ICD-10 and Public Health

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Note: ICD-9-CM and ICD-10 are owned and copyrighted by the World Health Organization. The codes in this guide were obtained from the US Department of Health and Human Services, NCHS website. This guide does not contain ANY legal advice. This guide shows what specific codes will change to when ICD-9-CM becomes ICD-10-CM

For the past thirty-one (31) years, we have learned and used ICD-9-CM when coding for our providers. As someone once said, just when we learned the answers, they changed the questions. Also, for years, there has been rumor that ICD-10 would be replacing ICD-9, and now this will soon be a reality.

ICD-10 will replace ICD-9-CM as of October 1, 2013. This can be found at https://www.cms.gov/ICD10/11b_2011_ICD10PCS.asp. As of May 4, 2011, you have 29 months to be ready for ICD-10-CM

There is an old saying in coding, “If it isn’t documented, it doesn’t exist or it didn’t happen.” When ICD-10 becomes effective, it’s success is dependent on the provider’s documentation. If the documentation shows, “OM”, many of us know this means Otitis Media. Under ICD-9-CM, you have the following codes for OM:

382.9 - Unspecified otitis media, Otitis media: NOS, acute NOS, chronic NOS
ICD-10 will require more work on the provider to document the exact type of diagnosis found with the patient. ICD-10 opens more with the anatomical area affected and allows for coding of chronic modalities.

Under ICD-10-CM, you have the following codes for Otitis Media:

H66.9 **Otitis media**, unspecified

H66.90 **Otitis media**, unspecified, unspecified ear

H66.91 **Otitis media**, unspecified, right ear

H66.92 **Otitis media**, unspecified, left ear

H66.93 **Otitis media**, unspecified, bilateral

As you can see, under ICD-9-CM, you have one code you can select if the documentation is not specific. The patient may have been a child with ear pain in both ears, but all the doctor wrote is “OM” and nothing more. ICD-9-CM was very forgiving to the documentationally challenged provider and coder. Under ICD-10-CM, you have a possibility of five (5) codes and you do need more anatomical information to select the best possible code. Using a pure unspecified code such as H66.9 could cause your claim to be pended or placed under review, which could cause a significant revenue loss for the practice. One of my favorite doctor is a certified expert witness. He is called by lawyers for the doctor and malpractice insurance company. He reviews the documentation of the visit to make a recommend to proceed to trial or to settle out of court. Most of the depositions I’ve reviewed, this doctor’s recommendation, most of the time, is to settle because the documentation is not sufficient to fight a lawsuit. His recommendation to doctors, medical school students, interns and residents is “Document the visit as if you had to
appear in court to defend your actions. “I usually add, “Document the visit as if your paycheck and career is on the line.” I spend a lot of my time returning medical records for additional information because the documentation is insufficient to code the visit with 100% truth, accuracy and correctness. I code to protect the doctor, the patient, and MY paycheck. I only code what is documented. I never code a visit just to get paid. Again, if it isn’t documented, I don’t code it because it doesn’t exist. With 30 years of clinical medicine, I can say I know what should have been done during the visit, but I can’t code based on that. I’ve seen doctors in court that have said, “I did this procedure.” The lawyers say, “Show Me!”

Let’s say you take your car to a mechanic to have your oil changed. You pick up your car and you are charged $3,000 for a new engine. You want to know why a $25 oil change cost $3,000. You are told the engine was replaced. You are entitled to see the old parts that were replaced. This happened to me one time and I asked to see the old part. I was told it was thrown away. I looked at the engine and couldn’t see the new part. All I saw was the old parts. I went to the dumpster and no part in the trash. The repair shop had no proof that they replaced the part. They dropped the charge for the replaced part.

The medical record is proof of the old part, unless the doctor, doctors the medical record and if so, then something more serious is taking place.
I just received a medical bill for care I received in 2007. There were charges I know didn’t take place. I demanded the medical record copy. The doctor refused. I did obtain the record copy which was maintained by the hospital. The doctor documented he saw me in my room on the ward. It was well documented to support a level 5 inpatient visit. The problem, I was in surgery having my heart operated on. It was impossible for the doctor to see me in my room while I was in surgery for 10 hours. The doctor is now being investigated for fraud because he trolled hospital wards, took medical records, documented extensive visits and waited for 4 years before sending a bill. It is very possible that this doctor will lose his medical license, not to mention patient lawsuits. I mention all of this to stress the importance of medical record documentation and to be 100% true, accurate, and correct with your documentation and coding.

