CPT 2014 Update & ICD-10: Orthopedic Surgery sponsored by CHMB
December 18th, 2013
CHMB Corporate Overview

• Founded in 1995
  o Privately Held, Profitable and P.E. Funded for Rapid Growth
  o Inc. 5000 Fastest Growing Private Companies 2008-2012
  o Dell Partner since 2003
  o Fully Integrated 4 Acquisitions 2008-2011

• Partners w/ Allscripts since 2007
  o Early Adopter - Star Reference Site for EHR/PM/Implementation
  o Deeply Connected Across Multiple Disciplines
    1) Enterprise EHR/PM
    2) Hosting and Software Implementation/Training
    3) RCM Services

• 4,000 + Providers
  o 300+ staff in 24/7 work-cycle
  o Locations – San Diego, Irvine, Oakdale and Chicago
  o Customers Located Across 4 U.S. Time Zones
  o Remote Workforce – 15 Different States

• Largest Install of Allscripts PM – End User Expertise
  o 450 + PM Databases Built, Deployed and Supported
  o 7,500 + End-Users
  o 1,000 + physicians supported on EHR

Service

Customer Focused
Completing “the last mile”

Technology

Leading Technology
Value Add Business Intelligence

Results

End-to-End Solution
Physician Hospital Alignment
CHMB Core Service Offerings

HIT
- PM/EHR Implementation
- Software Sales
- Hardware
- Application Support
- ASP/Hosting
- Software Development

RCM
- Billing Services
- Practice Management
- Reporting
- Credentialing
- Compliance & Auditing
- Coding
- Business Analytics
- Decision Support

Consulting
- Practice Formation
- Recruitment
- Practice Assessment
- Practice Valuations
- Payor Contracting
- PM Build, Implementation & Training
- Workflow
- Optimization
Putting Valuable Information Into The Hands That Matter

### Performance Indicators

<table>
<thead>
<tr>
<th>C. Mark (Internal Medicine)</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
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<tr>
<td>2013 Total Visits:</td>
<td>633</td>
<td>537</td>
<td>532</td>
<td>539</td>
<td>466</td>
<td>467</td>
<td>525</td>
<td>537</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4,234</td>
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#### Work RVU Analysis

- **2013**: Blue bars
- **2012**: Orange bars
- **Spec Avg WRVUs**: Green dotted line
- **Avg Work RVUs**: Yellow dotted line
- **MGMA50**: Red line
- **MGMA75**: Green line
- **MGMA90**: Black line

<table>
<thead>
<tr>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
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<td>2013 FTEs</td>
<td>Oct</td>
<td>1</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>2013 Work RVUs</td>
<td>719</td>
<td>627</td>
<td>578</td>
<td>578</td>
<td>549</td>
<td>491</td>
<td>574</td>
<td>608</td>
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<td>-</td>
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<td>4,723</td>
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<td>2012 Work RVUs</td>
<td>661</td>
<td>618</td>
<td>510</td>
<td>631</td>
<td>559</td>
<td>541</td>
<td>626</td>
<td>641</td>
<td>572</td>
<td>604</td>
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<td>2013 Specialty Average</td>
<td>438</td>
<td>400</td>
<td>389</td>
<td>410</td>
<td>328</td>
<td>348</td>
<td>394</td>
<td>387</td>
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<tr>
<td>2012 Specialty Average</td>
<td>403</td>
<td>380</td>
<td>386</td>
<td>428</td>
<td>384</td>
<td>379</td>
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<td>407</td>
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<td>12 Month Rolling Average</td>
<td>586</td>
<td>589</td>
<td>595</td>
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<td>585</td>
<td>581</td>
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<td>596</td>
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<td>583</td>
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#### Productivity Calculation:

- **YTD Average wRVUs per Visit**: 1.12
- **YTD Average Visits per Business Day**: 24
- **Next Percentile**: 90%
- **VE wRVUs at next percentile**: 7,392
- **Current YTD wRVUs**: 4,723
- **VE wRVUs for next percentile**: 2,668
- **Additional Visits per FTE per Bus. Day**: 5

