

ORTHOPAEDIC PROVIDER EDUCATION

ICD-10 CONVERSION

Major Differences

⦿ ICD-9

- 3 to 5 digits
- Does not include laterality
- Primarily Numeric only
- 14,000 codes
- Limited combination codes

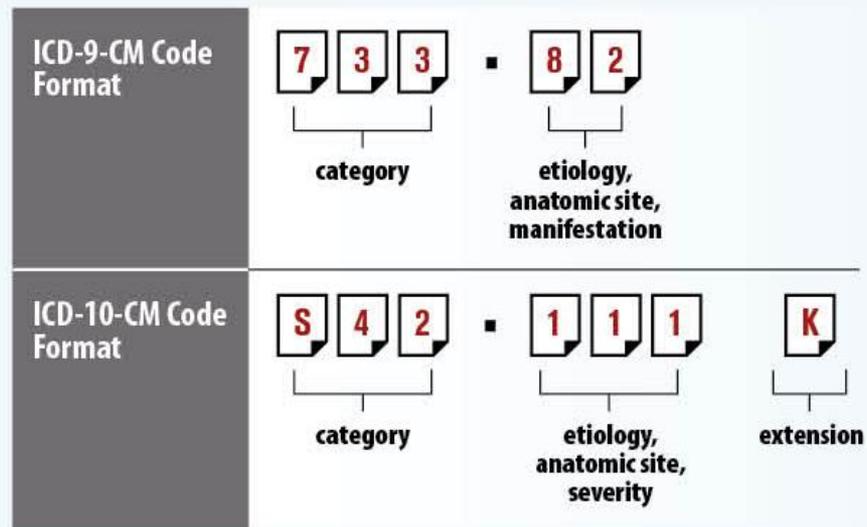
⦿ ICD-10

- 3 to 7 digits
- Diagnosis codes include laterality and anatomic location
- All Alpha-numeric
- 69,000 codes
- Extensive combination codes

ICD-10-CM Code Structure

ICD-9 versus ICD-10: Code structure changes

ICD-9-CM codes are three to five digits while ICD-10-CM codes can be from three to seven characters, with the seventh character extensions representing visit encounter, subsequent, or sequelae for injuries and external causes, etc.



Source: Renee Stantz, CPC, billing and coding consultant with VEI Consulting Services.

ICD-10 Chapters Related to Ortho

- ⦿ Chapter 6- Diseases of Nervous System (G00-G99)
- ⦿ Chapter 12- Diseases of Skin and Subcutaneous Tissue (L00-L99)
- ⦿ Chapter 13- Diseases of Musculoskeletal System and Connective Tissue (M00-M99)
- ⦿ Chapter 17- Congenital Malformations and Deformities (Q00-Q99)
- ⦿ Chapter 19- Injury and Consequences of External Causes (S00-T88)

Diseases/Conditions- M Codes

- ⦿ These codes can vary between 3-7 characters.
- ⦿ “X” is used in some codes as a “placeholder”
- ⦿ ICD-9- osteoarthritis knee- 715.16
- ⦿ ICD-10- you need to document exact location and side- **primary osteoarthritis of the left knee- M17.12**

Injuries- S Codes

- ⦿ These will all be seven digit codes that require more data than before.
- ⦿ ICD-9- fracture distal radius- 813.40
- ⦿ ICD-10- you need to document:
Right/left, name of bone plus EXACT location, fracture pattern, alignment, open/closed, encounter and result-
Closed non-displaced oblique fracture of the left distal radius, subsequent encounter, normal healing- S52.335D

Injury Coding (S codes)- Body Area

- S10-S19 Injuries to neck
- S30-S39 Injuries to low back, l-spine, pelvis
- S40-S49 Injuries to shoulder and upper arm
- S50-S59 Injuries to elbow and forearm
- S60-S69 Injuries to wrist and hand
- S70-S79 Injuries to hip and thigh
- S80-S89 Injuries to knee and lower leg
- S90-S99 Injuries to ankle and foot
- T79 Early complications of trauma
- T80-T88 Complications of surgical and medical care

Injury Coding- Type of Injury

- S@0. Superficial Injury
- S@1. Open Wound
- S@2. Fracture
- S@3. Dislocation & Sprain joints or ligaments
- S@4. Nerve Injury
- S@5. Blood Vessel Injury
- S@6. Muscle or Tendon Injury
- S@7. Crush
- S@8. Amputation Traumatic
- S@9. Other/Unspecified Injury

Injury Coding- Category Examples

- Shoulder Dislocation- S43.
- Digital Nerve of Thumb Injury- S64.
- Finger Open Wound- S61.
- Below Knee Amputation- S88.
- Quadriceps Muscle Strain- S76.
- Achilles Tendon Rupture- S86.

