2012 ICD-10-CM
Session I:
Introduction to ICD-10-CM

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Your Presenters Today

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Course Objectives:
Review Your Understanding of:

- The Format, Code Structure and Coding Conventions of ICD-10-CM
- The Requirements of the Uniform Hospital Discharge Data Set
- The Requirements of the 2012 Version 5010 and HIPAA Requirements
- Identify Ethical Coding and Reporting Standards
- The Official Coding Guidelines for the ICD-10-CM and the Assignment of POA Indicators
- The ICD-10-CM General Equivalence Mappings (GEMs)

Review Your Understanding the History of ICD-10-CM
What are ICD-10-CM and ICD-10-PCS?

• The *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM) and the *International Classification of Diseases, Tenth Revision, Procedure Coding System* (ICD-10-PCS) were developed as a replacement for ICD-9-CM.

• ICD-10-CM consists of diagnosis codes:
  – Clinical modification of the World Health Organization’s (WHO) ICD-10.

• ICD-10-PCS consists of procedure codes:
  – Classification of operations and procedures developed for use in the United States; not a part of the WHO classification.

Review Your Understanding of the Rationale for Change from ICD-9-CM to ICD-10-CM
Rationale for Change

- ICD-9-CM has been in use in the United States since 1979.
- Many improvements in medical practice and technology have taken place since ICD-9-CM was first implemented.
- ICD-9-CM is limited in its ability to expand enumeration because of physical numbering constraints.
- Some categories have vague and imprecise codes.

Rationale for Change cont.

- Lack of specificity creates problems, such as:
  - Inability to collect accurate data on new technology.
  - Increased requirements for submission of documentation to support claims.
  - Lack of quality data to support health outcomes.
  - Less accurate reimbursement.
- Many of the ICD-9-CM categories have become full, making it difficult to create new codes.
  - Once a category is full, several types of similar diagnoses or procedures are combined under one code, or a place is found in another section of the classification for a new code.
Rationale for Change cont.

• Due to a lack of space in the classification, several distinct procedures performed in different parts of the body with widely different resource utilization may be grouped together under the same procedure code.
• The structural integrity of the ICD-9-CM procedure classification has already been compromised:
  • New code numbers have been assigned to “chapter 00” and “chapter 17” when new numbers were not available within the appropriate body system chapter.

ICD-10-CM Improvements and Major Modifications

• Significant improvements in coding primary care encounters, external causes of injury, mental disorders, neoplasms, and preventive health
• Advances in medicine and medical technology that have occurred since the last revision
• Codes with more detail on socioeconomic conditions, family relationships, ambulatory care conditions, problems related to lifestyle, and the results of screening tests
• More space to accommodate future expansions (alphanumeric structure)
• New categories for post-procedural disorders
ICD-10-CM Improvements and Major Modifications

- The addition of laterality – specifying which organ or part of the body is involved when the location could be on the right, the left, or bilateral
- Expanded distinctions for ambulatory and managed care encounters
- Expansion of diabetes and injury codes
- Creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition
- Greater specificity in code assignment
- Inclusion of trimester information in pregnancy codes

Review Your Understanding of the ICD-10-CM Compliance Date
Compliance Date

- HHS adopting ICD-10-CM and ICD-10-PCS as medical data code sets under HIPAA:
  - Replacing volumes 1 and 2 for reporting diagnoses.
  - Replacing volume 3 for reporting procedures.
  - Replacing the official coding guidelines.
- ICD-10-PCS codes are not used in outpatient transactions, or by physicians:
  - ICD-10-PCS codes are used only by hospitals for inpatient procedures.
- Full compliance was initially required for claims received for encounters and discharges on or after October 1, 2013 (FY 2014).

Compliance Date (cont.)

- Compliance date is based on the date of discharge for inpatient claims, and the date of service for outpatient claims.
  - Consistent with the practice for inpatient facilities to use the version of ICD codes in effect at the date of discharge.
  - ICD-10-CM/PCS codes may not be reported before the compliance date.
Compliance Date (cont.)

• ICD-10 Implementation Schedule Pending Final Rule
  – Previously HHS had mandated October 1, 2013 as the single compliance date where all covered entities must begin using the ICD-10 code set.
  – On April 17, 2012, HHS published a rule proposing postponement of the ICD-10-CM/PCS for one year to take place then October 1, 2014. (provisional date)

Compliance Date (cont.)

  – On May 17, 2012, the comment period for interested parties to express and detail their particular position for or against the delay ended.
  – We are now in limbo for what the final rule will be, and although there is no set standard for the timeline in the rule-making process, the final decision currently was scheduled to be announced on June 30, 2012.
  – The announcement is still pending as of this date.
Compliance Date (cont.)

