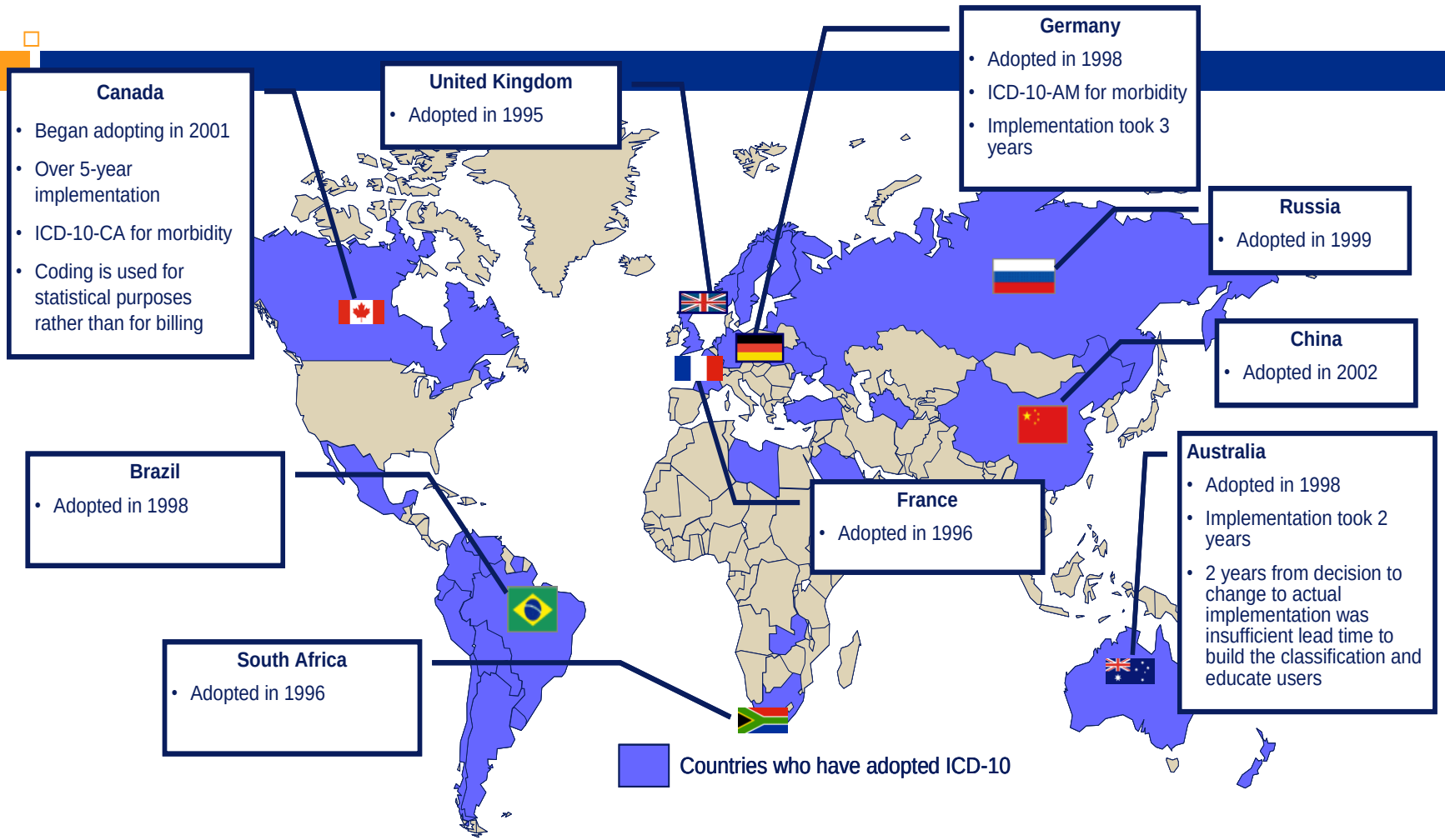
- RE-EVALUATION provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care.

