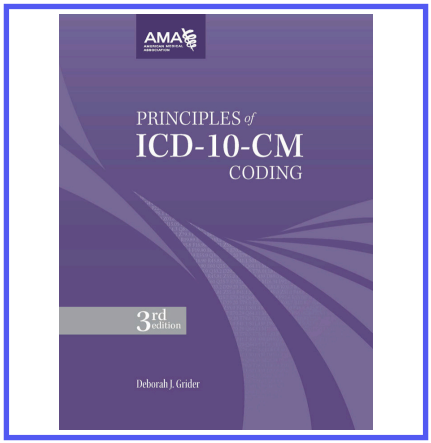


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Preface

Diagnostic coding began in Great Britain in 1839 as part of the London Bills of Mortality, an ongoing statistical study of disease that evolved into the International List of Causes of Death in 1937. Over the years, revisions were made and the title was changed to the International Classification of Causes of Death.

In 1948, the classification came under the direction of the World Health Organization (WHO), which used this information to track morbidity and mortality in order to make statistical assessments of international health and disease trends. The classification name was changed to the International Classification of Diseases. By 1950, hospitals in the United States used the listing to classify and index diseases.

The International Classification of Diseases has been revised periodically to incorporate changes in the medical field. ICD-9-CM is based on the official version of the WHO's ninth revision of the International Classification of Diseases. In February 1977, the National Center for Health Statistics convened a committee to provide advice and counsel in the development of a clinical modification of the ICD-9. The term *clinical* was used to emphasize the intent to use the modification as a tool when classifying morbidity data for indexing of medical records, medical care review, ambulatory care, other medical care programs, and basic health statistics. This resulted in the *International Classification of Diseases, 9th Revision,* Clinical Modification (ICD-9-CM).

Introduction to ICD-10-CM

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 includes provisions for the standardization of health care information. These administrative simplification provisions include standards for electronic transmission of claims, provider identifiers, privacy, and code sets. A national committee of the Department of Health and Human Services has worked extensively over the past several years to develop recommendations that meet the HIPAA requirements. Committee discussion of code sets has been lengthy and controversial due to potential costs of the transition to new and revised code sets in terms of infrastructure (computer software), anticipated delays in billing at startup, and costs associated with training and education.

The National Center for Health Statistics (NCHS) developed ICD-10-CM *(International Classification of Diseases, 10th Revision, Clinical Modification)* in consultation with a technical advisory panel, physician groups, and clinical coders to ensure clinical accuracy and utility. There are no codes for procedures in the ICD-10-CM; procedures are coded using the procedure classification appropriate for the encounter setting (eg, Physicians' Current Procedural Terminology [CPT®] and ICD-10-PCS).

The NCHS notes that this 10th revision, Clinical Modifications, represents a significant improvement over ICD-9-CM and ICD-10 mortality (cause of death) codes in terms of the increased number of codes. Improvements were also made to content and formatting and include the addition of information relevant to ambulatory and managed care encounters; expanded injury codes; the creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition; and the addition of alphanumeric subclassifications with up to 7 digits, which will increase the level of specificity with the addition of laterality in code assignment.

The term *clinical* is used to emphasize the intent to use the modification as a useful tool when classifying morbidity data for indexing of medical records, medical care review, ambulatory and other medical care programs, as well as for basic health statistics. To describe the clinical picture of the patient, the codes must be more precise than those needed for statistical groupings and trend analysis.

Origins of the International Classification of Diseases

This 10th edition of the International Classification of Disease is the latest in a series that originated in the 1850s. The first edition, known as the International List of Causes of Death, was adopted

by the International Statistical Institute in 1893. At its inception in 1948, the World Health Organization (WHO) took over the responsibility for the ICD when the sixth revision, which included causes of morbidity for the first time, was published. In 1967, the World Health Assembly adopted the WHO Nomenclature Regulations, which stipulate use of ICD in its most current revision for mortality and morbidity statistics by all Member States. ICD-10 was endorsed by the 43rd World Health Assembly in May 1990 and came into use by WHO Member States in 1994.

