Another ICD-10 delay leaves healthcare industry with more questions than answers

Congress needed just a week to throw a huge monkey wrench into the healthcare industry’s plans for ICD-10 implementation. On March 26, House leadership introduced H.R. 4302, “Protecting Access to Medicare Act of 2014.” By April 1, the bill had passed the Senate and been signed into law by President Obama.

The bill prevented a 24% cut in physician Medicare reimbursement by patching the Sustainable Growth Rate. It also included this line:

_The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD–10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d–2(c)) and section 162.1002 of title 45, Code of Federal Regulations._

Note that while the language specifies that HHS cannot implement ICD-10 before October 1, 2015, it doesn’t mandate a specific new implementation date. Until CMS weighs in (which, at presstime, had not yet happened), the industry is left wondering when—or if—ICD-10 will be implemented.

The transition to ICD-10 “remains inevitable and time-sensitive because of the potential risk to public health and the need to track, identify, and analyze new clinical services and treatments available for patients,” according to an AHIMA statement.

Congress is unlikely to pass a bill to rescind the delay of ICD-10, according to AHIMA’s Margarita Valdez, director of congressional relations. With less than six months between passage of the act and October 1, 2014, Congress just doesn’t have time to craft, debate, and pass a law reinstating the 2014 implementation date, Valdez says.

What happens next

HHS will at some point release a rule to set a new ICD-10 implementation date. It could be a final rule, simply declaring the new date, or it could be a proposed rule, where HHS asks for comments. Based on prior experience, though, HHS will probably issue a final rule if it chooses to aim for a 2015 implementation date.
When HHS first confirmed it would delay ICD-10 implementation (on February 16, 2012), it did not publish a new proposed compliance date until April 9. That new date was included in the proposed rule, Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets, with a shorter-than-normal 30-day comment period.

Healthcare stakeholders provided so many comments that HHS didn’t release the final rule until August 24, 2012. That final rule moved ICD-10 implementation from October 1, 2013, to October 1, 2014.

That delay time frame was significantly different from the one the industry currently faces. When HHS announced it would delay ICD-10 in 2012, the implementation date was 20 months away and many industry stakeholders were not far along in their preparations. This time, just six months away from October 2014, many organizations have invested a considerable amount of money in the ICD-10 transition.

“Unfortunately, I’m not sure the delay will have a beneficial impact,” says Cheryl Ericson, MS, RN, CCDS, CDIP, associate director of education for the Association of Clinical Documentation Specialists (ACDIS). “If it does, I think the benefit is for a minority of organizations rather than the majority of them.”

Benefits of the delay

The delay could also provide more time for end-to-end testing, especially for CMS. The agency originally announced it would not conduct end-to-end testing, but later reversed the decision. CMS is currently slated to conduct limited end-to-end testing with a sample group of providers in late July. Given the previous implementation date of October 2014, that time frame didn’t provide much breathing room for CMS to compile and share results of the testing, nor would it have given providers much time to plan and
implement corrective action.

“CMS could use the additional time to test to ensure it can pay under the ICD-10 code set, but too many organizations have invested so much effort and expense into training their staff that they may be unable to replicate these efforts next year,” Ericson says.

Even if organizations are leery of putting more resources into ICD-10 training, coders and CDI specialists still need to engage physicians to improve documentation. Good documentation is good documentation regardless of which coding system coders use to report diagnoses and procedures.

Start (or continue) updating EHR and query forms. Coders and CDI specialists now have more time to make changes and acclimate physicians. Not sure where physician documentation is falling short? Use the delay to pinpoint the biggest problem areas and address them.

Finally, don’t stop getting ready for the new code set. One mistake many organizations made when CMS delayed ICD-10 implementation in 2012 was to stop preparing. Some were unable to regain the momentum as they tried to gear up again for the 2014 compliance date.

**Downsides to the delay**

The delay will cause some significant problems, the first being a possible lack of buy-in on the new date. For months leading up to Congress’ actions, CMS officials repeatedly stressed that the 2014 implementation date would not change.

In fairness to CMS, the agency didn’t publicly propose or back the latest delay. However, stakeholders who were already reluctant to move forward with ICD-10 will likely point to Congress’ action as another reason not to prepare.

“I worry there won’t be an incentive to continue to prepare for future implementation, as the last delay was supposed to be the only one,” Ericson says. This new delay may cause organizations to stop preparation until after the transition to avoid additional wasted expenses. “I hope that organizations will use this extra time to refine their skills and continue to educate providers and the rest of the medical team about the impact of ICD-10-CM/PCS.”

Another problem: increased costs for implementation. One of the AMA’s arguments against ICD-10 implementation was the financial burden the change would place on providers, especially small physician practices. In a 2014 study, Nachimson Associates estimated the transition costs at:

- $56,639–$226,105 for small practices
- $213,364–$824,735 for medium practices
- $2,017,151–$8,018,364 for large practices

When CMS delayed ICD-10 implementation in 2012, it stated the one-year delay could increase industrywide costs by $1 billion to $6.6 billion. Those costs could further rise with the new delay, especially if it ends up being longer than one year. Many healthcare providers had completed some or all of their coder training. Now, with the delay, they will need to find ways for coders to maintain the ICD-10 coding skills they have learned while still using ICD-9.