Establishing a Plan of Care

- The plan, (also known as a plan of care or plan of treatment) must be established before treatment is begun. The plan is established when it is developed (e.g., written or dictated).
- The signature and professional identity (e.g., MD, OTR/L) of the person who established the plan, and the date it was established must be recorded with the plan.
- Establishing the plan, is not the same as certifying the plan.

Understanding ICD-10 CM

ICD-10 Around the World



The United States is the only country in the industrialized world still using older ICD-9 codes for administration and health care delivery

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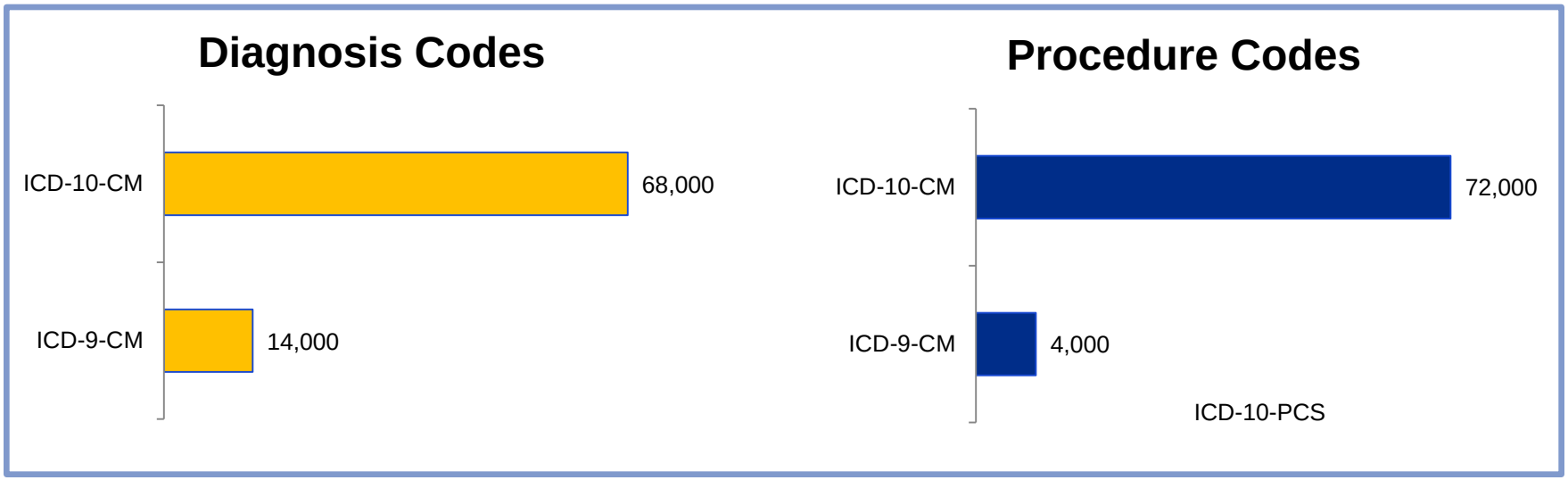
SOURCE: http://www.who.int/classifications/icd/en/

From 18,000 codes to over 140,000 codes

ICD-10 Changes



Change to procedure codes is for inpatient only. Outpatient CPT codes are not impacted by ICD-10.