- Proposed a one year delay in ICD-10-CM is to the implementation date and not to the code set.
- The HIM community to move forward, to:
  - Take a leadership role in educating colleagues about the benefits of ICD-10,
  - Use any time gained from a deadline extension to ensure a smooth transition and fine tune your preparations
  - Keep moving forward… lead the way…
  - Watch on AHIMA's YouTube channel, AHIMA on Demand.

ICD-10 timeline

Effective dates

- **2012** Version 5010 electronic billing process and format compliance on Jan. 1, 2012 (except for small health plans: Jan. 1, 2013); CMS enforcement discretion is in place until June 30, 2012
- **2013** ICD-10-CM/PCS compliance effective Oct. 1, 2013, for all HIPAA-covered entities
Review Your Understanding of the ICD-10-CM Coding and Reporting Guidelines

Coders Must Understand and Follow

- The basic principles behind the classification system in order to use ICD-10-CM and ICD-10-PCS appropriately and effectively.
- This knowledge is also the basis for understanding and applying the official coding advice provided through the AHA Coding Clinic®, published by the Central Office of the American Hospital Association.
  - Note: There are plans to publish ICD-10 coding advice in Coding Clinic for ICD-9-CM starting with Fourth Quarter 2012, and Coding Clinic for ICD-10-CM and ICD-10-PCS in 2013.
Coders Must Understand and Follow

- *Official Guidelines for Coding and Reporting*
- Developed through the editorial board for the *Coding Clinic* and approved by the four cooperating parties:
  - American Hospital Association,
  - American Health Information Management Association,
  - Centers for Medicare & Medicaid Services (CMS), and
  - National Center for Health Statistics (NCHS).

ICD-10-CM Official Guidelines for Coding and Reporting

- The term encounter is used for all settings, including hospital admissions.
- In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis.
- Only this set of guidelines, approved by the Cooperating Parties, is official.

• The guidelines are organized into sections.
  – Section I includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification.


• The guidelines are organized into sections.
  – Section II includes guidelines for selection of principal diagnosis for non-outpatient settings.
  – Section III includes guidelines for reporting additional diagnoses in non-outpatient settings.

- Section IV is for outpatient coding and reporting. It is necessary to review all sections of the guidelines to fully understand all of the rules and instructions needed to code properly.

Review Your Understanding of Section I. Conventions, general coding guidelines and chapter specific guidelines
ICD-9-CM Vol. 1 & 2 & ICD-10-CM Comparison

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 characters in length</td>
<td>3-7 characters in length</td>
</tr>
<tr>
<td>Approximately 13,000 codes</td>
<td>Approximately 68,000 available codes</td>
</tr>
<tr>
<td>First digit may be alpha (E or V) or numeric; Digits 2-5 are numeric</td>
<td>First digit is alpha; Digits 2-3 are numeric; Digits 4-7 are alpha or numeric</td>
</tr>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
<tr>
<td>Example: 453.41 Venous embolism and thrombosis of deep vessels of proximal lower extremity</td>
<td>Example: I82.411 Embolism and thrombosis of right femoral vein</td>
</tr>
</tbody>
</table>

Differences in the ICD-10-CM Code Structure

• All ICD-10-CM codes have an alphanumeric structure with all codes starting with an alphabetic character except the letter “U.”
• The basic code structure consists of three characters.
• A decimal point is used to separate the basic three-character category code from its subcategory and subclassifications.
• For example, L98.491.
Differences in the ICD-10-CM Code Structure

• Most ICD-10-CM codes contain a maximum of six characters, with a few categories having a seventh-character code extension.
• Each chapter in the main classification is structured to provide the following subdivisions:
  – Sections (groups of three-character categories), e.g., Infections of the skin and subcutaneous tissue (L00-L08)

Official Guidelines for Coding and Reporting

Current ICD-9-CM Guidelines

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in Volumes I, II, and III of ICD-9-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Volumes 1-2) have been adopted under HIPAA for all healthcare settings. Volume 3 procedure codes have been adopted for inpatient procedures reported by hospitals. A joint effort between the healthcare provider and the coder is essential to achieve accuracy.
ICD-10-CM Section I.

• Conventions, general coding guidelines and chapter specific guidelines
  – The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated.
  – The conventions and instructions of the classification take precedence over guidelines.