“T” - Complication Codes

- ⦿ T84-T87
- ⦿ Complications of internal joint prosthesis
- ⦿ Complications of internal fixation device
- ⦿ Infection and inflammatory reaction due to internal joint prosthesis
- ⦿ Complications of bone and skin grafts
- ⦿ Complications of amputation and reattachment
- ⦿ “Infection and inflammatory reaction due to internal right hip prosthesis- T84.51XA”

Fingers Identified in ICD-10

- CPT codes- you will still use modifiers FA-F9 on procedure coding
- ICD-10 fingers are named: thumb, index, middle, ring and little
- Metacarpals are labeled 1-5 from thumb to little finger on each hand
- Modifiers on CPT codes will need to match specified ICD-10 code.

Toes Identified in ICD-10

- CPT codes- you will still use modifiers TA-T9 on procedure coding
- ICD-10 toes are named: great toe and lesser toes
- Metatarsals are labeled 1-5 from great toe to little toe.
- Modifiers on CPT codes will need to match specified ICD-10 code.

ICD-10 Seventh Character

- ⦿ For injury diagnosis codes that are not related to fractures, you will primarily use:
 - ⦿ A – Initial encounter
 - ⦿ D – Subsequent encounter
 - ⦿ S – Sequela

ICD-10 Seventh Character

To provide additional specificity, the fracture extensions for **closed** fractures are expanded to include:

- A, Initial encounter for closed fracture
- D, Subsequent encounter for fracture with routine healing
- G, Subsequent encounter for fracture with delayed healing
- K, Subsequent encounter for fracture with nonunion
- P, Subsequent encounter for fracture with malunion
- S, Sequela

Epic Diagnosis Calculator buttons will code these for you.

ICD-10 Seventh Character

The extensions available for these **open** fractures are:

- ⦿ **B, Initial encounter for open fracture type I or II**
- ⦿ **C, Initial encounter for open fracture type IIIA, IIIB, or IIIC**
- ⦿ **E, Subsequent encounter for open fracture type I or II with routine healing**
- ⦿ **F, Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing**
- ⦿ **H, Subsequent encounter for open fracture type I or II with delayed healing**
- ⦿ **J, Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing**
- ⦿ **M, Subsequent encounter for open fracture type I or II with nonunion**
- ⦿ **N, Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion**
- ⦿ **Q, Subsequent encounter for open fracture type I or II with malunion**
- ⦿ **R, Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion**

Epic Diagnosis Calculator buttons will code these for you.

Initial Encounter in ICD-10

- **A – Initial encounter for injury**
Examples of active treatment are:
surgical treatment, emergency
department encounter, evaluation and
treatment by a new physician and
change of care plan.

“Initial” Example

- ④ The patient is evaluated in the emergency room (ER) for a displaced transverse fracture of the left ulna that cannot be managed at this time. The ER applies immobilization and ice and instructs the patient to follow up with orthopedics in the morning. This would be reported using *S52.222A Displaced transverse fracture of the left ulna, initial encounter for closed fracture*.
- ④ When the orthopedist rechecks the patient and reduces the fracture the next day, the patient is receiving initial active treatment for this fracture. That is, this is the first encounter at which the patient receives definitive care (the ER was able to apply comfort care only). Per ICD-10 guidelines, you would again report *S52.222A* for an initial encounter.

Subsequent Encounter in ICD-10

- 7th character “D” subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples of subsequent care are: cast change or removal, **an x-ray to check healing status of fracture**, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.
- The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care. For example, for aftercare of an injury, assign the acute injury code with the 7th character “D” (subsequent encounter).

“Subsequent” example

- The patient has a greenstick fracture of the shaft of the left ulna, which is definitively managed in the ER with a cast or splint. You would report this with *S52.212A Greenstick fracture of the shaft of left ulna, initial encounter for closed fracture.*
- At a later date, the same orthopedist who provided care in the ER rechecks the injury in her office. This is a subsequent encounter because the provider cared for the same condition, previously.
- If the fracture is healing as it should at the subsequent visit, the orthopedic office would report *S52.212D Greenstick fracture of the shaft of left ulna, subsequent encounter for fracture with routine healing.*

Sequela in ICD-10

- 7th character “S”, sequela, is for used for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character “S”, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The “S” is added only to the injury code, not the sequela code. The 7th character “S” **identifies** the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code with “S” as the 7th character.