A third potential problem is a lack of ICD-9 coding skills among recent graduates, who only learned ICD-10.

“Students who have recently graduated or will be graduating within the next 18 months and were taught only ICD-10-CM/PCS will have to seek additional learning via books, webinars, or courses,” says Shelley C. Safian, PhD, CCS-P, CPC-H, CPC-I, AHIMA-approved ICD-10-CM/PCS trainer, of Safian Communications Services in Orlando, Fla. She is also a senior assistant professor who teaches medical billing and insurance coding at Herzing University Online in Milwaukee.

“Some schools have been developing ICD-10-CM/PCS non-credit courses for previous alumni,” Safian says. “Now, it is expected that these schools, and other educational vendors, will also create non-credit ICD-9-CM courses to support the students caught in this gap. Students will require ICD-9-CM knowledge for both national certification and employment.”

AHIMA recently announced that all of its certification exams will continue to use ICD-9-CM codes until ICD-10 is implemented.

ACDIS’ CCDS exam for CDI specialists will also continue to use ICD-9-CM as its basis. The exam was originally slated to switch to using ICD-10 in January 2015, but that change has been put on hold pending the new implementation date.
Remaining questions

Because the implementation delay happened so quickly and with no advance warning, industry stakeholders face some additional outstanding questions:

- **Code freeze:** Will ICD-9 and ICD-10 codes remain frozen until the new implementation date? When HHS moved implementation from 2013 to 2014, it extended the code freeze. At the time, Pat Brooks, RHIA, senior technical advisor at CMS, indicated CMS believed that doing away with the code freeze “would be rather catastrophic,” both for CMS and for providers. The Cooperating Parties made the last regular update to ICD-9-CM on October 1, 2011. Since then, the parties have made only minor updates to both ICD-9-CM and ICD-10 for new technology.

- **Coding Clinic:** The AHA’s Coding Clinic stopped accepting ICD-9-CM questions on January 1, 2014, but planned to continue answering ICD-9-CM questions while introducing more ICD-10 Q&As. As of presstime, the AHA was evaluating whether to resume accepting ICD-9-CM questions to Coding Clinic.

Until HHS finalizes a new implementation date, industry stakeholders will be unable to create new timelines and training plans. However, the message from most industry insiders is the same: Keep moving forward with ICD-10 implementation. Make the most of the delay to make sure you are as prepared as possible when ICD-10 is implemented.

BCCS board weighs in on ICD-10 delay

When Congress passed the Protecting Access to Medicare Act of 2014, it mandated at least a one-year delay in ICD-10 implementation. Members of the Briefings on Coding Compliance Strategies editorial board, who represent a wide range of industry stakeholders, offered their thoughts on two questions related to the delay.

What does this delay mean for the healthcare industry?

**Lori Belanger, RN, BSN, RHIT,** inpatient coder and CDI specialist at Northern Maine Medical Center in Fort Kent: The delay has both positive and negative consequences to it in regards to the healthcare industry. For those facilities who were on board with the upcoming change, it means an added expense prior to the actual implementation of the new program. For those facilities who were not on board with the change, this allows them the time to catch up. One drawback is a comment I recently heard. The comment had to do with the increased documentation push on the medical staff: “Now that ICD-10 has been delayed, they don’t have to be as intense with learning and implementing the documentation changes.” From a CDI specialist viewpoint, it is discouraging. We were finally getting the physicians to understand the importance of documentation specification, and now this. In my opinion, this should be the time span the physicians use wisely in learning the documentation specifications needed in the future and not continue to procrastinate. I can say that as a CDI specialist, this extra time will be used in attempts to strengthen the documentation now prior to the eventual changeover.

**Paul Belton,** vice president of corporate compliance for Sharp HealthCare in San Diego: Undoubtedly, this has been an incredible week filled with a lot of disappointment, frustration, and perplexity as to what the ICD-10 delay really means to everyone involved. Initially, most healthcare professionals may be discouraged with the delay based on the significant and onerous amounts of time many individuals have put into the implementation of ICD-10 across the industry. However, in turn, what it does mean is that the industry will have to implement quick thinking and a reanalysis of strategizing what to do and deciding what message needs to be conveyed going forward. What the industry needs to do is find the silver
lining that the delay presents. I believe we all need to capitalize on the opportunity to improve in what we are doing now, but doing it even better. The industry needs to analyze what components of their ICD-10 implementation programs should be delayed and what goes forward. It also means a transformation or a shift to enhance and perfect the electronic medical record, clinical documentation, query management, coding as a whole, and education. The delay will afford the industry the opportunity to enhance computer-assisted coding (CAC) systems and denial management while refining communication between all affected parties, particularly physicians, HIM coders, and CDI specialists.