Current ICD-10-CM Guidelines

These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. The instructions and conventions of the classification take precedence over guidelines. These guidelines are based on the coding and sequencing instructions in the Tabular List and Alphabetic Index of ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings. A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code
ICD-10-CM Section I.A.

• A. Conventions for the ICD-10-CM
  – The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines.
  – These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-10-CM as instructional notes.

ICD-10-CM Section I.A.1.

• 1. The Alphabetic Index and Tabular List
  – The ICD-10-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a chronological list of codes divided into chapters based on body system or condition. Continued…
ICD-10-CM Section I.A.1.

• 1. The Alphabetic Index and Tabular List Continued…
  – The Alphabetic Index consists of the following parts:
    • the Index of Diseases and Injury,
    • the Index of External Causes of Injury,
    • the Table of Neoplasms and
    • the Table of Drugs and Chemicals.
      – See Section I.C2. General guidelines
      – See Section I.C.19. Adverse effects, poisoning, underdosing and toxic effects

ICD-10-CM Section I.A.2.

• 2. Format and Structure:
  – The ICD-10-CM Tabular List contains categories, subcategories and codes.
    Characters for categories, subcategories and codes may be either a letter or a number.
  – All categories are 3 characters.
  – A three-character category that has no further subdivision is equivalent to a code. Continued…
ICD-10-CM Section I.A.2.

• 2. Format and Structure: *Continued*…
  – Subcategories are either 4 or 5 characters.
  – Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.
  – The ICD-10-CM uses an indented format for ease in reference.

Review Your Understanding of ICD-10-CM Code Structure

For example:

• K29 Gastritis and duodenitis *(category)*
  K29.0 Acute gastritis *(subcategory)*
  K29.00 Acute gastritis without bleeding *(code)*

• R10 Abdominal and pelvic pain *(category)*
  R10.8 Other abdominal pain *(subcategory)*
  R10.81 Abdominal tenderness *(subcategory)*
  R10.811 Right upper quadrant *(code)*
  abdominal tenderness
Changes – Classifications
ICD-9-CM Structured Format

Numerics or Alpha (E or V) Numerics

8 0 5 0 0

Category Etiology, anatomic site, manifestation

3 – 5 Characters

ICD-10-CM Format

Category Etiology, anatomic site, severity

Extension
Review Your Understanding of ICD-10-CM Code Structure

- Subdivisions continued:
  - Categories (three-character code numbers)
    e.g., L02, Cutaneous abscess, furuncle and carbuncle
  - Subcategories (four-character code numbers),
    e.g., L02.2, Cutaneous abscess, furuncle and carbuncle of trunk
  - Fifth-, sixth-, or seventh-character subclassifications (five-, six-, or seven-character code numbers), e.g., L02.211,
    Cutaneous abscess of abdominal wall

Changes – Classifications ICD-10-CM Structured Format
ICD-10-CM Section I.A.3.

• 3. Use of codes for reporting purposes
  – For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required.

ICD-10-CM Section I.A.4.

• 4. Placeholder character
  – The ICD-10-CM utilizes a placeholder character “X”. The “X” is used as a placeholder at certain codes to allow for future expansion. An example of this is at the poisoning, adverse effect and underdosing codes, categories T36-T50.
  – Where a placeholder exists, the “X” must be used in order for the code to be considered a valid code.
ICD-10-CM Section I.A.4.

- 4. Placeholder character  *Continued…*
  - For Example, the use of the placeholder character “x” and the seventh-character extension is shown:
    - T16 Foreign body in ear
      Includes: foreign body in auditory canal
      The following seventh-character extensions are to be added to each code from category T16:
      - A initial encounter
      - D subsequent encounter
      - S sequela
      - T16.1 Foreign body in right ear
      - T16.2 Foreign body in left ear
      - T16.9 Foreign body in ear, unspecified ear

ICD-10-CM Section I.A.5.

- 5. 7th Characters
  - Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.
Coding and Use of 7th Character

• Obstetrics
• Injury
• External cause

Injury and External Cause - Identifies Injury

- Initial – Receiving active treatment
- Subsequent – Receiving routine care during healing or recovery (after active treatment)
- Sequela – Complications or conditions arising as result of a condition

• Either alpha or numeric
• Placeholder X
• Meanings vary

Coding and Use of 7th Character

Aftercare Z codes are not used for aftercare for injuries

Combination codes for poisonings and external cause (accidental, intentional self-harm, assault, undetermined)

Chapter 15 – represents fetus in multiple gestation affected by condition being coded
ICD-10-CM Section I.A.6.a.

