

ICD-10-CM

For the Busy Emergency Physician

1.0 Introduction

ICD-10-CM is here and it will change the way you document your ED encounter. ICD-10-CM is the code set that assigns diagnoses codes to your medical record. Many countries have been using a version of ICD-10 since the mid-1990s. In the United States, everyone must switch to ICD-10-CM for encounters on or after October 1, 2015.

This ICD-10-CM manual was created by ED physicians for ED physicians to help provide an easy to read, clinically based reference. Whether you are using an EMR, paper, or dictation to record your patient encounter, you will be expected to have a basic understanding of ICD-10-CM documentation principles.

2.0 What is ICD-10-CM?

ICD-10-CM stands for the International Classification of Diseases, 10th version, [US] Clinical Modification. ICD-10-PCS stands for International Classification of Diseases Procedural Coding System.

ICD-10-CM replaces ICD-9-CM which has been used for decades in the United States but has become antiquated due to new diseases and advancements in medicine. ICD-10-CM will expand our current diagnostic code set from about 18,000 to over 69,000 codes and will require the provider to document more details about illnesses and injuries.

3.0 Why Change to ICD-10-CM?

We are running out of ICD-9 codes for new diseases or conditions. With ICD-10-CM, more diseases and new conditions will have a code which will allow us to more effectively track and monitor diseases within the country and on a world-wide basis. CMS has mandated that all claims be reported using ICD-10-CM effective October 1, 2015. The basic diagnosis coding guidance of “code to your highest level of clinical certainty” does not change; however, ICD-10-CM supports a much higher level of specificity.

4.0 What is different?

The outline of your history, physical exam and medical decision making will not need to change. However, if your current narrative within your history doesn't provide significant detail, you will now need to make sure that information is included. For instance, if your patient had a displaced fracture of the left forearm and all that is documented is "forearm fracture" in both the current and new diagnosis coding system this would be coded as "Forearm, Unspecified." The lack of detail may cause payers to question the **medical necessity** of services provided and delay or decrease reimbursement for reported services. Just as now, your documentation should make it clear the precise mechanism (i.e. while playing football) and location of injury (i.e. while at school) and the precise anatomical injury (closed left mid-shaft) non-displaced slightly angulated ulnar and radius fracture). The final diagnosis should provide clear-cut anatomical details of the injury and disease status.

Overall, there isn't really an increased burden in documentation. Most of the ICD-10-CM documentation changes are within the musculoskeletal section and about 36% of the changes involve documentation of laterality. ICD-10-CM does allow documentation of alcohol, tobacco and drug abuse if it is related to the ED visit. In addition ICD-10-CM allows recording of complications related to a diagnosis, psychosomatic pathology, and signs and symptoms. ICD-10-CM provides the opportunity to provide more precise information to help with health and injury surveillance.

Comparison of ICD-9-CM to ICD-10-CM

Location of injury	ICD-9-CM	ICD-10-CM
Skull vault or base	Yes	Yes
Face bones (nasal bone, mandible, maxilla, orbit)	Yes	Yes
Vertebra (cervical, thoracic, lumbar, sacral)	Yes	Yes
Humerus (proximal, anatomical neck, shaft, supracondylar)	Yes	Yes
Forearm (proximal, shaft, distal, torus, radius or ulna only)	Yes	Yes
Carpals (navicular, lunate, trapezium, hamate, cuneiform)	Yes	Yes
Femur (base of neck, intertrochanteric, shaft, condyle)	Yes	Yes

Lower leg (proximal, shaft, distal torus, tibia or fibula only)	Yes	Yes
Ankle (medial or lateral malleolus, bimalleolar, trimalleolar)	Yes	Yes
Foot (calcaneus, talus, navicular, cuneiform, cuboid)	Yes	Yes
Identify open vs. closed	Yes	Yes
Identify open classification (Gustilo)	No	Yes
Identify displaced, non-displaced, transverse, spiral, greenstick	No	Yes
Identify laterality (side)	No	Yes

Mechanism of injury	ICD-9-CM	ICD-10-CM
Injured as driver or passenger in MVC	Yes	Yes
Injured as pedestrian or while riding a motorcycle or bicycle	Yes	Yes
Injured while using a cell phone	No	Yes
Injured while playing football, basketball, baseball or soccer	Yes	Yes
Accident occurred at home, farm, school, public park or building	Yes	Yes
Poisoning due to accident, intention or unknown circumstances	Yes	Yes
Fall on sidewalk, from stairs, ladder, chair, bed or second story	Yes	Yes

5.0 Key ICD-10-CM Concepts Severity of illness (SOI)

Severity of Illness is a term that indicates the acuity of the pathophysiologic changes that have occurred. It provides a basis for evaluating resource consumption, medical necessity and the patient care provided. Severity of Illness reflects the patient's level of sickness and disease complications. Sicker patients are more expensive to treat and they utilize more resources, have a higher rate of complications, and have worse outcomes. ICD-10-CM codes allow improved support for documentation of Severity of Illness.