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS, HIM professional with more than 30 years of experience in Fremont, Calif.: In general, I believe it means more cost due to an extension. Many organizations were not planning on ICD-10 implementation or education and training expenses in 2015. As a recent survey reported, the hospital portion of the healthcare industry was 95% confident they would be ready by the 2014 date. Many organizations small and large have started or had nearly completed their ICD-10 code set education and training. There will need to be educational refreshing into 2015 and certainly in the months just prior to go live. This also means we need to ensure that HIM coding and CDI professionals have the amount of time they need to practice and study the codes and the necessary documentation. This means our smaller physician practices have yet another year to prepare and use the tools and resources being provided, especially those available at no cost to the practice. But most of all, this means the fight is not over to get ICD-10 live in our healthcare system. There are special interest groups that are still opposed to ICD-10, so that also needs to be addressed. It is disappointed, to say the least, that this happened, but those of us who believe in and are dedicated to the advancement of quality data for quality healthcare will continue to work to achieve having ICD-10 as our national code set.

William E. Haik, MD, FCCP, CDIP, director of DRG Review, Inc., in Fort Walton Beach, Fla.: Obviously, much of the cost of preparing for ICD-10-CM/PCS will be wasted, as there will be a need for reeducation at a later date, or some level of continued education in the presumption ICD-10-CM/PCS will ultimately be adopted.

In the meantime, smaller healthcare facilities, physician groups, and insurers will now have time to prepare for the ICD-10-CM/PCS conversion. If already prepared, they can put greater financial resources into other health IT expenditures, such as electronic health records.

Additionally, to ensure clinical congruence with the code sets and provide physician buy-in and ownership of the transition, I believe it would be wise for the Cooperating Parties of the Editorial Advisory Board of AHA’s Coding Clinic for ICD-9-CM to recruit an equal number of physicians (representing different service lines) to be equal voting members of the Cooperating Parties.

In that vein, an equal number of physicians (medical and surgical) should be recruited to serve as equal cochairs to the National Center for Health Statistics and CMS on the Coordination & Maintenance Committee for ICD-10-CM/PCS rather than as mere presenters of clinical information. These physicians should have a strong clinical background and knowledge of the code sets and PPS.

James S. Kennedy, MD, CCS, CDIP, president of CDIMD – Physician Champions in Smyrna, Tenn.: The delay means that the healthcare industry will not have the specificity that ICD-10-CM and ICD-10-PCS offer as soon as we had hoped. It also means that we should listen to what the physicians are telling us, that they believe that their documentation, coding, and billing requirements are more onerous in ICD-10-CM and ICD-10-PCS. Those in control of ICD-10, the Cooperating Parties (AHA, AHIMA, CMS, CDC), must find ways of making ICD-10 consistent with the way physicians think and document. For example, physicians now define and document heart failure as “with reduced ejection fraction” or “with preserved ejection fraction,” yet the Cooperating Parties (Coding Clinic, First Quarter 2014, p. 6) will not accept this newer terminology, requiring physicians to say “systolic” or “diastolic” heart failure. Why can coders code off pathology reports on outpatients but cannot do so on inpatients? I can cite multiple examples where the Cooperating
Parties (none of which are a physician group) make ICD-9-CM and ICD-10 harder than it should be. There must be some way to alleviate their fears. Sadly, as a result of CMS’ and the hospitals’ political miscalculation, hospitals have spent billions of dollars getting ready for something that may never occur, particularly if it continues to be delayed as it was from 2011 to 2013; 2013 to 2014; 2014 to 2015. CMS can’t be trusted regarding any ICD-10 implementation unless we hear it from the White House itself.

Monica Lenahan, CCS, AHIMA-approved ICD-10-CM/PCS trainer, director of coding compliance and education for Centura Health in Englewood, Colo.: The delay means extreme disappointment and loss of trust in the process of implementing ICD-10, not to mention so much time and so many dollars spent and potentially lost. During implementation of our ICD-10 plan, we always had the issue of trying to convince folks that the compliance date was REAL and there would be no further delays. Prior to this latest delay, there was always resistance and the belief that yet another delay would happen. This latest delay reinforces the naysayers. It will be a huge challenge to gain organizational buy-in yet another time.

This latest delay also reinforces lack of confidence in the process of implementing, and the value of, ICD-10 by so many stakeholders. The fact that we can go from “it’s time to move on” and “there will be no more delays and the system will go live on October 1, 2014,” to a congressional delay in a matter of a few days without any discussion on the floor of the House or the Senate emphasizes that ICD-10 is not viewed as imperative.