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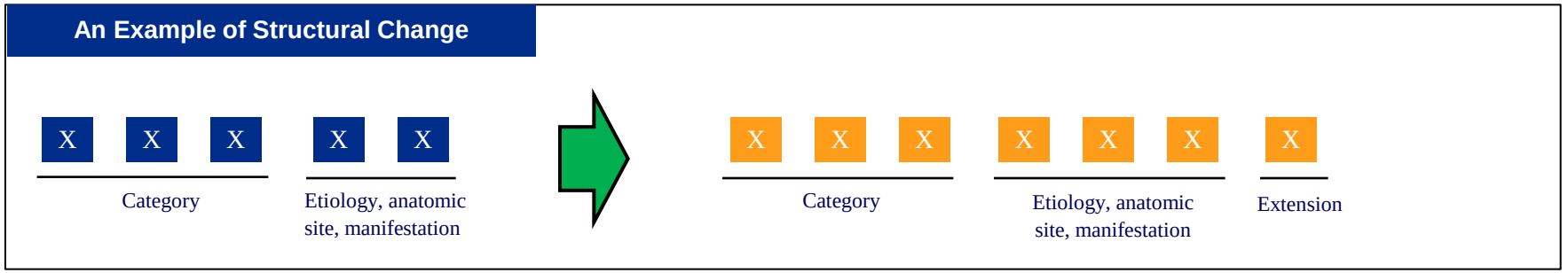
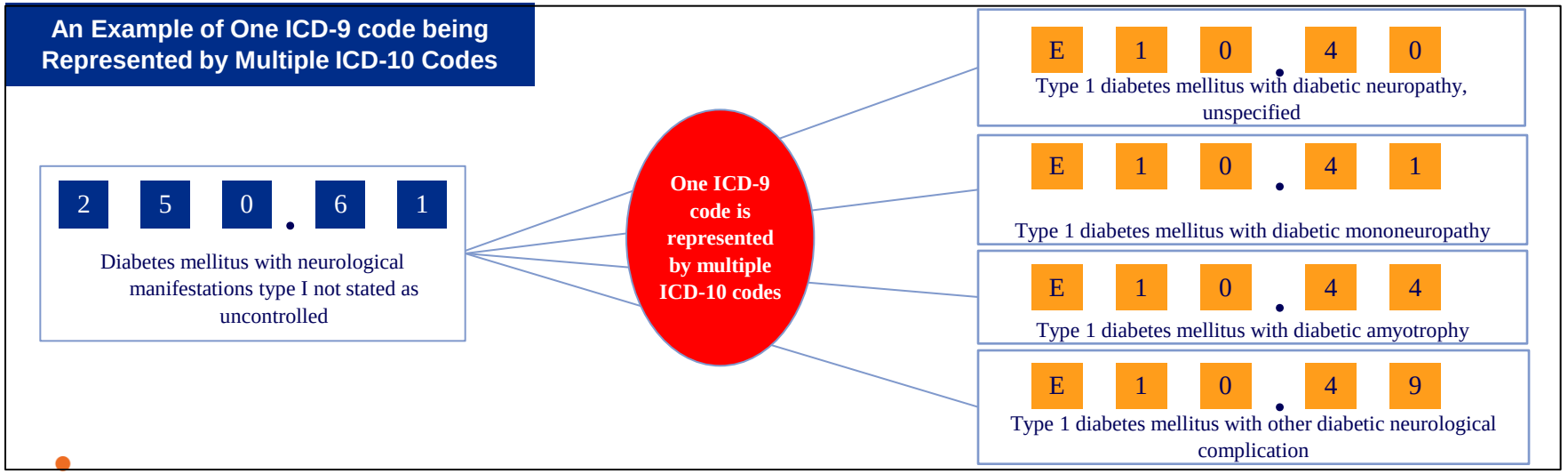
The Basics of the ICD-10 Change





Mapping ICD-9 and ICD-10 codes will be a complex task

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Guidelines under ICD-10 CM

Clinical Documentation Changes under ICD-10

- Combination codes for conditions and manifestations e.g. Type I Diabetes Mellitus with Diabetic Nephropathy
- Laterality – Right vs. Left; Dominant vs. Non-dominant
- Episode of Care – Initial vs. Subsequent
- Change in timeframes for certain diagnosis i.e. Myocardial Infarction

Important Note – Guidelines

- **ICD-10 CM does not provide a separate diagnosis code** for PT/OT/ST.
- **Do not assign "aftercare codes" for aftercare post injuries.** Use guidelines for selection of encounter type i.e. Initial vs. Subsequent Encounter
- **Do not assign a status code with a diagnosis code** if the diagnosis code is specific and includes patient status e.g. Z94.1 - Heart Transplant Status and T86.2 – Complications of Heart Transplant.