As with the old system, simply stating, "lab reviewed" is inadequate. Physicians need to clarify when an abnormal lab or symptom is related to a specific disease or condition. Laboratory results may only be coded when the physician specifically indicates that there is a clinical relevance and significance. For instance, a low bicarb is NOT considered inherent with dehydration so it would only add additional detail of severity, while an elevated lipase would be considered inherent with pancreatitis and would not be coded separately.

Examples of severity:

- Chronic Kidney Disease staging (1-5, ESRD)
- Ulcer staging (stage I-IV)
- Burn degree, extent of total body surface area and percent of third degree involved

Examples of significant lab:

- Dehydration with abnormal serum creatinine
- Hypoxia or hypercapnia with asthma or acute respiratory failure

Examples of Disease Complications

- Primary or secondary diabetic with nerve/kidney/circulatory manifestations
- Influenza complicated by pneumonia
- Febrile Neutropenia due to chemotherapy, HIV
- Angina secondary to uncontrolled hypertension

6.0 Key ICD-10-CM Concepts First Listed (Principal) Diagnosis

When documenting multiple final diagnoses, the order of your diagnosis is very important. While there are ICD rules that certain diagnoses should be listed first (principal), you should list your first (principal) diagnosis as the one which best addresses the primary reason for the patient encounter. Secondary (contributing) conditions that are addressed and provide additional details to support the medical necessity of the encounter are listed AFTER the principal diagnosis. Patients with multiple fractures or injuries, the injury that is most severe should be listed first.

Example:

A patient with a history of non-compliance with his high blood pressure medication who has deltoid ligament injury of the left ankle after falling off his bike while at the park would be coded:

- Sprain of left deltoid ligament of left ankle (principal)
- Bicyclist injured in fall from bike in the park (contributing)
- Noncompliance with hypertension medication (contributing)

Try to avoid simply stating “rule out”, “suspected”, or “evaluate for” in your final diagnosis without additional descriptors. For instance, “Rule out MI” is difficult to assign a code, while “Patient presents with acute exceptional left anterior chest pain. Evaluated for possible coronary artery disease as cause. Screening labs and EKG are inconclusive and patient will be admitted for observation and further cardiac evaluation by cardiology” is codeable.

7.0 Key ICD-10-CM Concepts: Signs and Symptoms/ Unspecified

ICD-10-CM does not require a “definitive final diagnosis”. Using signs and symptoms such as “chest pain” or “vomiting” as a principal diagnosis is appropriate. You should always strive to document to the highest level of certainty but there will be times when your highest level of clinical certainty results in an “unspecified” diagnosis.

Examples of acceptable documentation of supporting the principal (final) diagnosis:

- Chest pain with elevated cardiac enzyme (troponin), concern for acute coronary artery syndrome
- Pneumonia etiology unclear
- Dehydration from vomiting with hyponatremia requiring IV therapy

7.1 Key ICD-10-CM Concepts: Present On Admission

Be sure to include clinically significant co-morbidities in your diagnoses for patients who are admitted. This will help in documenting conditions that are present on admission (POA) indicators. POA is defined as “present at the time the order for inpatient admission occurs”. The purpose of the POA indicator is to differentiate between conditions present at the time of admission, such as pressure ulcers and catheter related infection, from those conditions that develop during the inpatient admission.

8.0 Key ICD-10-CM Concepts: Episodes of Care for Injuries and Poisonings, Initial encounter is used while the patient is receiving active

treatment for injuries, fractures, burns, poisonings, and similar conditions in the ED. Examples of active treatment are: emergency department encounter and evaluation and treatment by a new physician. An initial encounter is a patient who is new to the treating physician for that condition, whether or not active treatment is being provided. Almost all ED visits will be considered initial.

Subsequent encounter is used when the patient is receiving additional care during the healing or recovery phase from an injury, fracture, burn, poisoning and similar condition. In the ED this would include a cast change, suture removal, or medication adjustment.

Subsequent encounters are less common in the ED setting.

Examples:

A patient is asked to return to the emergency department for x-ray variance or antibiotic adjustment based on culture results.