Shannon E. McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS, director of coding and HIM at HCPro, a division of BLR, in Danvers, Mass.: Personally, I see billions of dollars potentially lost or interpreted as wasted teaching and preparing for implementation of the ICD-10 system to employees/providers. ICD-10 has officially been pushed out a minimum of 18 months to “not prior to October 1, 2015.” I know we had this happen in August 2012 and it was received with mixed reviews, but they were still mostly favorable because most stakeholders weren’t ready anyway. But this newest delay is disheartening for all those who invested in good faith in system enhancements such as CAC, paid for ICD-10 targeted education, and created a solid plan preparation for implementation. They will now feel as though they are being penalized for being proactive. The ones who have done little to prepare, which likely includes many physician offices, may see no harm. The AMA was a big advocate of delaying ICD-10, even though from a strict code set perspective, their changes were minimal because physicians would still use CPT® codes for procedures. Healthcare organizations who invested already may be hesitant to invest further dollars in education and enhancements because of a waning confidence in the actual adoption of ICD-10 in 2015. I don’t think anyone has faith in CMS getting this through when it wasn’t but a month ago they said “no delay,” and that wasn’t the truth. How are we to know it won’t happen again?

What should facilities be looking at or considering while they plan for the new implementation date?

Belanger: From the CDI standpoint, facilities should be taking a closer look at their top 10 diagnoses for each area of specialty. Take the time now to fully expand each diagnosis to its fullest capacity for an understanding of what is required. Continue with the education of staff and possibly expand the education to other groups of individuals who will be affected by this change. They should also be looking at their plans and expand on the areas that were skipped or only skimmed due to time constraints. This extra time will allow for a very strong educational foundation for the new program to be implemented, as opposed to the weaker, cracked foundation that caused these setbacks.

Belton: Regardless of the delay, we still have a significant amount of work to perform in regards to achieving appropriate and accurate documentation. Facilities don’t need to stagnate. What we need to do is reenergize our commitment to accurate documentation and continue to focus on mitigating risk. Facilities need to ensure they are achieving accuracy with ICD-9-CM. With all the external regulatory reviews and audits performed by the Recovery Auditors, MACs, and ZPICs,
facilities need to address denials and reviews. The large amount of Recovery Auditor and MAC “take-backs” prove this. National recovery rates from the external regulatory agencies mentioned above prove we have opportunities right in front of us.

Second, we need to understand conceptually that a lot of ICD-9-CM gets carried into ICD-10-CM; so often we have only looked at the differences and forget what can be carried over. In other words, perfection of ICD-9 concepts needs to be capitalized upon. Moreover, facilities need to continue to focus on the following: fewer denials based on medical necessity, the financial impact for value-based purchasing, accountable care organizations and other quality-driven incentives, improved clinical outcomes with patient related risk factors, treatment effectiveness, quality of care rendered metrics, resource intensity based on severity of illness, risk of mortality, and risk of complications. Finally, enhanced documentation does not have to be restricted to ICD-10 implementation. Facilities need to perfect their CDI programs and continue to dual code to continue to perfect coding skills, albeit in a slower fashion. In so doing, facilities should aim for a “seamless” transition into ICD-10 when the final date is solidified.

Bryant: We have more time for end-to-end testing now. This may allow some organizations to implement CDI programs or improve their CDI programs and processes. Also consider CAC technology with the implementation gap. There will also need to be some stretching out of current plans, especially dual coding, documentation improvement, and physician querying activities. Plan for coding refresher education and training around June to September 2015 (if October 1, 2015, is the new date).

Haik: Since many of the nonsurgical documentation issues that are present in ICD-9-CM will persist in ICD-10-CM/PCS, then physician education should continue. Analyze the individual physician’s documentation and use this analysis to help improve the documentation effort, while also involving the coding and CDI personnel. Regarding specific ICD-10-CM/PCS training, focusing on service line leaders, particularly in the surgical subspecialties, should proceed and accelerate during the delay.

In summary, the delay will simply provide additional time to fine-tune physician, coder, and CDI education to enable a successful transition. Remember, education is the key to future success and excellence!

Kennedy: First, I think that facilities and coders should not get stuck in self-pity or play the victim role with this setback, but instead recognize the good that has come out of the ICD-10 exercise. Let’s not forget that the Patient Protection and Affordable Care Act (PPACA) can still use ICD-9-CM codes to measure physician and facility outcomes; thus, we must program our EMR systems to capture disease and procedure specificity in a proactive, systematic way. We must hold providers accountable for their performance in risk-adjusted outcomes, engaging whoever we can to promote the good message of documentation and coding integrity.

We still need to get our MS-DRGs, APR-DRGs, and our hierarchical condition categories right if we are to thrive, not just survive, with healthcare reform. Don’t forget that the PPACA stipulates that the Secretary shall announce a plan for inpatient bundled payments by January 1, 2016. Have we worked to reduce our per-case cost and readmission rates in the same manner that high-functioning institutions have? Also, I personally think that the AHA or AHIMA should be more proactive in engaging physicians in the management of ICD-10 by advocating that they be a fifth Cooperating Party, not just settle for them to having a vote on the Coding Clinic Editorial Advisory Board, where they are outnumbered by a 2-to-1 ratio by nonphysicians. What physician wants his or her language ultimately governed by nonphysicians?