The ICD is the international standard diagnostic classification for all general epidemiological issues, many health management purposes, and clinical use. Included are analysis of the general health situation of population groups and monitoring of the incidence and prevalence of diseases and other health problems in relation to other variables such as the characteristics and circumstances of the individuals affected, reimbursement, resource allocation, quality, and guidelines.

ICD is used to classify diseases and other health problems recorded on many types of health and vital records, including death certificates and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological, and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States.

Final Rule for the Adoption of ICD-10-CM and ICD-10-PCS

On January 15, 2009, the Department of Health and Human Services released the final regulation that supported the move from the current ICD-9-CM coding system to the ICD-10 coding system beginning October 1, 2013. The final rule was modified in 2012 allowing an additional year for ICD-10 implementation to October 1, 2014. This time line allows for planning for and implementing this regulatory change. The final rule to update the current 4010 electronic transaction standard to the new 5010 electronic transaction format for electronic health care transactions was also published, with an implementation date of January 1, 2012. Version 5010 provides the framework needed to support ICD-10 diagnosis and procedure codes and is the prerequisite to implementing ICD-10. ICD-10-CM includes some terminology, conventions, classifications, and other features that are similar to those in ICD-9-CM. This publication will cover the basic information that every user will need in order to successfully use ICD-10-CM. Coders can expect to see numerous changes in ICD-10-CM, including:

- The addition of information relevant to ambulatory and managed care encounters
- Expanded injury codes in which ICD-10-CM groups injuries by site of the injury, as opposed to grouping by type of injury or type of wound, as was done in ICD-9-CM
- Creation of combination diagnosis/symptom codes, which reduces the number of codes needed to fully describe a condition
- The length of codes being a maximum of 7 characters, as opposed to 5 characters in ICD-9-CM
- Greater specificity in code assignment with the use of up to 7 characters
- V and E codes being incorporated into the main classification in ICD-10-CM
- ICD-10-CM codes being alphanumeric and including all letters except U

The systematic arrangement of ICD-10-CM makes it possible to encode, computerize, store, and retrieve large volumes of information from the patient's medical record. Hospitals, physicians' offices, and other health care providers can use ICD-10-CM to code and report clinical information required for participation in various government programs, such as Medicare, Medicaid, and professional standards review organizations. Even though diagnostic coding is important to the reimbursement process, it is equally important for tracking disease and compiling statistical data.

The US National Center for Health Statistics and the Centers for Medicare and Medicaid are responsible for the annual update of ICD-10-CM, which occurs every year on October 1. The changes are published in 3 publications—*Coding Clinic*, published by the American Hospital Association; the *American Health Information Management Association Journal*, published by the American Health Information Management Association; and the *Federal Register*, published by the US Government Printing Office.

The Official Coding and Reporting Guidelines were developed and approved by the following Cooperating Parties for ICD-10-CM: American Hospital Association; American Health Information Management Association; Centers for Medicare and Medicaid, formerly the Health Care Financing Administration; and the National Center for Health Statistics, to assist the user when coding and reporting situations where the ICD-10-CM manual does not

provide direction. Coding and sequencing instructions in ICD-10-CM take precedence over any other guidelines. When these guidelines appear within the text of the book, they are identified as the Official ICD-10-CM Guidelines with the appropriate section number for reference. A copy of the 2014 Official ICD-10-CM Guidelines for Coding and Reporting is included in Appendix C for your convenience.