• 6. Abbreviations
  – a. Alphabetic Index abbreviations
  • NEC “Not elsewhere classifiable”
    – This abbreviation in the Alphabetic Index represents “other specified”. When a specific code is not available for a condition, the Alphabetic Index directs the coder to the “other specified” code in the Tabular List.
  • NOS “Not otherwise specified”
    – This abbreviation is the equivalent of unspecified.

Continued…

ICD-10-CM Section I.A.6.b.

• 6. Abbreviations Continued…
  – b. Tabular List abbreviations
  • NEC “Not elsewhere classifiable”
    – This abbreviation in the Tabular List represents “other specified”. When a specific code is not available for a condition the Tabular List includes an NEC entry under a code to identify the code as the “other specified” code.
  • NOS “Not otherwise specified”
    – This abbreviation is the equivalent of unspecified.
ICD-10-CM Section I.A.7.

• 7. Punctuation
  – [ ] Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.
  – ( ) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers. Continued…

ICD-10-CM Section I.A.7.

• 7. Punctuation Continued…
  – : Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.
ICD-10-CM Section I.A.8.

• 8. Use of “and”
  – When the term “and” is used in a narrative statement it represents and/or.

ICD-10-CM Section I.A.9.a

• 9. Other and Unspecified codes
  – a. “Other” codes
    • Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designate “other” codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an “other” code.
ICD-10-CM Section I.A.9.b.

• 9. Other and Unspecified codes
  – b. “Unspecified” codes
    • Codes titled “unspec”ified” are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the “other unspecified” code may represent both other and unspecified.

ICD-10-CM Section I.A.10.

• 10. Includes Notes
  – This note appears immediately under a three character code title to further define, or give examples of, the content of the category.
ICD-10-CM Section I.A.11.

• 11. Inclusion terms
  – List of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may be synonyms of the code title, or, in the case of “other specified” codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.

ICD-10-CM Section I.A.12.

• 12. Excludes Notes
  – The ICD-10-CM has two types of excludes notes.
  – Each type of note has a different definition for use but they are all similar in that they indicate that codes excluded from each other are independent of each other.
ICD-10-CM Section I.A.12.a.

- 12. Excludes Notes
  - a. Excludes1
    - A type 1 Excludes note is a pure excludes note. It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

ICD-10-CM Section I.A.12.b.

- 12. Excludes Notes
  - b. Excludes2
    - A type 2 excludes note represents “Not included here”. An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.
ICD-10-CM Section I.A.13.

- 13. Etiology/manifestation convention (“code first”, “use additional code” and “in diseases classified elsewhere” notes)
  - Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. Continued…
ICD-10-CM Section I.A.13.

13. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes). Continued...

- In most cases the manifestation codes will have in the code title, "in diseases classified elsewhere." Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code. "In diseases classified elsewhere" codes are never permitted to be used as first-listed or principal diagnosis codes. They must be used in conjunction with an underlying condition code and they must be listed following the underlying condition. See category F02, Dementia in other diseases classified elsewhere, for an example of this convention. Continued…

ICD-10-CM Section I.A.13.

13. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes). Continued…

- There are manifestation codes that do not have "in diseases classified elsewhere" in the title. For such codes a "use additional code" note will still be present and the rules for sequencing apply.
- In addition to the notes in the Tabular List, these conditions also have a specific Alphabetic Index entry structure. In the Alphabetic Index both conditions are listed together with the etiology code first followed by the manifestation codes in brackets. The code in brackets is always to be sequenced second. Continued…
ICD-10-CM Section I.A.13.

• 13. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes). Continued…
  – An example of the etiology/manifestation convention is dementia in Parkinson’s disease. In the Alphabetic Index, code G20 is listed first, followed by code F02.80 or F02.81 in brackets. Code G20 represents the underlying etiology, Parkinson’s disease, and must be sequenced first, whereas codes F02.80 and F02.81 represent the manifestation of dementia in diseases classified elsewhere, with or without behavioral disturbance. Continued…

ICD-10-CM Section I.A.13.

• 13. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes). Continued…
  – "Code first" and "Use additional code" notes are also used as sequencing rules in the classification for certain codes that are not part of an etiology/ manifestation combination.
ICD-10-CM Section I.A.14.

14. “And”
   - The word “and” should be interpreted to mean either “and” or “or” when it appears in a title.

ICD-10-CM Section I.A.15.

15. “With”
   - The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.
   - The word “with” in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.
ICD-10-CM Section I.A.16.

16. “See” and “See Also”

- The “see” instruction following a main term in the Alphabetic Index indicates that another term should be referenced. It is necessary to go to the main term referenced with the “see” note to locate the correct code. *Continued…*

ICD-10-CM Section I.A.16.