Lenahan: From a coding standpoint, I believe facilities should concentrate on continuing their ICD-10 training efforts in some form or fashion, and not put the training off until 2015. For Centura Health, a majority of our coders had completed or nearly completed their formalized ICD-10 training, coded many sample claims in ICD-10, and were ready to embark on dual coding. We are developing a strategy to ensure that this training is not lost and will carry the coders through to the new compliance date.
McCall: It will be important to not lose their investment in any education already done for employees. I do think those learning ICD-10-CM find that it is very similar to ICD-9-CM and will be able to retain what they learned. But ICD-10-PCS is very different and will require continued practice/exposure between now and implementation. Keep ICD-10 as a continued focus, with quarterly refreshers at a bare minimum. I know it is hard trying to dual code. Budget time to practice can be cumbersome for most coding departments. Documentation improvement is needed no matter whether the code set is ICD-9 or ICD-10. I think CDI programs should stay the course and push for better documentation with ICD-10 in mind (even if it does get pushed back again). Many of the code enhancements may not affect which ICD-9-CM code is assigned, but will for ICD-10, so my thoughts are you won’t get penalized for over-documenting. Coders/CDI need to accept the delay, and if they have learned basic ICD-10, strive to retain the knowledge and incorporate it into daily work whenever possible.

ICD-10-CM offers a new twist on complications: Codes that act as their own CC or MCC

A diabetic patient is admitted with gangrene. The physician does not specifically link the diabetes and the gangrene, but also does not document any other potential cause of the gangrene. Should you code both conditions?

In ICD-9-CM, coders can assume a cause-and-effect relationship between the diabetes and the gangrene as long as the physician does not document any other causes of the gangrene (Coding Clinic, First Quarter 2004, pp. 14–15).

That guidance allows coders to report the gangrene, which is a CC, even if the physician does not state that the gangrene is due to diabetes. “Physicians are not always good at documenting cause-and-effect relationships,” says Jennifer Avery, CCS, CPC-H, CPC, CPC-I, AHIMA-approved ICD-10-CM/PCS trainer, senior coding instructor for HCPro, a division of BLR, in Danvers, Mass.

Coders cannot report the combination codes for diabetes and a complication, such as osteomyelitis, gangrene, or renal failure, unless the physician specifically documents the relationship between the diabetes and the condition, adds Christina Benjamin, RHIA, CCS, CCS-P, an independent coding and education consultant in Jesup, Ga. Per Coding Clinic, Third Quarter 2008, p. 5, the phrase “diabetes with [a certain condition]” satisfies this requirement.

Combination codes

In ICD-9-CM, coders need two codes to describe the patient’s condition: 250.7x (diabetes with peripheral circulatory disorders) and 785.4 (gangrene). In ICD-9-CM, the gangrene is a CC.

In ICD-10-CM, coders will only need one code: E11.52 (Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene). Because it’s a combination code in ICD-10-CM, facilities would lose the CC. So ICD-10-CM includes a new wrinkle—codes that act as their own CC or MCC. E11.52 is one of those codes.

“For the most part this shouldn’t impact coders at all as long as the documentation is appropriate for them to report the combination code,” Avery says.

Gangrene is still a CC, but in order to report the combination code in ICD-10-CM, the physician must establish the cause-and-effect relationship, she says.

If the physician does not link the diabetes and the gangrene, coders would report two ICD-10-CM codes: one for the diabetes (categories E10–E11) and one for the gangrene (code I96). Gangrene is still a CC even without the link.

“Regardless of whether we get the cause-and-effect relationship, we’ll still get credit for the CC,” Avery says.
From a CDI perspective, people are going to have to go back and question what they are doing, Avery notes. In ICD-9-CM, coders and CDI specialists did not have to query the physician for the relationship between the gangrene and the diabetes—they could assume the two conditions were related. In ICD-10-CM, physicians will need to document the relationship in order for coders to report the combination code.

Although gangrene would still be a CC without the physician documenting the cause-and-effect, facilities could still see a potential change in MS-DRG assignment.

If the patient is admitted for gangrene and the diabetes isn’t linked, diabetes becomes the secondary condition, Avery says. “Potentially, you could lose your CC.”

**Codes as their own MCC**

A total of 244 ICD-10-CM codes serve as their own CC, while an additional 82 codes work as their own MCC when reported as a principal diagnosis. Of those codes, 50 fall in the L89.- series (pressure ulcer). This category also includes:

- Bed sore
- Decubitus ulcer
- Plaster ulcer
- Pressure area
- Pressure sore

In ICD-9-CM, a wound care nurse can document the stage of the ulcer, but the physician must document the site and the type, says William E. Haik, MD, FCCP, CDIP, director of DRG Review, Inc., in Fort Walton Beach, Fla. The same holds true in ICD-10-CM.

“If the wound care nurse does not document the stage, but rather describes the stage and that description is similar to the inclusion term in the tabular part of the code book, then you can report that stage without the wound care nurse actually saying the stage,” Haik says.

In ICD-9-CM, coders need two codes to report the location and stage of the ulcer. For example, if a patient has a stage 4 pressure ulcer of the hip, coders would report 404.04 (pressure ulcer of the hip) and 707.24 (pressure ulcer stage 4).

The stage code is an MCC. An instructional note under category 707.0x (pressure ulcer) reminds coders to use an additional code to identify the pressure ulcer stage.