Sequela Example

- ⦿ A patient suffers a low back injury that heals on its own. The patient isn't seeking intervention for the initial injury, but for the pain that persists long after. The chronic pain is sequela of the injury.
- ⦿ Such a visit may be reported as G89.21 *Chronic pain due to trauma* and S39.002S *Unspecified injury of muscle, fascia and tendon of lower back, sequela*.

Sequela Example

Neuroma associated with healed tibial fracture =

- ⦿ D36.13 (Neuroma) followed by
- ⦿ S82.221S (Displaced transverse fracture shaft of right tibia, sequela)

External Causes Codes

From CMS:

- Similar to ICD-9-CM, **there is no national requirement for mandatory ICD-10-CM external cause code reporting.** Unless you are subject to a State-based external cause code reporting mandate or these codes are required by a particular payer, you are not required to report ICD-10-CM codes found in Chapter 20 of the ICD-10-CM, External Causes of Morbidity. If you have not been reporting ICD-9-CM external cause codes, you will not be required to report ICD-10-CM codes found in Chapter 20 unless a new State or payer-based requirement about the reporting of these codes is instituted. If such a requirement is instituted, it would be independent of ICD-10-CM implementation. In the absence of a mandatory reporting requirement, you are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.
- “Pedestrian on roller skates injured in collision with railway train, whether traffic or non-traffic accident- V05.91”

Tools Developed in Epic

- We developed a DUHS Ortho Preference List that should include all relevant codes. This list will prevent the long search times of querying the entire database for each diagnosis code.
- We worked with Epic and IMO to expand the diagnosis calculator to include all pieces of information necessary for you to choose specified ICD-10 codes.
- Creation of Problem List custom preference lists.
- Creation of diagnosis speed buttons.

Prescribed Workflow

- As soon as you finish seeing patient:
- Go to Problem List
- “Completion match” to find base of ICD-10 code.
- Respond to calculator buttons, but do not choose healing status on injury codes
- Share problem to Diagnosis Section
- Answer any further calculator questions that arise- usually type of encounter and level of healing for injury codes
- Indicate the primary diagnosis:

P	
1.	 Sciatica of right side
2. 	 Bilateral sciatica
3.	 Trigger index finger of right hand

Problem List Calculator

- We do not want to choose Encounter type or healing under Problem List.

Preference List Search - Test, Cotton

frac hum shaft

Name	ICD-9-CM	ICD-10-CM
Displaced comminuted fracture of shaft of humerus	812.21	S42.353A
Displaced oblique fracture of shaft of humerus	812.21	S42.333A
Displaced segmental fracture of shaft of humerus	812.21	S42.363A
Displaced spiral fracture of shaft of humerus	812.21	S42.343A
Displaced transverse fracture of shaft of humerus	812.21	S42.323A
Greenstick fracture of shaft of humerus	812.21	S42.319A
Nondisplaced comminuted fracture of shaft of humerus	812.21	S42.356A
Nondisplaced oblique fracture of shaft of humerus	812.21	S42.336A
Nondisplaced segmental fracture of shaft of humerus	812.21	S42.366A
Nondisplaced spiral fracture of shaft of humerus	812.21	S42.346A
Nondisplaced transverse fracture of shaft of humerus	812.21	S42.326A

Select additional details:

Humerus Location:

Fracture type:

Fracture alignment:

Fracture morphology:

Salter-Harris Fracture Type:

Laterality:

Fracture healing:

Diagnosis Calculator

Hyperspace - NORTH CAROLINA ORTHOPAEDIC CLINIC - Release Testing (REL) environment - JOHN B.