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About Our Speaker

- 33 years of operations experience in the practice management field
- An approved Professional Medical Coding Curriculum (PMCC) instructor by the American Academy of Professional Coders (AAPC),
- Education in current procedural terminology (CPT) and Ninth Revision, International Classification of Diseases (ICD-9) coding
- Evaluation and Management Coding and documentation; and compliance planning
- Specializes in chart auditing and is credentialed as a CPMA (Certified Professional Medical Auditor) and CEMC (Certified Evaluation and Management Coder)
- AAPC Approved ICD-10 Instructor and fellow in ACMPE
- Serves on the Section Council Steering Committee of MGMA
2014 CPT Changes

- 2014 CPT® changes include 175 new codes, 47 deleted codes, 107 revised codes, and guideline updates.
- Many changes are the result of the RUC’s efforts to redistribute $25 million within Medicare.
- This seminar will help you understand why the codes have changed, how to apply the new codes, and what should be documented to support them.
Musculoskeletal

<table>
<thead>
<tr>
<th>New</th>
<th>Revised</th>
<th>Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>26</td>
<td>0</td>
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</table>

3 new codes report the removal of a deep foreign body of the shoulder, and components of shoulder implants.

26 codes have been revised to describe Radical resection of tumor (eg sarcoma). Previously description stated (eg malignant neoplasm) and these codes were often used in error to report excision of malignant melanoma, a cancer of the **skin** and not the **connective tissue**.
Revised Codes-Musculoskeletal

• Radical resection of tumor codes (by site) have all been revised to state “eg sarcoma” instead of “eg malignant neoplasm”.
• 21015 – 21016, 21557-21558, 31935-21936, 22904-22905, 23077-23088, 24077-24079
• Guidelines at the beginning of the Musculoskeletal chapter are updated to clarify correct coding for excision of subcutaneous soft connective tissue tumors and radical resection of soft connective tissue tumors
Guideline Revisions

• Guideline Revisions clarify Excision of subcutaneous soft connective tissue tumors. These procedures include simple or intermediate repair. They involve the simple or marginal resection of tumors confined to subcutaneous tissue below the skin but above the deep fascia. These tumors are usually benign and are resected without removing a significant amount of surrounding normal tissue.

• Code selection is based on the location and size of the tumor

• Code selection is determined by measuring the greatest diameter of the tumor plus that margin required for complete excision of the tumor. The margins refer to the most narrow margin required to adequately excise the tumor, based on the physician's judgment.

• Extensive undermining or other techniques to close a defect created by skin excision may require a complex repair which should be reported separately.
Musculoskeletal

• New codes describe removal of **deep, foreign body** from the shoulder and removal of shoulder prosthesis
  – Foreign bodies are debris, such as the result of trauma, and not surgical implants
  – Ex 23330 Removal of foreign body, shoulder, subcutaneous
  – 23331, 23332 have been deleted
New Codes Musculoskeletal

- 23333 Removal of **foreign body**, shoulder; deep (subfascial or intramuscular)
- 23334 Removal of prosthesis, includes debridement and synovectomy when performed; **humeral or glenoid component**
- 23335 Removal of prosthesis, includes debridement and synovectomy when performed; **humeral and glenoid components** (eg, total shoulder)
• 23331  Removal of foreign body, shoulder; deep (eg, Neer hemiarthroplasty removal)
• 23332  Removal of foreign body, shoulder; complicated (eg, total shoulder)
  – To report, see code(s) To report, see 23333 for complicated removal of a foreign body; for prosthesis removal, see 23334-23335
Revised-Musculoskeletal

• 24160 Removal of prosthesis, includes debridement and synovectomy when performed; humeral and ulnar components
  – (previously described implant removal, elbow joint)

  – Note: 20680 should be used to report removal of an implant
CMS

- CMS: “On **October 1, 2014**, the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets.”
  - One implementation for all covered by HIPAA (not applicable to Automobile Insurance, Worker’s compensation, some Liability Insurance)
  - CMS is firm – No extensions

Source:
As of October 1, 2014, all providers, hospitals, and facilities must use the new ICD-10-CM for diagnosis reporting and the ICD-10 procedure codes for inpatient procedure reporting on claims.