16. “See” and “See Also” *Continued…*

- A “see also” instruction following a main term in the Alphabetic Index instructs that there is another main term that may also be referenced that may provide additional Alphabetic Index entries that may be useful. It is not necessary to follow the “see also” note when the original main term provides the necessary code.
ICD-10-CM Section I.A.17.

• 17. “Code also note”
  – A “code also” note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction.

ICD-10-CM Section I.A.18.

• 18. Default codes
  – A code listed next to a main term in the ICD-10-CM Alphabetic Index is referred to as a default code. The default code represents that condition that is most commonly associated with the main term, or is the unspecified code for the condition. If a condition is documented in a medical record (for example, appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.
Review Your Understanding of I.B. General Coding Guidelines for ICD-10-CM

Section I.B.1. General Coding Guidelines

1. Locating a code in the ICD-10-CM:
   - There are basic principles that all coders must follow.
   - It is important to use both the Alphabetic Index and the Tabular List during the coding process.
     - Follow all instructional notes
     - Even if common codes have been memorized, refer to the Alphabetic Index and Tabular List
Section I.B.2. General Coding Guidelines

• 2. Level of Detail in Coding:
  – Always assign codes to the highest level of detail.
    • All characters must be used
    • None can be omitted or added
  – NEC and NOS codes should be assigned only when appropriate.
  – Combination codes should be used if they are available.
    • Assign multiple codes as needed to fully describe a condition.
    • Avoid coding irrelevant information.

Section I.B.3. General Coding Guidelines

• 3. Code or codes from A00.0 through T88.9, Z00-99.8
  – The appropriate code or codes from A00.0 through T88.9, Z00-Z99.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.
Section I.B.4. General Coding Guidelines

• 4. Signs and symptoms
  – Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all codes for symptoms.

Section I.B.5. General Coding Guidelines

• 5. Conditions that are an integral part of a disease process
  – Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
Section I.B.6. General Coding Guidelines

• 6. Conditions that are not an integral part of a disease process
  – Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

Section I.B.7. General Coding Guidelines

• 7. Multiple coding for a single condition
  – In addition to the etiology/manifestation convention that requires two codes to fully describe a single condition that affects multiple body systems, there are other single conditions that also require more than one code.
  – “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition.
  – The sequencing rule is the same as the etiology/manifestation pair, “use additional code” indicates that a secondary code should be added.
Section I.B.8. General Coding Guidelines

• 8. Acute and Chronic Conditions
  – If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.

Section I.B.9. General Coding Guidelines

• 9. Combination Code
  – A combination code is a single code used to classify:
    • Two diagnoses, or
    • A diagnosis with an associated secondary process (manifestation)
    • A diagnosis with an associated complication
Section I.B.10. General Coding Guidelines

• 10. Sequela (Late Effects)
  – A *sequela* is the residual effect (condition produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a *sequela* code can be used. The residual may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous injury. Coding of *sequela* generally requires two codes sequenced in the following order:
    - The condition or nature of the *sequela* is sequenced first. The *sequela* code is sequenced second.

Section I.B.11. General Coding Guidelines

• 11. Impending or Threatened Condition
  – Code any condition described at the time of discharge as “impending” or “threatened” as follows:
    • If it did occur, code as confirmed diagnosis.
    • If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”
    • If the subterms are listed, assign the given code.
    • If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.
Section I.B.12. General Coding Guidelines

• 12. Reporting Same Diagnosis Code More than Once
  - Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

Section I.B.13. General Coding Guidelines

• 13. Laterality
  - For bilateral sites, the final character of the codes in the ICD-10-CM indicates laterality. An unspecified side code is also provided should the side not be identified in the medical record. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side.
Section I.B.14. General Coding Guidelines

• 14. Documentation for BMI and Pressure Ulcer Stages
  – For the Body Mass Index (BMI) and pressure ulcer stage codes, code assignment may be based on medical record documentation from clinicians who are not the patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis), since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI and nurses often documents the pressure ulcer stages).

Section I.B.15. General Coding Guidelines

• 15. Syndromes
  – Follow the Alphabetic Index guidance when coding syndromes. In the absence of Alphabetic Index guidance, assign codes for the documented manifestations of the syndrome.
Section I.B.16. General Coding Guidelines

• 16. Documentation of Complications of Care
  – Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.

Review Your Understanding of I.C. Chapter Specific Coding Guidelines for ICD-10-CM
Chapter-Specific Coding Guidelines

• Chapter-Specific Coding Guidelines
  – In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification.
  – These will be reviewed and discussed later in the FHA ICD-10-CM series.
  – Please consult your FHA schedule.

