Internal Medicine Coding Alert

ICD-10 Update: Bust Major ICD-10 Myths and Mysteries

Don't assume that ICD-10 will allow you to use the same code twice.

With the healthcare industry on edge and ready to jump into the ICD-10 transition, now is a critical time for coders to start the education process. Make certain your training is on-target, so you aren't caught up in any ICD-10 myths.

Check the Timeline

Fact: The transition to ICD-10 is already underway, with a "set in stone" implementation date of October 1st, 2014, points out **Brandi Whitemyer, RN, COS-C, HCS-D, HCS-O**, AHIMA Approved ICD-10 Trainer/Ambassador. And according to the timeline recommended by the **Centers for Medicare & Medicaid Services**, coders should have already initiated early training on the ICD-10 code set and transition, she says. Make sure your trainer isn't spinning one of these ICD-10 myths.

Myth #1: You don't need to purchase an ICD-10 coding manual.

"The truth is that coders planning to learn the ICD-10 code set must purchase an ICD-10 coding manual in order to properly complete training," Whitemyer says.

"Don't let someone fool you into thinking that the GEMs (General Equivalence Mappings) noted in the current ICD-9 Manual are an acceptable method for learning," Whitemyer says.

CMS states, "The GEMs are not a substitute for learning how to use ICD-10-CM and ICD-10-PCS. Providers' coding staff will assign codes describing the patients' encounters from the ICD-10-CM and ICD-10-PCS code books..."(CMS ICD-9-CM Notice, General Equivalence Mappings, April 2010, pg1).

"Not only is trying to use the GEMs for learning likely to mislead your ICD-10 coding experience, but without the use of a current ICD-10-CM manual, you will not have access to coding guidance," Whitemyer cautions.

Why? Just as is true in your current ICD-9 coding manual, the ICD-10 manual includes guidance such as when to use an additional code, and Excludes 1 and 2 notes, Whitemyer says. "These features are essential for the training process and any attempt to learn the ICD-10 code set without access to this information is incomplete."

"The manual may be in hard copy or electronic, but either way, an ICD-10-CM manual is an important reference tool for internal medicine coders," adds **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians.

Myth #2: Everyone will use the same codes in ICD-10, so you can code the same regardless of the provider setting.

Wrong again, says Whitemyer. The implementation and use of the ICD-10-CM code set is tied to HIPAA regulation, so all providers will be required to make the transition and use the same code set beginning October 1st, 2014. But coders will continue to utilize provider-specific guidance in assigning diagnoses codes, she says.

And the codes themselves cannot directly transfer for use from one provider setting to the next. For example, fracture codes will include a seventh character specifying the episode of care; such as in ICD-10 code S72.8X1D- (Other fracture of right femur; subsequent encounter for closed fracture with routine healing). The seventh character "D" in this code indicates subsequent episode, closed fracture, and routine healing, Whitemyer points out.

In ICD-10-CM, fracture codes such as S72.8X1D- include as many as sixteen possible seventh characters. And three of those seventh characters aren't likely to be applicable to home health providers, for instance, because they indicate an initial encounter, which typically occurs in a physician's office or hospital setting, Whitemyer says.

Myth #3: In ICD-10-CM, you can use the same code twice.

Absolutely not, Whitemyer says. Listing the exact same code twice in ICD-10-CM is no different than it is now a mistake. It would be redundant and violate coding guidelines.

Yet some coders have leapt to this conclusion when reviewing the ICD-10 code set. "Coders, this is where you must be cautiously diligent to involve yourself in ICD-10 education and assure your complete understanding," Whitemyer says.

Truth: The ICD-10-CM code set does provide specificity in codes to allow for laterality, Whitemyer says. Considering this, it might be appropriate to code, for example, a stage one decubitus (i.e. pressure) ulcer of the right elbow (L89.011), followed by a stage 1 decubitus ulcer of the left elbow (L89.021), she says.

In a case such as the one described above, the coder is reporting a stage one decubitus ulcer of the elbow twice, because the patient has bilateral ulcers, Whitemyer says. But the coder isn't reporting the same ulcer or the same code twice, she says.

On the other hand: If the ulcers were both located on one side, the coder would not duplicate the code, Whitemyer says. "One of the great benefits of the ICD-10-CM code set it is specificity. Coders need to keep in mind that specificity should not be confused with duplicity."

Myth #4: Internal medicine coders won't have to use any aftercare codes in ICD-10.

This couldn't be further from the truth, Whitemyer says. But there are definite changes in the use of aftercare codes within the ICD-10-CM code set, she says.

Most significantly for the internal medicine coding community, this means no longer coding aftercare for fractures, but instead using the seventh character modifier to specify episode of care and healing status, Whitemyer says.

But other coders, such as those working in orthopedic surgery, will continue to use other aftercare codes such as Z47.1 (Aftercare following joint replacement surgery) when appropriate, Whitemyer says.

Tip: Aftercare codes in ICD-10-CM can be located in Chapter 21, "Factors influencing health status and contact with health services" of the ICD-10-CM code set.

Have a Transition Plan

As you move from a code set of only 13,000 ICD-9-CM codes compared to ICD-10-CM's 68,000, internal medicine coders need to assure that they have a plan for a smooth and structured transition to the ICD-10 system, Whitemyer says.

"A good transition plan starts now," adds Moore. "The first steps are to select an internal Champion and/or transition committee to manage the process and to set a schedule for getting everything done between now and October 1, 2014.The AAFP has some great resources in this regard for internal medicine coders on its web site at http://www.aafp.org/dam/AAFP/documents/practice_management/payment/ICD10Timeline.pdf," according to Moore.

Gold standard: Be sure that an AHIMA Approved ICD-10-CM Trainer provides any ICD-10 training, and verify any information that sounds suspect, Whitemyer advises. "Coders need to keep in mind that just one course in ICD-10 won't do, and that training and practice will be necessary to become comfortable working in the new code set prior to October 1st , 2014."

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