The ICD-10 transition includes the introduction of more than 68,000 new diagnosis codes to be used by all providers, and approximately 72,000 new procedure codes to be used for inpatient hospital services.

These new codes will enable greater specificity in service descriptions. The new codes are expected to provide the increased level of detail needed due to advancements in medicine and technology and will bring the United States on par with the rest of the developed world.

Concerns that the current ICD-9 terminology and classifications of some conditions are outdated and inadequate have been cited as the primary reasons for the conversion to ICD-10.

“Unspecified codes will be the FIRST to be denied…..” Phyllis Bailey, Provider Relations Representative BCBSRI
ICD-9 Update- The Freeze is On!

- Because the compliance date for ICD-10 has been pushed back one year, the ICD-9-CM Coordination and Maintenance Committee, which includes an ACP representative, decided to also extend the partial code freeze by one year. There was considerable support for this partial, extended freeze.
- Here is the revised ICD-9 update schedule:
  - The last regular, annual updates to both the ICD-9-CM and ICD-10 code sets were made on Oct. 1, 2011.
  - On Oct. 1, 2012, only limited code updates were made to the ICD-10 code set to capture new technologies and diseases; no additions, deletions or revisions were made to the ICD-9-CM code set. Both code sets will again receive only limited code updates on Oct. 1, 2013.
ICD-10 Updates - the Freeze is On!

• On Oct. 1, 2013 and October 1, 2014, there will be only limited code updates to the ICD-10 code set. There will be no updates to ICD-9-CM because it will no longer be used for reporting.

• On Oct. 1, 2015, regular updates to ICD-10 will begin.
The Four T’s of ICD-Transition

• Timing
  – Phase I and Phase II
• Training
  – Identify training needs by role
• Technology
  – Evaluate tools that can mitigate financial risk of the ICD-10 transition
• Testing
  – New technology also can boost productivity to help offset the losses that occur during and after the transition
Comparison of ICD-9 to ICD-10
Reimbursement and Quality Problems with ICD-9

• Example – fracture of wrist
  Patient fractures left wrist

• A month later, fractures right wrist
  – ICD-9-CM does not identify left versus right –
    • requires additional documentation
  – ICD-10-CM describes
    • Left versus right
    • Initial encounter, subsequent encounter
    • Routine healing, delayed healing, nonunion, or malunion
## Comparison of Code Sets

<table>
<thead>
<tr>
<th></th>
<th>ICD-9</th>
<th>ICD-10</th>
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<tbody>
<tr>
<td>3-5 characters</td>
<td>3-7 characters</td>
<td></td>
</tr>
<tr>
<td>More than 17,000 codes</td>
<td>More than 155,000 codes</td>
<td><strong>68,000 are for ICD 10- CM</strong></td>
</tr>
<tr>
<td>First digit may be alpha or numeric (E or V only), digits are 2-5 are always numeric</td>
<td>First character is alpha; 2 &amp; 3 are numeric; 4-7 are alpha or numeric</td>
<td></td>
</tr>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible, new format allows for expansion</td>
<td></td>
</tr>
<tr>
<td>Lacks detail</td>
<td><strong>Very specific</strong></td>
<td></td>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Includes a specific field to identify laterality (right vs. left)</td>
<td></td>
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</table>
ICD-10 Changes Everything

Detailed Clinical Information

- Episode of care
- Laterality
- Severity

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ICD-10 Differences

- Combination Codes
- Laterality
- Episode of Care
- Exact Anatomic Location
- Clinical Details
- Cause/etiology
Combination Code

• Represents a single code used to classify two diagnoses
  – A diagnosis with an associated sign or symptom
  – Diagnosis with an associated complication
  – Simplifies the number of codes needed to clinically spell out a condition
  – *Documentation will need to support all elements*
Combination Code

