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Complete Healthcare Compliance Manual
Health Information Management: Coding with ICD-10 Clinical Modification (ICD-10-CM)

By Sonal Patel,[1] CPMA, CPC, CMC

What Is the ICD-10-CM?

Currently in the United States, certified medical coders abide by the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). ICD-10-CM was modified by the National Center for Health Statistics (NCHS) from the World Health Organization's (WHO) ICD-10 to report diagnoses for reimbursement purposes. Although WHO authorized the publication of ICD-10 for mortality coding and classification based on death certificates in the United States in 1999, it was not until October 1, 2015, that ICD-10-CM was implemented. In fact, it was the U.S. Department of Health and Human Services (HHS) that mandated all entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must transition to this new code set from ICD-9-CM for all electronic healthcare claims.[2]

To reflect ongoing changes in the medical field, ICD has, in fact, been revised over the years.[3] There have been numerous advancements and developments in U.S. healthcare since 1979 that have warranted increasing clinical accuracy, adding more codes, and revising code structure by expansion. Integral to our current clinical modification of ICD-10-CM is the notable differences in the quality of data reporting. For instance, there are expanded injury codes for tracking public health conditions; additions of sixth and seventh characters for greater specificity; laterality capability; and the creation of combination codes for better epidemiological research. Moreover, since the transition, the U.S. can finally compare morbidity diagnosis data at the international level, because many developed countries adopted ICD-10 code sets much earlier than the U.S. did. As an additional bonus, ICD-10-CM allows for further expansion.

Certified medical coders are prepared for new ICD-10-CM additions, deletions, and revisions on October 1 each year, as well as any periodic updates made throughout the year.

Characteristics of ICD-10-CM

ICD-10-CM is an exceptional representation of the best minds in medicine, epidemiology, and nosology. It captures current healthcare concepts and codes that reflect the breadth of modern medicine. Continuous involvement and maintenance are required by the Centers for Disease Control and Prevention (CDC). It is the CDC that approves of all code extensions, interpretations, modifications, addenda, or errata.[4]

The 2021 code book totals 1,360 pages and contains more than 70,000 codes. It includes the Tabular List, Alphabetic Index to Diseases and Injuries, Table of Neoplasms, Table of Drugs and Chemicals, and Index to External Causes of Injuries.

There are also ICD-10-CM official guidelines for coding and reporting that are issued by the CDC as an official accompaniment to the official version of the ICD-10-CM as published on the NCHS website.[5] Adherence to guidelines is a requirement under HIPAA; specifically, the diagnosis codes found in the Tabular List and

Alphabetic Index of the ICD-10-CM manual, have been adopted under HIPAA for all healthcare settings. The "ICD-10-CM Official Coding Guidelines for Coding and Reporting" always takes precedence over any and all other coding advice, including the American Health Association's, *Coding Clinic Advisor*.

The information is structured to assist the certified medical coder. There are 22 chapters, as well as three appendices that detail the diagnosis codes.

ICD-10-CM Guidelines

The guidelines are organized into four sections. Section I covers the structure and conventions of the classification; general guidelines that apply to the entire classification; and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification. Section II has guidelines for selection of principal diagnoses for non-outpatient settings. Section III contains guidelines for reporting additional diagnoses in non-outpatient settings. Section IV is highly detailed for outpatient coding and reporting. Certified coders must review all sections of the guidelines to fully understand all of the rules and instructions needed to code correctly and compliantly.

Certified medical coders must know these guidelines in order to understand and follow sequencing and specificity within the codes that change annually.

ICD-10-CM Structure

ICD-10-CM codes are composed of alphanumeric characters that describe the diagnosis, or signs and symptoms, and other conditions documented by the physician or other qualified healthcare professional in code format. There are seven characters in the code sequence. Character 1 is identified with capital letters A–Z. Characters 2 and 3 are captured with a numerals. Characters 4–6 are identified with either numerals or letters (capital or lowercase). And Character 7 is used only in specific chapters (which include Pregnancy, Musculoskeletal, Injuries, and External Causes of Morbidity) and is captured with either numerals or letters (capital or lowercase).

Documentation and ICD-10-CM Coding

Proper clinical documentation is critical for certified medical coders to correctly assign ICD-10-CM codes. After all, accurate, concise, and complete clinical documentation is central to reflecting patient care, as well as for coding and billing medical encounters. Unfortunately, many diseases, signs and symptoms, even conditions and injuries require specific and detailed documentation. This specific and detailed documentation is needed for compliance not only with the ICD-10-CM code structure, but also for compliance with capturing the highest level of specificity available within ICD-10-CM for accurate reporting and correct reimbursement.

Therefore, insufficient clinical documentation is one of the highest areas of risk due to the many inadvertent holes in documentation capture. Certified medical coders must abstract codes with less-than-acceptable accuracy, despite multiple queries from clinical documentation specialists. When this happens, the claim is billed despite an incomplete medical picture, and the inevitable denial or post-payment audit ensues.

There are areas of improvement that can be made to reduce compliance risks. First, continued education for certified medical coders and physicians alike is required. It is critical that both parties understand the myriad of documentation requirements, changes, and updates; support them all; and find mutual benefits. Second, certified medical coders, clinical documentation integrity specialists, and other health information management professionals should be allowed to communicate freely amongst one another and break down the silos that currently exist in healthcare. Once all of the instrumental players in the revenue cycle provide their insights, it will become evident that all have one identical goal: protecting the provider. Third, documentation

improvements can be made after developing an internal self-auditing and self-monitoring plan that isolates targeted areas of deficiencies. And finally, all three of these actions must be supported at the highest level within the organization. It is the compliance team that should spearhead the movement to see greater accuracy in medical documentation that is driven by medical necessity for each and every encounter. Inevitably, once documentation accuracy increases, the correct coding levels will increase accordingly.