Review your Understanding of Section II. Selection of Principal Diagnosis
Section II. Selection of Principal Diagnosis

• The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.” Continued…

Section II. Selection of Principal Diagnosis cont.

• The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner.

• Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc.). Continued…
Section II. Selection of Principal Diagnosis cont.

- In determining principal diagnosis, coding conventions in the ICD-10-CM, the Tabular List and Alphabetic Index take precedence over these official coding guidelines. *(See Section I.A., Conventions for the ICD-10-CM)*
- The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

Section II.A. Selection of Principal Diagnosis cont.

- A. Codes for symptoms, signs, and ill-defined conditions
  - Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established.
Section II.B. Selection of Principal Diagnosis cont.

• B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.
  – When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

Section II.C. Selection of Principal Diagnosis cont.

• C. Two or more diagnoses that equally meet the definition for principal diagnosis
  – In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.
Section II. Selection of Principal Diagnosis cont.

• D. Two or more comparative or contrasting conditions.
  – In those rare instances when two or more contrasting or comparative diagnoses are documented as “either/or” (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

Section II.E & II.F Selection of Principal Diagnosis cont.

• E. A symptom(s) followed by contrasting/comparative diagnoses
  – When a symptom(s) is followed by contrasting/comparative diagnoses, the symptom code is sequenced first. All the contrasting/comparative diagnoses should be coded as additional diagnoses.

• F. Original treatment plan not carried out
  – Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.
Section II.G Selection of Principal Diagnosis cont.

• G. Complications of surgery and other medical care
  – When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

Section II.H Selection of Principal Diagnosis cont.

• H. Uncertain Diagnosis
  – If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out”, or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.
  – Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.
Section II.I.1. Selection of Principal Diagnosis cont.

• I.1. Admission Following Medical Observation
  – When a patient is admitted to an observation unit for a medical condition, which either worsens or does not improve, and is subsequently admitted as an inpatient of the same hospital for this same medical condition, the principal diagnosis would be the medical condition which led to the hospital admission.

Section II.I.2. Selection of Principal Diagnosis cont.

• I.2. Admission Following Post-Operative Observation
  – When a patient is admitted to an observation unit to monitor a condition (or complication) that develops following outpatient surgery, and then is subsequently admitted as an inpatient of the same hospital, hospitals should apply the Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
Section II.J Selection of Principal Diagnosis cont.

• J. Admission from Outpatient Surgery
  – When a patient receives surgery in the hospital's outpatient surgery department and is subsequently admitted for continuing inpatient care at the same hospital, the following guidelines should be followed in selecting the principal diagnosis for the inpatient admission: Continued…

Section II.J Selection of Principal Diagnosis cont.

• J. Admission from Outpatient Surgery continued...
  – If the reason for the inpatient admission is a complication, assign the complication as the principal diagnosis.
  – If no complication, or other condition, is documented as the reason for the inpatient admission, assign the reason for the outpatient surgery as the principal diagnosis.
  – If the reason for the inpatient admission is another condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis.
Review your Understanding of Section III. Reporting Additional Diagnoses

Section III. Reporting Additional Diagnoses

• General Rules for Other (Additional) Diagnoses
  – For reporting purposes the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:
    • clinical evaluation; or
    • therapeutic treatment; or
    • diagnostic procedures; or
    • extended length of hospital stay; or
    • increased nursing care and/or monitoring. Continued…
Section III. Reporting Additional Diagnoses cont.

• General Rules for Other (Additional) Diagnoses
  – The UHDDS item #11-b defines Other Diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.” UHDDS definitions apply to inpatients in acute care, short-term, long term care and psychiatric hospital setting. The UHDDS definitions are used by acute care short-term hospitals to report inpatient data elements in a standardized manner.

Section III. Reporting Additional Diagnoses cont.

• General Rules for Other (Additional) Diagnoses
  – Since that time the application of the UHDDS definitions has been expanded to include all non-outpatient settings (acute care, short term, long term care and psychiatric hospitals; home health agencies; rehab facilities; nursing homes, etc.).
  – The following guidelines are to be applied in designating “other diagnoses” when neither the Alphabetic Index nor the Tabular List in ICD-10-CM provide direction. The listing of the diagnoses in the patient record is the responsibility of the attending provider.
Section III. Reporting Additional Diagnoses cont.