• Represents a single code used to classify two diagnoses
  – A diagnosis with an associated sign or symptom
    K71.51 Toxic liver disease with chronic active hepatitis with ascites

• What additional documentation will be needed?
   Chronic, acute, subacute, persistent
   Active, Lobular, fibrosis, cirrhosis, necrosis
   With or without coma
Combination Code

• Represents a single code used to classify two diagnoses
  – A diagnosis with an associated sign or symptom
  – Diagnosis with an associated complication
  – Simplifies the number of codes needed to clinically spell out a condition
  – *Documentation will need to support all elements*
Laterality

• Code descriptions include designations for left, right and in many cases bilateral
• Documentation should always include laterality
• **What additional documentation will be needed?**
  - Right
  - Left
  - Bilateral
Laterality- Left versus Right

• M24.011 Loose body in right shoulder
• M24.011 Loose body in left shoulder
• M24.019 Loose body in unspecified shoulder

• Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.
ICD-10 Structure

• The expanded number of characters of the ICD-10 diagnosis codes provides greater specificity to identify disease etiology, anatomic site, and severity
• Characters 1-3 - Category (“Block”)
• Characters 4-6 - Etiology, anatomic site, severity, or other clinical detail
• Character 7 – Extension (example- episode of care or other clinical detail)
Structural Change

ICD-9
Diagnosis:
- Category
- Etiology, anatomic
  Site, manifestation

ICD-10
- Category
- Etiology, anatomic
  Site, severity
- Extension
Fifth/Sixth Characters

- **Identifies the most precise level of specificity**

Example:
- M43.12 Spondylolisthesis, *cervical region*
- M43 identifies the block for Other Deforming dorsopathies
- M43.1 Spondylolisthesis
  - Add sixth character to identify level of spine
    - Occipito-atlanto-axial region
    - Cervical region
    - Cervicothoracic region
    - Thoracic region
    - Thoracolumbar region
    - Lumbar
    - Sacral and sacrococcygeal
    - Multiple sites
Seventh Character Extenders

- Required for certain categories
- Must always remain in the 7th character
- Explains the status or encounter
Seventh Character Extenders

Examples:

A – Initial Encounter
D – Subsequent Encounter
S – Sequela- complications or conditions arising from the injury

What additional documentation will be required?

- Initial care (document active care)
- Subsequent care (document follow up or after care)
- Sequela (Provider must state the relationship is a late effect or residual effect)
Detailed Example

- S52 Fracture of Forearm
- S52.5 Fracture of lower end of radius
- S52.52 Torus fracture of lower end of radius
- S52.521 Torus fracture of lower end of right radius
- S52.521A Torus fracture of lower end of right radius, initial encounter for closed fracture
A Place for everything, everything in its place- Benjamin Franklin

• The fact that the codes are up to seven characters in length is a major difference that brings two new considerations: seventh character extenders and dummy placeholders.

• The seventh character extenders are usually a letter, and are used to identify the encounter type. The most common seventh character extenders used in ICD-10-CM are:
  
  A- Initial Encounter for closed fracture
  B- Initial encounter for open fracture
  D- Subsequent Encounter for fracture with routine healing
  G- Subsequent encounter for fracture with delayed healing
  K- Subsequent encounter for fracture with nonunion
  P- Subsequent encounter for fracture with malunion
  S- Sequela
A unique twist- the “Placeholder”

- Some codes are 7 characters, but no 4\textsuperscript{th}, 5\textsuperscript{th} or 6\textsuperscript{th} place is necessary, so “x” is a placeholder
- **T68.xxxA** - Hypothermia

- The appropriate 7\textsuperscript{th} character is to be added to code T68
- A – initial encounter
- D – Subsequent encounter
- S – sequela
Dummy Placeholders

• Used for those codes that require a 7th character extender that do not consist of 6 characters and represented by the letter “x”

Example

• A patient is treated for the first time for a pathological fracture.
  – M84.40x A Pathological fracture, unspecified site, initial encounter for fracture
Example