Guidelines continued …

- **Documenting treatment of ongoing chronic conditions** i.e. Diabetes Mellitus and the use of insulin.
- If your patient is using insulin (independently or being administered) the medical record must document the same. This is even more important if you are treating a patient s/p surgery or for wound care as this demonstrates existing conditions that may delay the progress or justify additional visits due to medical necessity.

Guidelines continued …

- **Sequelae of Cerebrovascular Disease** (Category I69).
- **"Late effects" include neurological deficits that persist after initial onset of conditions** i.e. "loss of movement", "loss of balance and equilibrium" etc ..
- Document clearly if the neurologic deficits caused by the cerebrovascular disease were present from the onset or were identified at anytime after the onset of the primary neurological condition.

Guidelines continued …

- Use the correct 'Extension' character for complications and conditions that arise as a direct result of an injury i.e. Scar formation after a burn.
- Document the injury and sequela. The primary reason for the therapy treatment is not the burn it is the scar.
- Therapy documentation must indicate that the reason for the treatment is "Scar due to Burn (and describe the burn and the scar).

More guidelines …

- **External cause status** – when evaluating your patient and documenting the history make note of the external cause status of the injury i.e. indicate whether the event occurred during military activity, whether a non-military person was at work, whether and individual including a student or volunteer was involved in a non-work activity at the time of the event.

Guidelines continued …

- **A fracture not clearly identified as "open" or "closed" will be coded to "closed".**
- How will this impact your revenue?
- **Describe the type of injury and condition at the time of occurrence as this will demonstrate the need for level of care** e.g. 65 year old male was referred/ admitted for OT services following hospitalization for Type 1 Open Traumatic Fracture of the left radius and ulna.

More documentation clarity for ICD-10…

- Orthopedic cases will need additional documentation clarity from physicians …
- Type and Classification of Fracture
  - Salter-Harris
  - Gustilo Classification for Open Fractures e.g.
    - Type I – Low energy, wound less than 1 cm
    - Type II – Wound greater than 1 cm with moderate soft tissue damage
    - Etc.

Examples

ICD-9 Code	Description	ICD-10 CM Codes	
724.2	LUMBAGO	M54.5	LOW BACK PAIN
723.1	CERVICALGIA	M54.2	CERVICALGIA
719.46	JOINT PAIN-LOWER LEG	M25.561	PAIN IN RIGHT KNEE
		M25.562	PAIN IN LEFT KNEE
		M25.569	PAIN IN UNSPECIFIED KNEE
719.41	JOINT PAIN-SHOULDER REGION	M25.511	PAIN IN RIGHT SHOULDER
		M25.512	PAIN IN LEFT KNEE
		M25.519	PAIN IN UNSPECIFIED KNEE