Let’s look at some of the most used codes in Public Medicine. Please understand that this guide does NOT contain all codes used. This guide does not take the place of coding or published coding manuals.

NUMERICAL ORDER BY ICD-9-CM

ICD-9-CM
038.9  Unspecified septicemia, Septicemia NOS

ICD-10-CM
A41.9 - Sepsis, unspecified
ICD-9-CM
276.51 Dehydration

ICD-10-CM
E86.0 — Dehydration

ICD-9-CM
414.01 (Coronary atherosclerosis; of native coronary artery
Stricture of artery)

ICD-10-CM
Needs to be more specific

I25 Chronic ischemic heart disease

I25.1 Atherosclerotic heart disease of native coronary artery

I25.10 Atherosclerotic heart disease of native coronary artery
without angina pectoris

I25.11 Atherosclerotic heart disease of native coronary artery
with angina pectoris

I25.110 Atherosclerotic heart disease of native coronary artery
with unstable angina pectoris

I25.111 Atherosclerotic heart disease of native coronary artery
with angina pectoris with documented spasm

I25.118 Atherosclerotic heart disease of native coronary artery
with other forms of angina pectoris
I25.119 Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris

I25.2 Old myocardial infarction

I25.3 Aneurysm of heart

I25.4 Coronary artery aneurysm and dissection

I25.41 Coronary artery aneurysm

I25.42 Coronary artery dissection

I25.5 Ischemic cardiomyopathy

I25.6 Silent myocardial ischemia

I25.7 Atherosclerosis of coronary artery bypass graft(s) and coronary artery of transplanted heart with angina pectoris

I25.70 Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris

I25.700 Atherosclerosis of coronary artery bypass graft(s), unspecified, with unstable angina pectoris

I25.701 Atherosclerosis of coronary artery bypass graft(s), unspecified, with angina pectoris with documented spasm

I25.708 Atherosclerosis of coronary artery bypass graft(s), unspecified, with other forms of angina pectoris
I25.709  Atherosclerosis of coronary artery bypass graft(s), unspecified, with unspecified angina pectoris

I25.71  Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris

I25.710  Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris

I25.711  Atherosclerosis of autologous vein coronary artery bypass graft(s) with angina pectoris with documented spasm

I25.718  Atherosclerosis of autologous vein coronary artery bypass graft(s) with other forms of angina pectoris

I25.719  Atherosclerosis of autologous vein coronary artery bypass graft(s) with unspecified angina pectoris

I25.72  Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris

I25.720  Atherosclerosis of autologous artery coronary artery bypass graft(s) with unstable angina pectoris

I25.721  Atherosclerosis of autologous artery coronary artery bypass graft(s) with angina pectoris with documented spasm

I25.728  Atherosclerosis of autologous artery coronary artery bypass graft(s) with other forms of angina pectoris

I25.729  Atherosclerosis of autologous artery coronary artery bypass graft(s) with unspecified angina pectoris
I25.73 Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris

I25.730  Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris

I25.731  Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with angina pectoris with documented spasm

I25.738  Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with other forms of angina pectoris

I25.739  Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unspecified angina pectoris

I25.75 Atherosclerosis of native coronary artery of transplanted heart with angina pectoris

I25.750  Atherosclerosis of native coronary artery of transplanted heart with unstable angina

I25.751  Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm

I25.758  Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris

I25.759  Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris
I25.76 Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris

I25.760  Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina

I25.761  Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm

I25.768  Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris

I25.769  Atherosclerosis of bypass graft of coronary artery of transplanted heart with unspecified angina pectoris

I25.79 Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris

I25.790  Atherosclerosis of other coronary artery bypass graft(s) with unstable angina pectoris

I25.791  Atherosclerosis of other coronary artery bypass graft(s) with angina pectoris with documented spasm

I25.798  Atherosclerosis of other coronary artery bypass graft(s) with other forms of angina pectoris

I25.799  Atherosclerosis of other coronary artery bypass graft(s) with unspecified angina pectoris

I25.8 Other forms of chronic ischemic heart disease
I25.81 Atherosclerosis of other coronary vessels without angina pectoris

I25.810 Atherosclerosis of coronary artery bypass graft(s) without angina pectoris

I25.811 Atherosclerosis of native coronary artery of transplanted heart without angina pectoris

I25.812 Atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris

I25.82 Chronic total occlusion of coronary artery

I25.83 Coronary atherosclerosis due to lipid rich plaque

I25.89 Other forms of chronic ischemic heart disease

I25.9 Chronic ischemic heart disease, unspecified

ICD-9-CM

427.31 (Atrial fibrillation)