Epic Anc Orders Patient Lists Schedule In Basket Workqueue List Telephone Call Refill Enc Chart Edit Template Patient Station Remind Me Reports Apts Dept App

Test, Cotton

Test, Cotton
Female, 47 y.o., 01/01/1968

MRN: D1359506 Primary Loc: None Allergies: **Unknown: Not on File** Ht: None FAMS: None Isolation: None Patient FYIs: N
CSN: 117263810 Primary CVG: 1005999... Code: Not on file Wt: None BPA: None Infection: None Pref Language:
HM Modifiers: HM Secondary CVG: 10021... **Health Maintenance** Dosing Wt: None Falls Risk: None Need Interp: N
Outside Info: None

8/19/2015 visit with Selene Gunvant Parekh, MD for Orders Only

Questionnaires Admin Benefits Inquiry Open Orders Care Teams Preview AVS Print AVS Media Manager Request Outside Records

Problem List

Add a new problem **+ Add**

Diagnosis

Unprioritized

- ▶ Closed stable burst fracture of fourth thoracic vertebra **+ Creat**
- ▶ Closed displaced comminuted fracture of shaft of left humerus **+ Creat**

Mark as Reviewed **Never Reviewed**

Close F9

Select a specific diagnosis.

Problem: Closed stable burst fracture of fourth thoracic vertebra

Calculator **List**

Encounter type:

Fracture healing:

Visit Diagnosis:

Accept Cancel

Visit Diagnoses

None

Medications & Orders

+ Create Medication List

Search for new order

Review open orders

No active orders.

Mark All Taking Mark as Reviewed Last Reviewed by Charmaine Mack on 10/2/2014 at 3:15 PM

Snapshot
Chart Review
Review Flowshe...
Results Review
Synopsis
Medications
Immunizations
Order Entry
Communications
Demographics
Flowsheets
Health Maintena...
Patient Station
Orders Only Enc...

Diagnosis Using Speed Buttons

Visit Diagnoses

Search for new item Previous

Common

P

1.
2.
3.
4.
5.

- Change diagnosis
- Add to Routine Dx preference list
- Add to Common Dx preference list
- Add to Common Dx button list

SmartSets

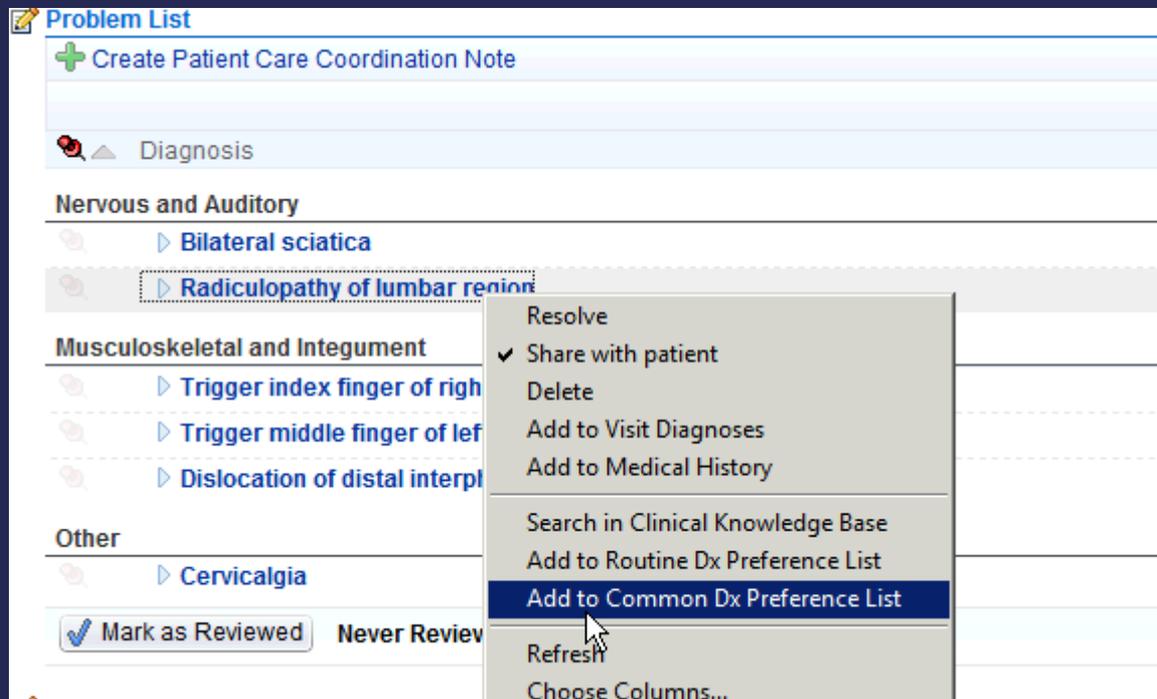
Search

Diagnoses - Edit Common

Diagnosis	Caption (Optional)
1 Sciatica of left side [M54.32]	
2 Sciatica of right side [M54.31]	
3 Bilateral sciatica [M54.31, M54.32]	
4 Midline low back pain without sciatica [M54.5]	
5	

Preference Lists

This can be used for common diagnosis codes, but will not work well for the fracture codes due to the amount of detail and number of potential choices. This can work well for M codes frequently used.