Coders also need to report whether the pressure ulcer is present on admission (POA) or is a hospital-acquired condition. If the ulcer is not POA, then it is not an MCC, Haik says.

Coders should also code to the highest level of evolution of a decubitus ulcer if it’s POA, he adds. If a patient comes in with a stage 1 pressure ulcer (not a CC or MCC) and it evolves to a stage 3 pressure ulcer, report the code for a stage 3 ulcer (which is an MCC).

“For the most part [the new combination codes in ICD-10-CM] shouldn’t impact coders at all as long as the documentation is appropriate for them to report the combination code.”

—Jennifer Avery, CCS, CPC-H, CPC, CPC-I

In ICD-10-CM, coders will only need one code to report both the location and stage of the ulcer, Avery says. For a stage 4 pressure ulcer of the hip, coders have three choices:

- L89.204, pressure ulcer of unspecified hip, stage 4
- L89.214, pressure ulcer of right hip, stage 4
- L89.224, pressure ulcer of left hip, stage 4

If the physician or nurse does not stage the ulcer, then coders will default to unspecified stage (ICD-9-CM code 707.20). Each ICD-10-CM category includes a separate code for unspecified stage. For example, coders would report L89.329 for a pressure ulcer of the left buttock, unspecified stage.

Both ICD-9-CM and ICD-10-CM include codes for an unstageable ulcer. In ICD-9-CM, coders would report 707.25. In ICD-10-CM, they would use the code listed for the specific site—for example, L89.320 (pressure ulcer of left buttock, unstageable).

When coders report unspecified stage or unstageable ulcer in both ICD-9-CM and ICD-10-CM, they lose the MCC, Avery says.

© 2014 HCPro, a division of BLR. For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, contact the Copyright Clearance Center at copyright.com or 978-750-8400.
WHEW! The ICD-10 pressure’s off, or is it?

by Robert S. Gold, MD

At the time of this publication, the Protecting Access to Medicare Act of 2014 bill was recently passed. The status quo regarding physician reimbursement from Medicare has been maintained. So what? That system has been broken for 20 years. ICD-10 will be postponed for provider billing for another year. So what? Life will go on as it has for the past 36 years with ICD-9-CM. In other words, nothing has changed. We’re good for another year. Pressure’s off! ...Right?

If you’re thinking that way, you’re in for a rude awakening when your hospital gets disenrolled by insurance companies, loses Center of Excellence status by Reuters and U.S. News & World Report and Parents magazine, and has the news stations announcing how your facility’s statistics reveal that it’s hurting patients and has one of the country’s top 15% readmission rates, demonstrating poor patient care.

Sure, AHIMA is disappointed that Congress delayed ICD-10 implementation. Maybe a bit of a reprieve isn’t such a bad idea with all the government-mandated stresses placed on physicians in hospitals or private practices, such as EHR implementation, meaningful use, and all the other new concepts that interfere with the consistent and efficient delivery of healthcare. After all, the federal government came up with these mandates before the systems were ready, tested, and proven, and everybody is suffering.

Practicing physicians were the last group of people brought into the development of EHRs. And without physician participation in records, without their input, there is no billing for healthcare. So why didn’t anybody get the system ready for meaningful use by the doctors?

Well, that’s neither here nor there at this time. What is here, though, is the opportunity to identify, take hold of, and create an infrastructure that is friendly to physicians in order to make a system that is friendly to patients.

When all is said and done, the dollars that are delivered to the hospital’s board should not be the driving force behind the creation of this infrastructure—it should be the welfare of the patients treated in your facility, by your service lines, by your physicians.

EHR shortcomings

How can there be “meaningful use” of a health record if nobody knows what’s wrong with the patient? How can we provide care integration at the time of release from the hospital, allowing us to minimize avoidable readmissions, if the database is incomplete at the time of discharge? How can we develop statistically significant mortality or complication data if we can’t tell whether the patients are sick or how sick they are?

Every one of these data streams comes from one source—ICD codes. The only initiative out there that hospitals and physicians are being judged against that doesn’t come from ICD codes is patient satisfaction. When the medical staff can’t participate in holistic care of the patients because they are overburdened with other mandates that interfere with their ability to develop good patient rapport and good thought processes, we’ll lose that piece, as well. Yes, the goal of healthcare is the long-term care of the patients, not the short-term profitability for the investors.

I said it at the HIMSS conference in Las Vegas two years ago—there’s not one EHR out there that’s friendly to the physicians. That created a bit of a stir, and some companies actually started redirecting their efforts toward trying to help achieve something friendly to the docs. The big EHR companies didn’t. They were—they are—too involved with selling their products. They leave it up to someone on the outside to maybe develop some instrument that can interface with their product that will be “physician friendly.” And even those companies have started to change their models a bit when it was recognized that, with ICD-10, the existing algorithms won’t work.