ICD-10-CM

I48.0 - Atrial fibrillation

ICD-9-CM

428.0 (Congestive heart failure, unspecified, Congestive heart disease, Right heart failure secondary to left heart failure),

ICD-10-CM

Needs to be more specific:
I50 Heart failure
I50.1 Left ventricular failure
I50.2 Systolic (congestive) heart failure

I50.20 Unspecified systolic (congestive) heart failure
I50.21 Acute systolic (congestive) heart failure
I50.22 Chronic systolic (congestive) heart failure
I50.23 Acute on chronic systolic (congestive) heart failure

I50.3 Diastolic (congestive) heart failure

I50.30 Unspecified diastolic (congestive) heart failure
I50.31 Acute diastolic (congestive) heart failure
I50.32 Chronic diastolic (congestive) heart failure
I50.33 Acute on chronic diastolic (congestive) heart failure

I50.4 Combined systolic (congestive) and diastolic (congestive) heart failure

I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
I50.41 Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.42 Chronic combined systolic (congestive) and diastolic (congestive) heart failure

I50.43 Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure

I50.9 Heart failure, unspecified

I51 Complications and ill-defined descriptions of heart disease

I51.0 Cardiac septal defect, acquired

I51.1 Rupture of chordae tendineae, not elsewhere classified

I51.2 Rupture of papillary muscle, not elsewhere classified

I51.3 Intracardiac thrombosis, not elsewhere classified

I51.4 Myocarditis, unspecified

I51.5 Myocardial degeneration

I51.7 Cardiomegaly

I51.8 Other ill-defined heart diseases

I51.81 Takotsubo syndrome

I51.89 Other ill-defined heart diseases

I51.9 Heart disease, unspecified
ICD-9-CM
466.11  Acute bronchiolitis due to respiratory syncytial virus (RSV)

ICD-10-CM
J21.0 - Acute bronchiolitis due to respiratory syncytial virus

ICD-9-CM
486  Pneumonia, organism unspecified

ICD-10-CM
J18.9 - Pneumonia, unspecified organism

ICD-9-CM
491.21  Obstructive chronic bronchitis; with (acute) exacerbation, Acute exacerbation of chronic obstructive pulmonary disease [COPD], Decompensated chronic obstructive pulmonary disease [COPD]

ICD-10-CM
J44.1 - Chronic obstructive pulmonary disease with (acute) exacerbation

ICD-9-CM

518.81  Acute respiratory failure, Respiratory failure NOS

ICD-10-CM
J96.00 - Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
ICD-9-CM
578.9 Hemorrhage of gastrointestinal tract, unspecified, Gastric hemorrhage, Intestinal hemorrhage

ICD-10-CM
K92.2 - Gastrointestinal hemorrhage, unspecified

ICD-9-CM
584.9 Acute kidney failure, unspecified

ICD-10-CM
N17.9 - Acute kidney failure, unspecified

ICD-9-CM
599.0 Urinary tract infection, site not specified, Pyuria

ICD-10-CM
N39.0 - Urinary tract infection, site not specified

ICD-9-CM
780.6 Fever

ICD-10-CM
Needs more information

R50 Fever of other and unknown origin

R50.2 Drug induced fever

R50.8 Other specified fever

R50.81 Fever presenting with conditions classified elsewhere

R50.82 Postprocedural fever

R50.83 Postvaccination fever

R50.84 Febrile nonhemolytic transfusion reaction
**Fever, unspecified**

**ICD-9-CM**

786.50  Chest pain, unspecified

**ICD-10-CM**

R07.9 - Chest pain, unspecified

**Abdominal pain; unspecified site**

**ICD-9-CM**

789.00  Abdominal pain; unspecified site

**ICD-10-CM**

R10.9 - Unspecified abdominal pain

**Alphabetical Index of Codes by Disease**

Abdominal pain; unspecified site

**ICD-9-CM**

789.00  (ICD-9-CM)

**ICD-10-CM**

R10.9  (ICD-10-CM)

Acute bronchiolitis due to respiratory syncytial virus (RSV)

**ICD-9-CM**

466.11  (ICD-9-CM)

**ICD-10-CM**

R21.0  (ICD-10-CM)

Acute kidney failure, unspecified

**ICD-9-CM**

584.9  (ICD-9-CM)

**ICD-10-CM**

N17.9  (ICD-10-CM)

Acute respiratory failure, Respiratory failure NOS

**ICD-9-CM**

518.81  (ICD-9-CM)