• A patient is treated for the first time for a pathological fracture.
  – M84.40 Pathological fracture, unspecified site, initial encounter for fracture
“Unspecified” Codes

• The Doctor has not given enough information in the documentation

• Differs from “Other specified” which means there is no exact code description for the documentation

• **Payers will not pay a claim with an unspecified code!**
Chapter Specific Changes

• This is a representation of some of the changes made to specific diagnosis. This does not include ALL changes from ICD-9-CM to ICD-10-CM.
ICD-10 CM 21 Chapters

1. Infectious and Parasitic Diseases
2. Neoplasm’s
3. Diseases of the Blood and Blood-Forming Organs
4. Endocrine, Nutritional and Metabolic Diseases
5. Mental and Behavioral Disorders
6. Disease of the Nervous System
7. Diseases of the Eye and Adnexa
8. Diseases of the Ear and Mastoid Process
9. Diseases of the Circulatory System
10. Diseases of the Respiratory System
11. Diseases of the Digestive System
12. Diseases of the Skin and Subcutaneous Tissue
13. Diseases of the Musculoskeletal System and Connective Tissue
14. Diseases of the Genitourinary System
15. Pregnancy, Childbirth and the Puerperium
16. Newborn (Perinatal)
17. Congenital Malformations, Deformations and Chromosomal Abnormalities
18. Symptoms, Signs and Abnormal Clinical and Laboratory Findings
19. Injury, Poisoning and Certain Other Consequences of External Causes
20. External Causes of Morbidity
21. Factors Influencing Health Status and Contact with Health Services
Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

- The musculoskeletal Chapter contains approximately 60% of the codes in ICD-10. The expanded codes are due to the increased specificity in anatomic locations, laterality, episode of care, and cause codes.
- Injuries (fractures) are reported in Chapter 19.
Arthritis and Osteoarthritis

- Arthritis and osteoarthritis have both site and laterality designations in ICD-10-CM. It also includes the type of arthritis such as primary, secondary or post-traumatic.
Musculoskeletal System Chapter 15

- Osteoarthritis
  - Degenerative arthritis
  - Degenerative joint disease – DJD
  - Cartilage decreases over time
  - Bone becomes exposed
  - Pain
  - Bone damage

- Tendonitis, Tenosynovitis, Synovitis, Bursitis, Fasciitis
  - Tendonitis - inflammation of the tough fibrous tissue of tendon
  - Tenosynovitis - inflammation of synovial sheath
  - Synovitis - synovial membrane inflammation
  - Bursitis - bursae inflammation
  - Fasciitis - fascia inflammation
    - Result of overuse
Primary and Secondary

- **Primary osteoarthritis** is considered "wear and tear" osteoarthritis, this type of osteoarthritis is more commonly diagnosed, whereas secondary osteoarthritis is usually caused by an injury, heredity, obesity or something else. The treatment for both types are usually the same.

- Arthritis and osteoarthritis are classified as “Primary” due to normal aging, and “secondary” which has a defined cause such as trauma, heredity, or obesity.
Example

- A patient is treated by an orthopedic surgeon for primary osteoarthritis of the right knee. The patient complains of chronic knee pain that worsens at night. The physician prescribed an anti-inflammatory drug to relieve the pain.
  - M17.11 Unilateral primary osteoarthritis, right knee
Rheumatoid (RA)

- Rheumatoid (RA) is a chronic systemic disease that affects the joints, connective tissues, muscle, tendons, and fibrous tissue, and is a chronic disabling condition often causing pain and deformity.