ICD-9 Code	Description	ICD-10 CM Codes	
813.42	OTHER CLOSED FX DISTAL END OF RADIUS NEC	S52.501A	UNSPECIFIED FRACTURE OF THE LOWER END OF THE RIGHT RADIUS
		S52.502A	UNSPECIFIED FRACTURE OF THE LOWER END OF THE LEFT RADIUS
		S52.509A	UNSPECIFIED FRACTURE OF THE LOWER END OF THE UNSPECIFIED RADIUS
		S52.511A	DISPLACED FRACTURE OF RIGHT RADIAL STYLOID PROCESS
		S52.512A	DISPLACED FRACTURE OF LEFT RADIAL STYLOID PROCESS
		S52.513A	DISPLACED FRACTURE OF UNSPECIFIED RADIAL STYLOID PROCESS
		S52.514A	NONDISPLACED FRACTURE OF RIGHT RADIAL STYLOID PROCESS
		S52.515A	NONDISPLACED FRACTURE OF LEFT RADIAL STYLOID PROCESS
		S52.516A	NONDISPLACED FRACTURE OF UNSPECIFIED RADIAL STYLOID PROCESS
		S52.521A	TORUS FRACTURE OF LOWER END OF RIGHT RADIUS
		S52.522A	TORUS FRACTURE OF LOWER END OF LEFT RADIUS
		S52.529A	TORUS FRACTURE OF LOWER END OF UNSPECIFIED RADIUS
		S52.531A	COLLES' FRACTURE OF RIGHT RADIUS
		S52.531A	COLLES' FRACTURE OF LEFT RADIUS
		S52.531A	COLLES' FRACTURE OF UNSPECIFIED RADIUS
		S52.541A	SMITH'S FRACTURE OF RIGHT RADIUS
		S52.542A	SMITH'S FRACTURE OF LEFT RADIUS
		S52.549A	SMITH'S FRACTURE OF UNSPECIFIED RADIUS
		S52.551A	OTHER EXTRA-ARTICULAR FRACTURE OF LOWER END OF RIGHT RADIUS
		S52.552A	OTHER EXTRA-ARTICULAR FRACTURE OF LOWER END OF LEFT RADIUS
		S52.559A	OTHER EXTRA-ARTICULAR FRACTURE OF LOWER END OF UNSPECIFIED RADIUS
		S52.561A	BARTON'S FRACTURE OF RIGHT RADIUS
		S52.562A	BARTON'S FRACTURE OF LEFT RADIUS
		S52.569A	BARTON'S FRACTURE OF UNSPECIFIED RADIUS
		S52.571A	OTHER INTRAARTICULAR FRACTURE OF LOWER END OF RIGHT RADIUS
		S52.572A	OTHER INTRAARTICULAR FRACTURE OF LOWER END OF LEFT RADIUS
		S52.579A	OTHER INTRAARTICULAR FRACTURE OF LOWER END OF UNSPECIFIED RADIUS
		S52.591A	OTHER FRACTURES OF LOWER END OF RIGHT RADIUS
		S52.592A	OTHER FRACTURES OF LOWER END OF LEFT RADIUS
		S52.599A	OTHER FRACTURES OF LOWER END OF UNSPECIFIED RADIUS

ICD-9 Code	Description	ICD-10 CM Codes	
729.5	PAIN IN LIMB	M79.601	PAIN IN RIGHT ARM
		M79.602	PAIN IN LEFT ARM
		M79.603	PAIN IN ARM, UNSPECIFIED
		M79.604	PAIN IN RIGHT LEG
		M79.605	PAIN IN LEFT LEG
		M79.606	PAIN IN LEG, UNSPECIFIED
		M79.607	PAIN IN UNSPECIFIED LIMB
		M79.621	PAIN IN RIGHT UPPER ARM
		M79.622	PAIN IN LEFT UPPER ARM
		M79.629	PAIN IN UNSPECIFIED UPPER ARM
		M79.631	PAIN IN RIGHT FOREARM
		M79.632	PAIN IN LEFT FOREARM
		M79.639	PAIN IN UNSPECIFIED FOREARM
		M79.641	PAIN IN RIGHT HAND
		M79.642	PAIN IN LEFT HAND
		M79.643	PAIN IN UNSPECIFIED HAND
		M79.644	PAIN IN RIGHT FINGERS
		M79.645	PAIN IN LEFT FINGERS
		M79.646	PAIN IN UNSPECIFIED FINGERS
		M79.651	PAIN IN RIGHT THIGH
		M79.652	PAIN IN LEFT THIGH
		M79.659	PAIN IN UNSPECIFIED THIGH
		M79.661	PAIN IN RIGHT LOWER LEG
		M79.662	PAIN IN LEFT LOWER LEG
		M79.663	PAIN IN UNSPECIFIED LOWER LEG
		M79.669	PAIN IN RIGHT LOWER LEG
		M79.671	PAIN IN RIGHT FOOT
		M79.672	PAIN IN LEFT FOOT
		M79.673	PAIN IN UNSPECIFIED FOOT
		M79.674	PAIN IN RIGHT TOES
		M79.675	PAIN IN LEFT TOES
		M79.676	PAIN IN UNSPECIFIED TOES

Yeah! There is a code for that …

- ICD-10 Code X38.xxxA
- Guess that code?
- ICD-10 Code Z72.820
- ICD-10 Code W55.42

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