• A. Previous conditions
  – If the provider has included a diagnosis in the final diagnostic statement, such as the discharge summary or the face sheet, it should ordinarily be coded. Some providers include in the diagnostic statement resolved conditions or diagnoses and status-post procedures from previous admission that have no bearing on the current stay. Such conditions are not to be reported and are coded only if required by hospital policy.
  – However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Section III. Reporting Additional Diagnoses cont.

• B. Abnormal findings
  – Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.
  – Please note: This differs from the coding practices in the outpatient setting for coding encounters for diagnostic tests that have been interpreted by a provider.
Section III. Reporting Additional Diagnoses cont.

• C. Uncertain Diagnosis
  – If the diagnosis documented at the time of discharge is qualified as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still to be ruled out” or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.
  – **Note:** This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Review your Understanding of Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services
Diagnostic Coding and Reporting Guidelines for Outpatient Services

- Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services
  - These coding guidelines for outpatient diagnoses have been approved for use by hospitals/providers in coding and reporting hospital-based outpatient services and provider-based office visits. Continued…

Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

- Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services Continued…
  - Information about the use of certain abbreviations, punctuation, symbols, and other conventions used in the ICD-10-CM Tabular List (code numbers and titles), can be found in Section IA of these guidelines, under “Conventions Used in the Tabular List.” Information about the correct sequence to use in finding a code is also described in Section I. Continued…
Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

- Section IV. Diagnostic Coding and Reporting Guidelines for Outpatient Services *Continued*…
  - The terms encounter and visit are often used interchangeably in describing outpatient service contacts and, therefore, appear together in these guidelines without distinguishing one from the other. *Continued*…

- Though the conventions and general guidelines apply to all settings, coding guidelines for outpatient and provider reporting of diagnoses will vary in a number of instances from those for inpatient diagnoses, recognizing that:
  - The Uniform Hospital Discharge Data Set (UHDDS) definition of principal diagnosis applies only to inpatients in acute, short-term, long-term care and psychiatric hospitals.
  - Coding guidelines for inconclusive diagnoses (probable, suspected, rule out, etc.) were developed for inpatient reporting and do not apply to outpatients.
A. Selection of first-listed condition

- In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis.
- In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines. Cont.
• **A1. Outpatient Surgery**
  – When a patient presents for outpatient surgery (same day surgery), code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

• **A.2. Observation Stay**
  – When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.
  – When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.
Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

- B. Codes from A00.0 through T88.9, Z00-Z99
  - The appropriate code(s) from A00.0 through T88.9, Z00-Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

- C. Accurate reporting of ICD-10-CM diagnosis codes
  - For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient’s condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter.
  - There are ICD-10-CM codes to describe all of these.

- D. Codes that describe symptoms and signs
  - Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider.
  - Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (codes R00-R99) contain many, but not all codes for symptoms.
Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

- **E. Encounters for circumstances other than a disease or injury**
  - ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00-Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.
  - See Section I.C.21. Factors influencing health status and contact with health services.

- **F. Level of Detail in Coding**
  - 1. **ICD-10-CM codes with 3, 4, 5, 6 or 7 characters**
    - ICD-10-CM is composed of codes with 3, 4, 5, 6 or 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 fourth, fifth, sixth or seventh characters to provide greater specificity.
Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

- F. Level of Detail in Coding
  - 2. Use of full number of characters required for a code
    - A three-character code 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 for that code, including the 7th character, if applicable.

Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

- G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit
  - List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.
Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

• H. Uncertain diagnosis
  – Do not code diagnoses documented as “probable”, “suspected,” “questionable,” “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
  – Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

• I. Chronic diseases
  – Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)
Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

• J. Code all documented conditions that coexist
  – Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

• K. Patients receiving diagnostic services only
  – For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.
• K. Patients receiving diagnostic services only Continued…
  – For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the Z code and the code describing the reason for the non-routine test.

– For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

– Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.
Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

• L. Patients receiving therapeutic services only
  – For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.
  – The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

• M. Patients receiving preoperative evaluations only
  – For patients receiving preoperative evaluations only, sequence first a code from subcategory Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.
N. Ambulatory surgery

- For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

O. Routine outpatient prenatal visits

- See Section I.C.15. Routine outpatient prenatal visits.

P. Encounters for general medical examinations with abnormal findings

- The subcategories for encounters for general medical examinations, Z00.0-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first-listed diagnosis. A secondary code for the abnormal finding should also be coded.
Diagnostic Coding and Reporting Guidelines for Outpatient Services cont.

• Q. Encounters for routine health screenings
  – See Section I.C.21. Factors influencing health status and contact with health services, Screening

Review Your Understanding of Ethical Coding and Reporting Standards
Ethical Coding and Reporting

• Medicare reimbursement depends on:
  – The correct designation of the principal diagnosis,
  – The presence or absence of additional codes that represent complications, comorbidities, or major complications or comorbidities as defined by the MSDRG system, and
  – Procedures performed.