- Coding for rheumatoid arthritis in ICD-10-CM is broken down by site, laterality, complication, and with or without rheumatoid factor. Rheumatoid factor is an antibody in the blood that's present in many, but not all, people with RA.
Examples

- M05.141 Rheumatoid lung disease with rheumatoid arthritis of right hand
- M06.022 Rheumatoid arthritis without rheumatoid factor. left elbow
- M08.261 Juvenile rheumatoid arthritis with systemic onset. right knee
Site and Laterality

• Most of the codes within chapter 13 have site and laterality designations. The site represents the bone, joint or the muscle involved. For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis. There is a "multiple sites" code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved.
Bone vs. Joint

• For certain conditions, the bone may be affected at the upper or lower end, (eg, avascular necrosis of bone, M87, Osteoporosis, M8O, M81). Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.
Acute Traumatic Versus Chronic or Recurrent Musculoskeletal Conditions

• Many musculoskeletal conditions are a result of previous injury or trauma to a site, or are recurrent conditions.
• Bone, joint, or muscle conditions that are the result of old healed injury are usually found in chapter 13. Recurrent bone, joint, or muscle conditions are also usually found in chapter 13.
• Any current, acute injury should be coded to the appropriate injury code from chapter 19.
Osteoporosis

• Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected.

• Site is not a component of the codes under category M81, Osteoporosis without current pathological fracture.

• The site codes under category M80, Osteoporosis with current pathological fracture, identify the site of the fracture, not the osteoporosis.
Osteoporosis without Pathological Fracture

• Category M81, Osteoporosis without current pathological fracture, is for use for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past.

• For patients with a history of osteoporosis fractures, status code Z87.31O Personal history of healed osteoporosis fracture should follow the code from M81.
Example

• A patient is treated with medication for postmenopausal osteoporosis. The patient had a pathologic fracture one year ago and the physician is following her condition every three months.
  – M81.0 Age-related osteoporosis without current pathological fracture
  – Z87.310 Personal history of (healed) osteoporosis fracture
Osteoporosis with Current Pathological Fracture

• Category M80, Osteoporosis with current pathological fracture, is for patients who have a current pathologic fracture at the time of an encounter.
• The codes under M80 identify the site of the fracture.
• A code from category M80, not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, *if that fall or trauma would not usually break a normal, healthy bone.*
Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99)

• Chapter 18 includes symptoms, signs, abnormal results of clinical or other investigative procedures, and ill-defined conditions regarding which no diagnosis classifiable elsewhere is recorded.
Use of Symptom Codes

• Codes that describe symptoms and signs are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.
  – Never use a definitive diagnosis code when the documentation includes phrases such as “Rule out, Question of, Suspected or Probable”. Code the signs and symptoms unless there is a definite diagnosis
Use of a Symptom Code with a Definitive Diagnosis Code

- Codes for signs and symptoms may be reported in addition to a related definitive diagnosis when the sign or symptom is not routinely associated with that diagnosis, such as the various signs and symptoms associated with complex syndromes.
- The definitive diagnosis code should be sequenced before the symptom code.
- Signs or symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
Repeated Falls

- Code R29.6 Repeated falls is for use for encounters when a patient has recently fallen and the reason for the fall is being investigated.
- Code Z91.81 History of falling is for use when a patient has fallen in the past and is at risk for future falls.
- When appropriate, both codes R29.6 and Z91.81 may be assigned together.
Functional Quadriplegia

• *Functional quadriplegia* (code R53.2) is the lack of ability to use one's limbs or to ambulate due to extreme debility.

• It is not associated with neurologic deficit or injury, and code R53.2 should not be used for cases of *neurologic quadriplegia*. It should only be assigned if functional quadriplegia is specifically documented in the medical record.
Chapter 19: Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88)

• Musculoskeletal Injuries
  – Sprains
  – Fractures

• Burns and Corrosions
Musculoskeletal System Documentation

- New ICD-10-CM Documentation Elements Related to Musculoskeletal System Coding
  - Fractures
    - Greater site specificity
    - Laterality
  - General characteristics
    - Displaced or non-displaced – default is displaced
    - Open or closed – default is closed
  - More specific fracture type information
    - Example: surgical neck of humerus - 2-, 3- or 4-part fracture
New ICD-10-CM Documentation
Elements Related to Musculoskeletal System Coding

- Fractures (con’t)
- Other specific types
  - Greenstick
  - Transverse
  - Oblique
  - Spiral
  - Comminuted
  - Segmental
  - Other
  - unspecified