**ICD-10-CM**

J96.11  (ICD-10-CM)
Atrial fibrillation
427.31 (ICD-9-CM)
I48.80 (ICD-10-CM)

Chest pain, unspecified
786.50 (ICD-9-CM)
R07.9 (ICD-10-CM)

Congestive heart failure, unspecified, Congestive heart disease, Right heart failure (secondary to left heart failure)
428.0 (ICD-9-CM)
I50.20  Unspecified systolic (congestive) heart failure
I50.21  Acute systolic (congestive) heart failure
I50.22  Chronic systolic (congestive) heart failure
I50.23  Acute on chronic systolic (congestive) heart failure

Coronary atherosclerosis; of native coronary artery
414.01 (ICD-9-CM)
I25.75  Atherosclerosis of native coronary artery of transplanted heart with angina pectoris
I25.750  Atherosclerosis of native coronary artery of transplanted heart with unstable angina
I25.751  Atherosclerosis of native coronary artery of transplanted heart with angina pectoris with documented spasm
I25.758  Atherosclerosis of native coronary artery of transplanted heart with other forms of angina pectoris
I25.759  Atherosclerosis of native coronary artery of transplanted heart with unspecified angina pectoris
I25.76  Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris
I25.760  Atherosclerosis of bypass graft of coronary artery of transplanted heart with unstable angina
I25.761  Atherosclerosis of bypass graft of coronary artery of transplanted heart with angina pectoris with documented spasm
I25.768  Atherosclerosis of bypass graft of coronary artery of transplanted heart with other forms of angina pectoris
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I25.8  Other forms of chronic ischemic heart disease
I25.81  Atherosclerosis of other coronary vessels without angina pectoris
I25.810  Atherosclerosis of coronary artery bypass graft(s) without angina pectoris
I25.811  Atherosclerosis of native coronary artery of transplanted heart without angina pectoris
I25.812  Atherosclerosis of bypass graft of coronary artery of transplanted heart without angina pectoris

Dehydration
276.51 (ICD-9-CM)
E86.0 (ICD-10-CM)

Fever
780.6 (ICD-9-CM)
R50  Fever of other and unknown origin
R50.2  Drug induced fever
**R50.8 Other specified fever**

**R50.81  Fever presenting with conditions classified elsewhere**

**R50.82  Postprocedural fever**

**R50.83  Postvaccination fever**

**R50.84  Febrile nonhemolytic transfusion reaction**

**R50.9  Fever, unspecified**

Hemorrhage of gastrointestinal tract, unspecified, Gastric hemorrhage, Intestinal hemorrhage

578.9 (ICD-9-CM)  
K92.2 (ICD-10-CM)

Obstructive chronic bronchitis; with (acute) exacerbation, Acute exacerbation of chronic obstructive pulmonary disease [COPD], Decompensated chronic obstructive pulmonary disease [COPD]

491.21 (ICD-9-CM)  
J44.1 (ICD-10-CM)

Pneumonia, organism unspecified

486 (ICD-9-CM)  
J18.9 (ICD-10-CM)

Unspecified septicemia, Septicemia NOS

038.9 (ICD-9-CM)  
A41.9 (ICD-10-CM)

Urinary tract infection, site not specified, Pyuria

599.0 (ICD-9-CM)  
N39.0 (ICD-10-CM)
Coding for ICD-10 appears to be no different than that of ICD-9, but documentation will be the success or failure of ICD-10. Improper or lack of documentation will only delay claims processing and will decrease practice revenue.

Under ICD-9-CM, you have the following:

Chapter 1: Infectious and Parasitic Diseases (001-139)
Chapter 2: Neoplasms (140-239)
Chapter 3: Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
Chapter 4: Diseases of Blood and Blood Forming Organs (280-289)
Chapter 5: Mental Disorders (290-319)
Chapter 6: Diseases of Nervous System and Sense Organs (320-389)
Chapter 7: Diseases of Circulatory System (390-459)
Chapter 8: Diseases of Respiratory System (460-519)
Chapter 9: Diseases of Digestive System (520-57)
Chapter 10: Diseases of Genitourinary System (580-629)
Chapter 11: Complications of Pregnancy, Childbirth, and the Puerperium (630-677)
Chapter 12: Diseases Skin and Subcutaneous Tissue (680-709)
Chapter 13: Diseases of Musculoskeletal and Connective Tissue (710-739)
Chapter 14: Congenital Anomalies (740-759)
Chapter 15: Newborn (Perinatal) Guidelines (760-779)
Chapter 16: Signs, Symptoms and Ill-Defined Conditions (780-799)
Chapter 17: Injury and Poisoning (800-999)
Chapter 18: Classification of Factors Influencing Health Status and Contact with Health Service (Supplemental V01-V84) and Supplemental Classification of External Causes of Injury and Poisoning (E-codes, E800-E999)
Under ICD-10, you have the following:

Chapter 1: Certain infectious and parasitic diseases (A00-B99)
Chapter 2: Neoplasms (C00-D48)
Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)
Chapter 4: Endocrine, nutritional and metabolic diseases (E00-E90)
Chapter 5: Mental and behavioral disorders (F01-F99)
Chapter 6: Diseases of the nervous system (G00-G99)
Chapter 7: Diseases of the eye and adnexa (H00-H59)
Chapter 8: Diseases of the ear and mastoid process (H60-H95)
Chapter 9: Diseases of the circulatory system (I00-I99)
Chapter 10: Acute upper respiratory infections (J00-J06)
Chapter 11: Diseases of oral cavity and salivary glands (K00-K14)
Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)
Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)
Chapter 14: Diseases of the genitourinary system (N00-N99)
Chapter 15: Pregnancy, childbirth and the puerperium (O00-O99)
Chapter 16: Certain conditions originating in the perinatal period (P00-P96)
Chapter 17: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)
Chapter 18: Symptoms and signs involving the circulatory and respiratory systems (R00-R09)
Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T98)
Chapter 20: External causes of morbidity (V01-Y98)
Factors influencing health status and contact with health services (Z00-Z99)

E Codes will become V-Y Codes
V Codes will become Z Codes.

The Table of Drugs and Biologicals that were 900 series codes and E Codes are now T Codes.
The proposed effective date for ICD-10 is October 1, 2013.

So, what do we have to do?

- **Retraining**

  Staff Coders with training and certification need to undergo ICD-10 familiarization training to show coding using ICD-10 codes is not going to be difficult. Untrained staff members in coding positions must undergo training and they should also undergo certification. While certification is not mandated by State or Federal law, Certification assures that the coder can code per established standards. AAPC Coders will need to undergo retesting for certification. PAHCS and POMAA certified coders do not.

  Providers need training to be more detailed with health record documentation and the importance of how their documentation improves coding and improves practice revenue.

  Billers will need to have knowledge of ICD-10 to ensure claims go out with the appropriate ICD-10 codes and to fight claim denials due to coding issues. Untrained billing staff members should undergo training and certification as a medical biller.

- **New Manuals**

  ICD-10 Manuals will need to be obtained and used.

- **Updated Software**

  Medical Billing software needs to be updated to include both ICD-9-CM and ICD-10. This is because with an October 1, 2013 proposed effective date, Claims for September 30th and before September 30th dates of service will still use ICD-9 Codes. You may have a patient who was seen under ICD-9-CM that did not provide insurance information and after 10/1/13, the patient reveals coverage, so the claim must go out using the ICD that was in effect. You also need to contact your clearinghouse, software company and insurance
company regarding ANSI 5010 testing. Medicare requires ANSI 5010 testing to be completed by 12/31/2012.

• **Updated Carrier Policies and Procedures**
  Providers who are contracted and have agreed to carrier coding policies should be reviewing these policies and to make sure the contracted carrier is ready to accept the new codes. You should find out if there are going to be any claims payment delays due to the changeover to ICD-10 as this may affect contract payment timeframes.

• **Updated Compliance Plans**
  Practices and Billing Companies should update their compliance plans regarding ICD-10 coding. Extra attention should be directed to performing internal audits of charts and claims.

• **Updated Coding Denial Appeals**
  If the billing company is using a cookie cutter appeal, then the appeals should be reviewed and updated to conform to ICD-10 standards.

• **Updated Superbills**
  If the practice is using a superbill that contains ICD-9 codes, these should be replaced with the appropriate ICD-10 code(s).

• Continue to fight fraud, abuse and any up/downcoding issues.
  As with any changes there is always the fear that using something new is better resolved by downcoding a claim to remain under the “radar” Finding more codes available could lead to temptation to upcode or to submit a false claim to increase practice revenue.

  If we use the time we have been given for preparation, the transition from ICD-9 to ICD-10 can be very seamless.

  The key to the successful use and transition to ICD-10 is going to ensure our Providers are aware of their responsibility towards better documentation of the patient’s medical condition(s).
Use the following formula: PPD = Lawsuits and LOR (Loss of Revenue). (PXSS Poor Documentation = Lawsuits and LOR.

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I wish all much success.

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