Purpose of ICD-10-CM

Physicians' offices, hospitals, clinics, home health care agencies, and other health care providers use ICD-10-CM coding to substantiate the need for patient care or treatment and to provide statistics for morbidity and mortality rates. ICD-10-CM coding serves the following purposes:

- Establishes medical necessity
- Translates written terminology or descriptions into a universal, common language
- Provides data for statistical analysis

ESTABLISHES MEDICAL NECESSITY

The first step in the reimbursement process is to establish medical necessity. Each service or procedure performed for a patient must be reported with a diagnosis that justifies the care provided by presenting the appropriate diagnostic facts. An insurance company will "link," or match, the diagnosis submitted with the procedure or service performed. If the diagnostic code submitted does not establish medical necessity, the insurance carrier may deny the service or procedure. An example of this would be a provider who submits an insurance claim for a chest X-ray with a diagnosis of foot pain. The insurance carrier would not be able to associate the need for the chest X-ray with the diagnosis reported (foot pain) and would deny the service.

TRANSLATES WRITTEN TERMINOLOGY OR DESCRIPTIONS INTO A UNIVERSAL, COMMON LANGUAGE

When health care professionals submit claims for procedures or services performed or supplies issued, they must establish medical necessity through specific diagnoses, signs, symptoms, and/or complaints reported on the claim form. Prior to the Medicare Catastrophic Coverage Act of 1988, most health care professionals included a simple written description of the injury, illness, sign, or symptom that was the reason for the encounter on the insurance claim. This meant that insurance carriers who used ICD-10-CM coding had to code the diagnostic descriptions before entering them into the computer system. Today, most third-party payers, Medicare included, require the use of ICD-10-CM codes to report diagnoses on insurance claim forms. Health care professionals who accept assignment on a Medicare claim and fail to include ICD-10-CM codes will have their claims returned for proper coding, may be subject to postpayment review by the Medicare contractor, and may be subject to payment denials.

PROVIDES DATA FOR STATISTICAL ANALYSIS

Diagnostic coding has evolved from the initial efforts to classify causes of death to more sophisticated statistical data sets and analyses. ICD-10-CM is used as a statistical reporting medium and allows researchers to calculate everything from the leading causes of death, to the number of cases of certain infectious diseases, to the number and percent distribution of physician office visits by principal diagnosis. This same data can be used to study health care costs associated with a diagnosis or group of diagnoses to research the quality of health care and even to predict and plan for health care trends and needs.

Coding involves far more than assigning numbers to services and diagnoses. It involves abstracting information from patient records and/or other source documents and combining that information with reimbursement and coding guidelines to optimize payment for services and/or procedures provided to the patient. The consequences of inaccurate ICD-10-CM codes are numerous. For example, it can affect a physician's level of reimbursement as well as cause claims to be denied, fines or penalties to be levied, and sanctions to be imposed.

How to Use This Book

This book introduces the reader to the principles of ICD-10-CM coding for outpatient and physician services. The information provided herein will prepare the reader to accomplish the following objectives:

- Understand the purpose of ICD-10-CM and its relationship to the reimbursement process
- Understand and apply coding conventions when assigning codes
- Interpret basic coding guidelines for outpatient care

- Assign ICD-10-CM codes to the highest level of specificity
- Properly sequence ICD-10-CM codes

Principles of ICD-10-CM Coding contains 12 chapters. The first 4 chapters provide an overview of the material contained in ICD-10-CM, including the following: content, format, general coding guidelines, the coding process, and supplementary classifications. Chapters 5 through 11 present the basic guidelines for the coding in each chapter of ICD-10-CM. These chapters provide concrete instructions on how to code the diseases and injuries categorized in ICD-10-CM. Chapter 12 covers medical terminology and anatomy.

Also included as ancillary content are checkpoint exercise answers, along with slide presentations for each chapter that instructors or readers can use as an overview of each chapter. An exam testing module is included, with a midterm examination, final examination, and answer keys for both exams.

The text is designed for use by community colleges, career colleges, and vocational school programs for training medical assistants, medical insurance specialists, and other health care providers. It can also be used as an independent study tool for new medical office personnel, physicians, independent billing services personnel, and any others in the health care field who want to obtain additional skills.

Resources

National Center for Health Statistics. International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM); About the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM. http://www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm.

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