- 7th digits
  - Episode of care (initial, subsequent, sequela)
  - Open or closed

- Classification of open fractures (Gustilo)
  - Type I
  - Type II
  - Type IIIA, IIIB, IIIC
Types of Fractures

- Displaced fractures
- Non-displaced fractures
- Closed fracture
- Open fracture
- Greenstick Fracture
- Transverse fracture
- Spiral fracture
- Oblique fracture
- Compression fracture
Classification is needed for open fractures using the “Gustilo Open fracture classification system”

This system identifies fractures as Type I, II, IIIA, IIIB and IIIC

I – Low energy, wound less than 1 cm

II – Wound greater than 1 cm with moderate soft tissue damage

III – High energy wound greater than 1 cm with extensive soft tissue damage

IIIA – Adequate soft tissue cover

IIIB – Inadequate soft tissue cover

IIIC – Associated with arterial injury
Open versus Closed

- A fracture not indicated as an open or closed should be coded to closed.
- A fracture not indicated whether displaced or not displaced should be coded to displaced.
Traumatic Fractures

- Listed in Chapter 19
- Seventh character extenders
- Most include three (except for fractures)
  - A Initial encounter
  - D Subsequent encounter
  - S Sequela
• Extension "A," initial encounter is used while the patient is receiving active treatment for the injury. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.
• Extension "D" subsequent encounter is used for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase. Examples of subsequent care are: cast change or removal, removal or external of internal fixation device, medication adjustment, other aftercare and follow-up visits following injury treatment.

• The aftercare Z codes should not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the seventh character “D” (subsequent encounter).
• Extension "S," sequela, is for use for complications that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequela of the burn. When using extension "S" it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The “S” is added only to the injury code, not the sequela code. The "S" extension identifies the injury responsible for the sequela. The specific type of sequela (eg. scar) is sequenced first, followed by the injury code.
Active Treatment and Aftercare

• Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation.

• Examples of fracture aftercare are cast change or removal, removal of external or internal fixation device, medication adjustment, and follow-up visits following fracture treatment by a new physician.
Initial vs. Subsequent

• Initial encounter is while receiving active treatment
  – Surgical treatment
  – Emergency treatment
  – E/M by a new provider
  – Those who seek delay for treatment of a nonunion or fracture
Initial vs. Subsequent

• Subsequent Encounter
  – Patient has completed active care and is receiving routine fracture care during healing or recovery phase.
  • Cast change or removal, removal of external or internal fixation devices, medication adjustment, follow up visits
Additional 7\textsuperscript{th} Characters

- Complication of fractures
  - Nonunions
    - K  Subsequent encounter for closed fracture with nonunion
    - M  Subsequent encounter for open fracture type I or II with nonunion
    - N  Subsequent encounter for open fracture type IIIA, IIIB or IIIC with nonunion
  - Malunions
    - K  Subsequent encounter for closed fracture with malunion
    - M  Subsequent encounter for open fracture type I or II with malunion
    - N  Subsequent encounter for open fracture type IIIA, IIIB or IIIC with malunion
Fractures

ED visit: A 14 year-old boy is at a movie theater and running in a parking lot when he was hit by a car. He was diagnosed with a nondisplaced fracture of the medial condyle of the lower end of the left femur. The leg was placed in a long leg splint and no further intervention was required.

ICD-9-CM code:

821.21 Fracture of condyle, femoral

Note: Additional E codes are reported to indicate the circumstances surrounding the injury.