Preference List

Add to Common Diagnosis Preference List [X]

Diagnosis:

Group:

Section:

Physician Sign at close encounter

Problem List | **Preference List Browser - Test, Cotton**

Search: Browse (F4) Preference List (F5) Only Favorites (★)

Common DX	Common DX
↳ Musculoskeletal	Musculoskeletal (Common DX)
↳ Other	+★ Cervicalgia
↳ Routine DX	+★ Rupture of anterior cruciate ligament of left knee
	+★ Radiculopathy of lumbar region
	Other (Common DX)
	+★ Bilious vomiting with nausea
	+★ Osteoarthritis, unspecified whether generalized, unspecified
	Routine DX

Diagnosis Display in Epic

Visit Diagnoses click

P		ICD-9-CM	ICD-10-CM	
1.	Closed stable burst fracture of fourth thoracic vertebra, initial encounter	805.2	S22.041A	Change Dx
2.	Closed displaced comminuted fracture of shaft of left humerus, initial encounter	812.21	S42.352A	Change Dx

Medications & Orders click

Progress Notes (F3 to enlarge)

HPI

Exam

Assessment

		ICD-9-CM	ICD-10-CM	
1.	Closed stable burst fracture of fourth thoracic vertebra, initial encounter	805.2	S22.041A	
2.	Closed displaced comminuted fracture of shaft of left humerus, initial encounter	812.21	S42.352A	

Plan

Orthopaedic Coding Tools

- Ortho Booklets (Spine/UE/LE) will give you the codes for most common disease/conditions and the base code for injury codes, in case you want reference to make sure you are coding accurately or completion match fails.
- Ortho Flip Chart Booklets contain all sections above as well as Comorbidity. They will indicate the quickest way to get you to a specific code- whether by completion matching or entering a code.
- **Distribute tools and demonstrate how to reference them and use them with Diagnosis Calculator.**

Staff Using ICD-10 Codes

- ⦿ Problem list and Diagnosis sections on the Visit Navigator should be entered timely as staff will need to reference ICD-10 codes in your progress notes to:
 - ⦿ Post surgical cases
 - ⦿ Acquire authorizations
 - ⦿ Enter Orders
 - ⦿ Enter Charges
- ⦿ All managers and relevant staff have received ICD-10 training.

Charges- Associate ICD-10 Code

- When you are in **Charge Capture** posting a procedure (injection, casting etc), your CPT code should always indicate a side with LT or RT modifier or the specific finger FA-F9 or toe TA-T9 modifier (if applicable) It is important you associate the correct ICD-10 code with each charge in the Charge Capture section of the Visit Navigator.

Charge Capture (cont'd)

File Charges

Description ▲	Code	Dx	Service Date	Service Pr												
PR INJ SNGL TNDN/SHTH/LGMNT																
Service date:	8/19/2015	Department:	NORTH CAROLINA ORTHOPAEDI													
Place of service:	DUKE MEDICINE - OFFICE [100]	Service provider:	Attending Physician 2 Inpatient, I													
Billing provider:	Attending Physician 2 Inpatient, I	Referring provider:	Physician Assistant Inpatient [27]													
Quantity:	1															
Diagnosis:	<div style="display: flex; justify-content: space-between;"> All Diagnoses Visit Dx Non-hosp Prob List </div> <table border="1"> <thead> <tr> <th>Diagnosis</th> <th>Qualifier</th> </tr> </thead> <tbody> <tr> <td><input checked="" type="checkbox"/> Trigger index finger of right hand [M65.321 (ICD-10-CM)]</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Closed displaced comminuted fracture of shaft of left humerus, initial enc</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Closed stable burst fracture of fourth thoracic vertebra, initial encounter [S2</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Trigger middle finger of left hand [M65.332 (ICD-10-CM)]</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Trigger ring finger of left hand [M65.342 (ICD-10-CM)]</td> <td></td> </tr> </tbody> </table>				Diagnosis	Qualifier	<input checked="" type="checkbox"/> Trigger index finger of right hand [M65.321 (ICD-10-CM)]		<input type="checkbox"/> Closed displaced comminuted fracture of shaft of left humerus, initial enc		<input type="checkbox"/> Closed stable burst fracture of fourth thoracic vertebra, initial encounter [S2		<input type="checkbox"/> Trigger middle finger of left hand [M65.332 (ICD-10-CM)]		<input type="checkbox"/> Trigger ring finger of left hand [M65.342 (ICD-10-CM)]	
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Other diagnosis:																
▼ Additional Charge Details																
NDC:	<table border="1"> <thead> <tr> <th></th> <th>Code</th> <th>Admin Amt</th> <th>Units</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>					Code	Admin Amt	Units	1							
	Code	Admin Amt	Units													
1																
Modifiers:	RIGHT HAND, SECOND DIGIT [F6]	Start time:														
		End time:														
		Bill area:														