The part of the EHR that is most dangerous is the ability to defraud patient interactions by entering data just for the purpose of entering data. It doesn’t necessarily matter if the data entered is true or not—it fills the space, so the record is considered complete. The tons and tons of useless data developed in these
burdensome tools leads to useless information about patient care and patient disease.

The second most dangerous part is that the diagnostic information that comes out of these things is flawed and inaccurate because people have been so buried in filling in blanks for reimbursement purposes. They don’t care about the validity of the information that is entered. Recovery Auditors love that part.

We have a great opportunity now. We can work to fix the friendliness of EHRs for the medical staff and for the community physicians. We can work to improve the communication of disease entities between the endless products out there that don’t talk to each other as the first order of business. We can slowly indoctrinate our physicians into the concepts of how the language of ICD-10 is actually good for the patients’ welfare before we have to rely on this system for billing. We have the chance to prepare. That’s really not so bad.

ICD-10 implementation

I don’t know if anything other than dictation and voice recognition or scribes following the docs around to permit them to spend more time talking with their patients instead of looking to a computer screen will solve the burden of data entry into an EHR. I don’t know if anything other than an external force working with the patient problem list will have a chance of distilling the miles of useless entries into something that represents the patient’s needs. But we can take some proactive steps in preparing the docs for this ICD-10 thing.

We know we’re going from a system with about 14,000 diagnosis codes to one with about 73,000 diagnosis codes. ICD-10-CM in the U.S. is totally different from the World Health Organization’s ICD-10 that the rest of the world is using. So how did we get this massive proliferation of codes?

Actually, it was from the medical societies—the American Colleges of Cardiology and Surgery, the American Academies of Family Practice and Pediatrics—who thought that any physician who sees the patient would find this additional information valuable as a baseline of the patient’s current status.

The insurance companies didn’t ask for these diagnostic additions. They’re the ones who came up with the codes that explain how patient injuries occurred—the ones we hear about on the evening news and laugh about as being ludicrous (catching fire while waterskiing, or being struck by a cobra as significantly different from being bitten by a cobra).

It started with ICD-9-CM. There just wasn’t enough room in a model that had a maximum of five digits and only 10 possible entries into each of those digits. Going to a model with an alpha increases the possible codes exponentially. And expanding it to seven characters makes for a lot of room to discuss pathogenesis of diseases. Cool. So long as it’s reasonable.

Heart failure

We have all of these heart failure codes since ICD-9-CM. Why? Because patients with systolic left ventricular failure had been identified as having four times the annual mortality risk of patients with diastolic left ventricular failure. With the capability of identifying those cases concurrently, we can treat these patients more effectively and maybe save lives.

The annual mortality risk dropped by half when we turned our attention to these people. We are saving lives. And without knowing whether the patients in the country or in your city or in your county have this increased risk, you can’t turn your efforts to saving their lives. That’s why the specificity is needed.

Is it worthwhile to know if fractures of the distal radius that are open and nondisplaced heal better than fractures of the distal radius that are closed and nondisplaced? Maybe not to the individual patient, because the doc is going to treat the individual based on skills and expertise. But we can’t determine fracture healing patterns and evaluate who has better results from their method of treatment unless we can do large studies of all fractures of the distal radius. The insurance companies don’t care about this—they just care whether it happened on the job or not.

We face a lot of issues regarding the new system because folks aren’t used to providing documentation and codes for inpatient or outpatient billing purposes. But the information about the specific patient’s diseases is very valuable to the patient and to the development of disease statistics. And to think that we can force this system into the daily thought processes of the medical staffs of our communities in just a few months is folly.

Nor is it realistic to think that we can teach the docs a computer-based learning module created for coders
over such a short time period. Docs have learned about diseases for ICD-9-CM over the past 36 years. Billing has been present using ICD-9-CM for 36 years. Many physicians have memorized ICD-9-CM codes because they've had such a long period of time to learn them.

Let’s take advantage of the year’s delay. Let’s develop tools for the physicians that are clinically oriented. Let’s make tools that think like a doc thinks. Let’s ensure that communication exists between the electronically mandated information in the hospital and the hospital next door and the physician group down the street and the family practice doc at the corner of the block and the pharmacy and the home health agency—AND the revenue cycle department.

**Coding Clinic offers specific ICD-10 guidance**

*By Cheryl Ericson, MS, RN, CCDS, CDIP*

**Diabetes and osteomyelitis**

Take note of the guidance on p. 114 as it’s a huge change. *Coding Clinic*, First Quarter 2004 allows us to assume the relationship of diabetes and osteomyelitis when both are present, unless a physician says otherwise. However, *Coding Clinic* says that we can no longer make that assumption in ICD-10. This underscores the fact that we can’t assume the guidance *Coding Clinic* issued for ICD-9 will also be true in ICD-10.

**Hemoptysis**

The discussion on p. 118 asks whether hemoptysis can be reported when it occurs with pneumonia. *Coding Clinic* says it should be added as an additional code, as it is not routinely associated with the diagnosis of pneumonia. The takeaway here is about what is integral vs. nonintegral, and this helps us know that hemoptysis is not routinely associated with pneumonia.