ICD-10-CM code:

S72.435A Nondisplaced fracture of medial condyle of left femur, initial encounter for closed fracture

Note: Additional V, W, X, Y codes are reported to indicate the circumstances surrounding the injury.
Fracture Clavicle

• Fracture Clavicle
  – 24 choices available

• Documentation must include:
  – Laterality
  – Displaced/nondisplaced
  – Location: sternal end, shaft, lateral end, unspecified

  S42.011B Anterior displaced fracture of the sternal end of the right clavicle initial encounter open fracture
EXAMPLE

- A patient underwent surgery for an open burst fracture of the first lumbar vertebra which became unstable.
  - S32.012B Unstable burst fracture of first lumbar vertebra
Coding of Burns and Corrosions

- The ICD-10-CM makes a distinction between burns and corrosions. The burn codes are for thermal burns, except sunburns, that come from a heat source, such as a fire or hot appliance.
- The burn codes are also for burns resulting from electricity and radiation. Corrosions are burns due to chemicals. The guidelines are the same for burns and corrosions.
Rule of Nines for Burns

• Categories T31 and T32 are based on the classic "rule of nines" in estimating body surface involved: head and neck are assigned 9 percent, each arm 9 percent, each leg 18 percent, the anterior trunk 18 percent posterior trunk 18 percent, and genitalia 1 percent.
Place of Occurrence

• Secondary codes for use after other external cause codes to identify the location of the patient at the time of the injury.
• Only used once
• Do not use Y92.9 (unspecified) if not stated or not applicable
EXAMPLE

- A fireman suffered a third degree burn of scalp with a 10 percent, total body surface area (TBSA) a second degree burn of the neck and a third degree burn of the right forearm involving four percent TBSA battling a house fire. He was in the house containing the fire when the burns occurred. He was taken to the hospital emergency department for treatment.
  T20.35xA Burn of third degree of scalp; (any part), initial encounter
  T22.311A Burn of third degree of right forearm, initial encounter
  T20.27xA Burn of second degree of neck; initial encounter
  T31.11xA Burns involving 10-19 percent of body surface with 10-19 percent third degree burns
- X00.0xxA Exposure to flames in uncontrolled fire in building or structure, initial encounter
- Y92.019 Unspecified place in single family residence (private) house as the place of occurrence as the external cause
Chapter 20: External Causes of Morbidity (V01-Y99)

• These guidelines are provided for the reporting of external causes of morbidity codes in order that there will be standardization in the process. These codes are secondary codes for use in any health care setting. External cause codes are not required for reporting to some third-party payers.
External Cause Status

- Used to indicate the work status
- Used only once at the initial encounter
- Not used for poisonings, adverse effects, misadventures or late effects
- Do not use Y99.9, unspecified, if not known
External Cause Codes

• An external cause code should be used with burns and corrosions to identify
  1. The source
  2. Intent of the burn
  3. Place where it occurred

Ex: 1) injury  2) Y93 Activity  3) Y92 Place of occurrence  4) Work Status (W Comp, Hobby or Recreational Activity)
Used with Any Code in the Range of A00.0-T88.9, Z00-Z99

• An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that is a health condition due to an external cause.

• Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.
Never a Principal Diagnosis

• Combination External Codes-
  – Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.
Activity Code

• Describes the activity of the patient at the time of the injury
• Used only once at the initial encounter

Y93.61 American Tackle football
Y93.62 American flag or touch football
Place of Occurrence

• Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use after other external cause codes to identify the location of the patient at the time of injury or other condition.

Y92.312 Tennis court as the place of occurrence of the external cause
Military Activity Y99.1

Y99.0 Civilian activity done for income or pay
Initial encounters generally require four codes

- **External cause codes**
  - Used for length of treatment
  - Utilizes 7th character extender

- **Place of Occurrence**
  - Used only at initial encounter

- **Activity code**
  - Used only once at the initial encounter

- **External cause status**
  - Used only once at the initial encounter
Example

• While alpine skiing in Utah, the patient fell and suffered a stress fracture of the right femur.
  – **M84.351A** Stress fracture, right femur, initial encounter
  – **V00.321A** Snow-ski accident
  – **Y92.39** Other specified sports and athletic area as the place of occurrence of the external cause
  – **Y93.23** Other individual sport (Activity)
  – **Y99.8** Leisure activity
Get Ready!

• Become familiar with the new details ICD-10-CM will require in your notes
• Review crosswalks of your most frequently used ICD-9 codes
• There will be a “One to Many” crosswalk—don’t depend on a simple encounter form
• Many Denials and Delays can be avoided with training and good documentation!
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