• Other third-party payers may follow slightly different reimbursement methods, but the accuracy of *ICD-9-CM* coding is always vital.

Ethical Coding and Reporting cont.

• Accurate and ethical *ICD-9-CM* coding
  – Depends on correctly following all instructions in the coding manuals, official guidelines, and *Coding Clinic for ICD-9-CM*.
  – Requires the correct selection of conditions that meet the criteria set by the UHDSS and the official guidelines.

• Over-coding and over-reporting is unethical and may be considered fraudulent.

• Failure to include all diagnoses or procedures that meet reporting criteria may result in financial loss for the health care provider.

• Coders should abide by the AHIMA Standards of Ethical Coding.
Ethical Coding and Reporting *cont.*

- Medicare identifies certain codes as unacceptable as the principal diagnosis.
- Third-party payers may question or deny payment.
- It is important to code correctly, and then make whatever adjustment is required for reporting.
- Otherwise, the coder runs the risk of developing incorrect coding practices that will distort data used for other purposes.
- A facility may collect nonreportable diagnoses or procedures for internal use if the information is maintained outside the external reporting system.

Review Your Understanding of the 2012 Version 5010 and HIPAA Requirements

- The Version 5010 enforcement discretion period ended on June 30, 2012
Overview

• All health plans, providers, and clearinghouses that conduct business electronically are preparing to convert to the next Health Insurance Portability and Accountability Act (HIPAA) standard for electronic transactions—Version 5010.

• HIPAA will require entities conducting electronic claim submissions, claim status requests and responses, referral/authorization requests and responses, eligibility/benefit requests and responses, and claim remittances to use Version 5010.

2012 Version 5010 and HIPAA Requirements

• **Version 5010 is Critical**
  – Make sure to submit claims in Version 5010 to ensure that your claims are not rejected.
  – Software upgrades to Version 5010 are required for your systems to accommodate ICD-10 codes.
  – As of January 1, 2012, everyone covered by HIPAA should have completed the upgrade to Version 5010.
ICD-10-CM Resources & References

- ICD-10-CM Draft Official Guidelines for Coding and Reporting 2012
- 2012 Release of ICD-10-CM Code
  - [http://www.cdc.gov/nchs/icd/icd10cm.htm](http://www.cdc.gov/nchs/icd/icd10cm.htm)
  - Guidelines, Addenda, List of Codes, GEMS
- HHS Announces Intent to Delay ICD-10-CM/PCS Compliance Date
  - Search for the February 16, 2012 press release
ICD-10-CM Resources & References

2012 ICD-10-CM is available at
http://www.cdc.gov/nchs/icd/icd10cm.htm or
http://www.cms.hhs.gov/ICD10

- 2012 ICD-10-CM Index to Diseases and Injuries
- 2012 ICD-10-CM Tabular List of Diseases and Injuries
  - Instructional Notations
- 2012 Official Guidelines for Coding and Reporting
- 2012 Table of Drugs and Chemicals
- 2012 Neoplasm Table
- 2012 Index to External Causes
- 2012 Mapping “ICD-9-CM to ICD-10-CM” and
  “ICD-10-CM to ICD-9-CM”

ICD-10-CM Resources & References

- General ICD-10 Information
  - http://www.cms.gov/ICD10
- General Equivalence
  Mappings and User’s Guides
ICD-10-CM Resources & References

ICD-10-CM: The Complete Official Draft Code Set 2012 (by OptumInsight, formerly Ingenix)
- Introduction
- ICD-10-CM Draft Conventions
- ICD-10-CM Official Guidelines for Coding and Reporting (Draft 2012)
- ICD-10-CM Index to Diseases and Injuries
- ICD-10-CM Neoplasm Table
- Table of Drugs and Chemicals
- ICD-10-CM Index to External Causes
- ICD-10-CM Tabular List of Diseases and Injuries

ICD-10-CM Resources & References

- 2013 Release of ICD-10-CM
  - The National Center for Health Statistics has posted some of the 2013 ICD-10-CM files, including the ICD-10-CM Addenda and the 2013 version of ICD-10-CM in PDF and XML format.
  - Watch for further updates as additional 2013 ICD-10-CM files are posted, including mapping files and the updated ICD-10-CM coding guidelines.
  - Click here to access the 2013 ICD-10-CM files: http://www.cdc.gov/nchs/icd/icd10cm.htm#10update
Audience Questions

August 24, 2012