Open Case (Schedule Surgery)

- ⦿ Entering ICD-10 codes may bring up a calculator when typed in Case Request.
- ⦿ If you entered most “M” codes, you will simply be able highlight the accurate choice in the calculator pop-up, except for non-injury fractures.
- ⦿ If you Open a **Case Request** on a patient with an Injury Diagnosis, the 7th character of the diagnosis should be an “A” for initial encounter.

Documentation

- ⦿ The central challenge of the shift: documentation.
- ⦿ Regardless of how well physicians or their coders understand the new coding system, practices will not fare well on reimbursement unless their providers can document encounters in sufficient detail to support the new codes.

Documentation Guidelines

- ⦿ New patient HPI should have **detail** about how injury was sustained and place of occurrence (if applicable).
- ⦿ HPIs should have bullets about quality and timing of pain, along with alleviating and aggravating factors.
- ⦿ List the principal diagnosis first
- ⦿ When the diagnosis is inconclusive use terms such as “probable”, “suspected” and “rule out”.
- ⦿ Improve notes through appropriate use of “due to” and “manifested by” in relation to comorbidity codes.
- ⦿ Be very specific in describing radiologic and pathologic findings. (Saying a biopsy is positive or there is a fracture of the right femur does not meet documentation burden.)
- ⦿ Be very specific about details of all procedures performed.
- ⦿ Full diagnosis description and code should be added to all progress notes under Assessment.

ICD-10-PCS in the Hospital

- ⦿ Your surgical services are billed using the same ICD-10-CM codes used the clinic setting.
- ⦿ The hospital has to submit ICD-10-PCS procedural codes for inpatient surgeries to get paid. The coders in the hospital have to create these codes from documentation in your Op Notes.
- ⦿ If all data is not present, you will receive an In Basket Message requesting you modify your Op Note to include the missing data so the hospital can be paid.

ICD-10-PCS Codes for Inpatient

Character 1	Character 2	Character 3	Character 4	Character 5	Character 6	Character 7
Section	Body System	Root Operation	Body Region	Approach	Method	Qualifier

Ortho Body Systems

J	Subcutaneous Tissue/Fascia
K	Muscles
L	Tendons
M	Bursae and Ligaments
P	Upper Bones
Q	Lower Bones
R	Upper Joints
S	Lower Joints

Root Operations

Detachment
 Excision
 Fusion
 Insertion
 Inspection
 Reattachment
 Release
 Removal
 Repair
 Replacement
 Resection
 Revision
 Transfer

Approach

Open
 Percutaneous
 Percutaneous Endoscopic
 External

Op Note Documentation

- ⦿ Documentation from the operative report will be critical in the selection of the appropriate ICD-10-PCS code. In order to make a code assignment, the following will need to be included in physician documentation:
- ⦿ Body system upon which the affected body part belongs (musculoskeletal sub-section)
- ⦿ Type of operation- describe clinically the procedure performed to the extent necessary for a coder to accurately translate the clinical description of the procedure to the appropriate root operation (i.e., replacement, revision, repair etc.)
- ⦿ Specific part of the body and laterality where the procedure was performed (i.e., shaft of the right radius, third cervical vertebra)
- ⦿ The approach as referenced on prior slide.
- ⦿ The type of device (if any) that remains in the body upon completion of the procedure (i.e., grafts, implants, etc.) and a potential qualifier.