**Severe sepsis due to pneumonia**

We get some confusing guidance from an entry on p. 119 related to a patient admitted with severe sepsis due to healthcare-associated pneumonia. *Coding Clinic* states that it is appropriate to assign code Y95 (nosocomial condition) for this encounter. This may leave people thinking that healthcare-associated pneumonia is a hospital-acquired condition (HAC), but not everything that happens to a patient in a hospital is a HAC.

Nosocomial means occurring during the stay, which could be a quality issue for organizations when a patient comes in with pneumonia. *Coding Clinic* may be confusing present on admission (POA) with nosocomia. This entry makes it appear as though the hospital gave the patient the pneumonia. This will add confusion to HACs vs. POAs.

**Acute respiratory failure**

On p. 121, *Coding Clinic* states to assign acute respiratory failure, unspecified (J96.00) as principal, and toxic effect of smoke, accidental (T59.811A), along with respiratory conditions due to smoke inhalation (J70.5), as secondary, in a patient admitted through the ED for smoke inhalation with acute respiratory failure.

It’s interesting that we get these mixed messages in the guidelines—even though the patient’s respiratory failure is because of the smoke, it’s still considered the principal diagnosis.
**How will principal diagnosis selection be impacted by ICD-10?**

In some situations, the ICD-10 official coding guidelines vary from ICD-9 official coding guidelines, which could affect principal diagnosis selection. ICD-10-CM has some sequencing guidelines that will affect principal diagnosis selection. So you will see some variation. It’s minimal, though, because the UHDDS definition remains the same. It’s the condition after study which occasioned the admission to the hospital for care.

That basic rule is the same in both worlds, but if there are sequencing guidelines, then those sequencing guidelines take precedence. Some sequencing guidelines in the official coding guidelines change in ICD-10-CM.

One of the biggest sequencing differences relates to anemia associated with malignancy. ICD-10-CM differentiates whether anemia is due to:

- Cancer
- Treatment for the cancer
- Both

This information will affect new sequencing requirements under ICD-10-CM and MS-DRG assignment. When a patient is admitted or seen for management of anemia associated with the malignancy, coders will report the malignancy as the principal diagnosis, followed by a code for the anemia, according to ICD-10-CM coding guidelines.

In ICD-9-CM, coders would sequence the anemia code as the principal diagnosis followed by the appropriate code for the malignancy.

The **ICD-10-CM Official Guidelines for Coding and Reporting** state:

When admission/encounter is for management of an anemia associated with the malignancy, and the treatment is only for anemia, the appropriate code for the malignancy is sequenced as the principal or first-listed diagnosis followed by the appropriate code for the anemia (such as code D63.0, anemia in neoplastic disease).

This could potentially drive us to a different DRG because our principal diagnosis selection is going to be different.

_Heather Taillon, RHIA_, manager of coding compliance at St. Francis Hospital in Beech Grove, Ind., answered this question.

**I have a question about the sequencing of sepsis as a principal diagnosis.** In an inpatient acute care setting, sepsis and a localized infection are both present on admission, and the physician documents the cause-and-effect relationship between a localized infection and the sepsis. Is the sepsis assigned as the principal diagnosis in every one of those situations? For example, if there was documentation that the pneumonia was the cause of the admission, and documentation also supported the patient had sepsis, which was present on admission, what is the appropriate principal diagnosis?

The coding rules are very clear. If you look in the ICD-9-CM Official Guidelines for Coding and Reporting and _Coding Clinic_, it says that when the patient has sepsis documented and the patient has pneumonia as the localized infection, sepsis is the principal diagnosis.
Robert S. Gold, MD, CEO of DCBA, Inc., in Atlanta, answered the two previous questions.

Q Our physicians document a diagnosis of pneumonia but do not normally make a specific connection with the patient’s ventilator status, even when this is obvious from the record. For example, the patient’s been on the ventilator support immediately prior to the diagnosis. Can I report this as ventilator-associated pneumonia in ICD-10-CM without the documentation specifically connecting the conditions?

A I’m sorry to tell you no, unfortunately, we are specifically not permitted to make that leap, even when it is obvious. According to the ICD-10-CM official guidelines for reporting ventilator-associated pneumonia, the providers must specifically document the relationship between the pneumonia and the ventilator. This is not a gray area.

If you do have patients who are on ventilators, then take a look at the documentation you have now. Are your physicians documenting the connection? If they are not already documenting the specific connection, then you’re going to need to discuss this with them and you’re going to need to get them to do it.

You can address the connection in two ways. You or your CDI specialists can query the physician. Or you can ask your IT department to insert an alert in the EHR so that when the physician documents the patient’s been on a ventilator and has pneumonia, an alert box might appear to ask the physician, “Is this cause and effect?”

I definitely think it’s an important thing to address. Start now even though we know ICD-10 has been delayed.

Shelley C. Safian, PhD, MAOM/HSM, CCS-P, CPC-H, CPC-I, AHIMA-approved ICD-10-CM/PCS trainer, of Safian Communications Services in Orlando, Fla., answered this question.