Sequelae is used when a patient is being seen for a late effect (complication) due to an injury, fracture, burn, poisoning, or similar condition. In the ED, this would include management of a scar that was the result of a burn.

9.0 Key ICD-10-CM Concepts: Enhanced Anatomic Specificity.

ICD-10-CM supports much more precise anatomic description of the injury or condition. Simply stating “pneumonia” or “ankle sprain” may be inadequate. While many of these descriptors were present in the older system, they are more prominent and enhanced, such as laterality, with ICD-10-CM.

Be sure to document:

- Laterality - Right/Left/or Bilateral
- Arm or Leg - Upper or Lower/Proximal or distal
- Hand - document individual metacarpals
- Foot - document individual metatarsals
- Fingers - specify which fingers are involved, avoid using numbers
- Phalanges - document whether proximal, mid, or distal phalanges
- Toes - document which toe(s) and joint(s) are involved
- Face - document whether upper or lower eyelids and lips
- Pneumonia - specify whether right, left, or bilateral)
- Abscess/Cellulitis – document the precise anatomic location

10. Key ICD-10-CM Concepts: Sprains and Strains

Be specific if the injury is a sprain, which describes damage to a ligament, or strain, which is damage to a tendon or an overstretching overexertion of some part of the musculature. The IDC-9 system did not differentiate between sprains and strains. ICD-10-CM does make that distinction and allows documentation of the **specific** tendon, ligament or muscle.

11. Key ICD-10-CM Concepts: External Cause of Injury

Injuries need to have the how, where (geographic location) and mechanism of the injury.

Document:

External causes: Fall, assault, accident, or complication from a procedure.

Activity: Work related, sports, tripped.

Geographic location: Home, work, boat etc.

Examples:

- Slipping, tripping, stumbling and falls
- Exposure to inanimate mechanical forces
- Accidental non-transport drowning and submersion
- Exposure to electric current, radiation and extreme ambient air temperature and pressure
- Exposure to smoke, fire and flames
- Exposure to forces of nature
- Intentional self-harm

12. Key ICD-10-CM Concepts Summary

ICD-10-CM clinical documentation can be summarized as encompassing three major clinical presentations in the emergency department: 1) Injuries and poisoning; 2) infectious diseases and 3) medical conditions.

For injuries, poisonings, musculoskeletal and connective tissue problems, pathologic and osteoporosis injuries; remember the mnemonic: location, location, location.

Location: Document precise anatomical location
Location: Laterality – left right
Location: Where- geographic location (home, work, car, etc.)
Why - circumstances/activity surrounding injury
underlying osteoporosis, neoplasm etc.
How - If the injury was related to military, work,

recreation, etc.

For infections such as pneumonia, cellulitis, and UTIs seven documentation components need to be considered.

Type of infection:	Cellulitis, viral diarrhea, suppurative otitis media
Location of infection:	Specific anatomic structure involved
Acuity/Temporal:	Acute, chronic, recurrent, persistent
Causative organism:	MRSA, staph, strep
Clinical manifestation:	Palpitations, pain, fever,
Complication/ sig lab:	Hypoxia, tachycardia, hyponatremia

Tobacco /ETOH involvement and exposure to secondhand smoke.

For medical conditions such as diabetes, hypertension, or angina, seven components also need to be documented; but also include the disease condition and stage if known.

Medical condition/ type:	NIDDM with long term insulin
Temporal:	Acute, recurrent, persistent, episodic
Stage/severity:	Severe, metastatic prostate cancer
Body system affected:	Left ventricle, small bowel
Signs and symptoms that justify medical necessity:	Palpitations, SOB, dysphagia, hematuria, anorexia
Significant findings/ lab:	Hyperkalemia, hypoxia

Documentation of Tobacco /ETOH involvement and exposure to secondhand smoke also contributes to the coding.

These three clinical presentations; trauma, infections, and medical conditions, represent the major themes and motif of ICD 10-CM. In general, be sure to document if tobacco, second hand smoke or alcohol is impacting the clinical presentation or final diagnosis. Severity, temporal course, clinical manifestations

and significant abnormalities and findings need always to be charted regardless of presentation.

Unless the physician has a sound understanding of the underlying logic and organization of ICD 10 –CM, chart documentation has the possibility to evolve into a dangerous distraction.

ICD-10-CM does present some unique challenges for the ED physician, especially with EMRs that are not well designed, and documentation at point of care in a highly distractible uncontrolled environment. This paper attempts to summarize the key concepts of ICD -10 for the busy emergency physicians allowing the ED physician to stay focused on patient care, minimize extraneous documentation and generate a meaningful medical record.