ADDENDUM

Transition to ICD-10

OVERVIEW

On October 1, 2015, the U.S. health care system transitioned to the International Classification of Diseases, 10th Revision (ICD-10). This addendum provides an introduction to the ICD-10, which will become the standard for reporting diagnoses in all U.S. health care settings. Because U.S. health care facilities transitioned between ICD-9-CM and ICD-10-CM, it is helpful to look at the two side by side. That comparison will familiarize you with the new system and highlight the differences between the two.

The ICD coding and classification system is used worldwide. It is maintained by the World Health Organization (WHO), which updates it about every 10 years. The United States decided that ICD-10 needed to be modified before acceptance there. The result is a new system called ICD-10-CM/PCS. ICD-10-CM was developed by the Centers for Disease Control and Prevention (CDC) and will be used in all U.S. health care settings. ICD-10-PCS was developed by the Centers for Medicare and Medicaid Services (CMS) and will be used only in U.S. hospital settings.

Comparing ICD-9-CM and ICD-10-CM

The designated uses of the ICD-9-CM system included the following.

- Classifying morbidity (the number of cases of disease in a specific population and morbidity) and mortality (the incidence of death in a specific population)
- Indexing hospital records by disease and operations
- Reporting diagnoses by physicians
- Storing and retrieving data
- Reporting national morbidity and mortality data
- Serving as the basis of diagnosis-related group (DRG) assignment for hospital reimbursement
- Reporting and compiling health care data to assist in the evaluation of medical care planning for health care delivery systems
- Determining patterns of care among providers
- Analyzing payments for health services
- Conducting epidemiological and clinical research

Structure of ICD-9-CM

ICD-9-CM was made up of three volumes.

- Volume 1: Tabular List of Diseases and Injuries
- Volume 2: The Alphabetic Index to Diseases and Injuries
- Volume 3: The Classification for Procedures for Reporting Hospital Procedures
Table 5.1 describes what is in each volume.

### TABLE 5.1 Structure of ICD-9-CM

<table>
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<th>VOLUME 1: TABULAR LIST OF DISEASES AND INJURIES</th>
<th>VOLUME 2: ALPHABETIC INDEX TO DISEASES</th>
<th>VOLUME 3: CLASSIFICATION FOR PROCEDURES</th>
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<td>Index to diseases and injuries</td>
<td>Alphabetic index to procedures</td>
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In Volume 1, the chapters are divided into sections. Sections are groups of three-digit code numbers. For example, “290-294” is the disease classification for organic psychotic conditions.

Sections are subdivided into categories, a group of closely related conditions, or a single disease entity. For example, “290” is the specific category for senile and pre-senile organic psychotic conditions.

To get even more specific, you can go to the sub-category level of specificity, which is a four-digit code number (or sub-classification level), which is represented by five-digit code numbers. For example, “290.10” shows the following.

- Pre-senile dementia, uncomplicated
  - Pre-senile dementia
  - Not otherwise specified (NOS)
  - Simple type

There are two supplementary classifications in Volume 1: V codes and E codes. V codes are used to classify visits when circumstances other than disease or injury are the reason for the appointment. These circumstances include the following.

- When a person who is not currently sick goes to a health care professional for a specific reason, such as to act as an organ or tissue donor; to receive prophylactic vaccination; or to discuss a problem or issue, such as whether to get a certain vaccination.
- When a person goes to a health care professional for a specific treatment related to a known disease or injury. For example, a V code could be used when a patient seeks follow-up care for a previously applied cast.
- When a problem influences a person’s health status but is not a current injury or illness. For example, a patient makes an appointment to discuss her smoking habit.

V codes always begin with a V, followed by numbers. V15.04, allergy to seafood, is an example of a V code.

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**V codes.** Codes used to classify visits when circumstances other than disease or injury are the reason for the appointment. Specific to ICD-9-CM.

**E codes.** Codes used to classify environmental events, circumstances, and conditions, such as the cause of injury, poisoning, and other adverse events. Specific to ICD-9-CM.
E codes are used to classify environmental events, circumstances, and conditions, such as the cause of injury, poisoning, and other adverse events, as well as where it happened. E codes are important because they provide additional information to insurance companies, safety programs, and public health agencies. E codes begin with the letter E followed by four numbers and are always listed as the second code. The injury code must always be sequenced first as the primary diagnosis or first-listed code. For example, “E935.0” is used to describe an accident caused by an electric current in domestic wiring and appliances.

The final subdivision in Volume 1 is appendices. The following two are usually included.

- **Appendix A: Morphology of Neoplasms** identifies the type of neoplasm (tumor), whether its behavior is benign or in situ (has not spread to another area), and whether it is the primary or secondary tumor. Only used by pathologists and hospital tumor registry, not on claims submitted to third-party payers.
- **Appendix B: Classification of Drugs by American Hospital Formulary Service List Number** is used in a facility setting.

### Improvements in ICD-10-CM

It is expected that ICD-10-CM will improve the accuracy of coding, in part due to the following improvements.

- Provides more detailed clinical information, resulting in:
  - Improved ability to measure health care services, such as the addition of information relevant to ambulatory and managed care encounters.
  - Expanded injury codes.
  - Increased sensitivity when refining grouping and reimbursement methodologies.
  - Enhanced ability to conduct public health surveillance.
  - The creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition.
  - Decreased need to include supporting documentation with claims.
- Has updated medical terminology and classification of diseases.
- Has codes that allow comparison of mortality and morbidity.
- Better data for:
  - Measuring care given to patients.
  - Designing payment systems.
  - Processing claims.
  - Making clinical decisions.
  - Tracking public health.
  - Identifying fraud and abuse.
  - Conducting research.

According to the National Center of Health Statistics (NCHS), ICD-10-CM replaces Volumes 1 and 2 of ICD-9-CM. The new classification system does not include a procedure volume, which is why ICD-10-PCS was created.
Structure of ICD-10-CM

ICD-10-CM contains new chapters and categories, and the disease classification has been expanded to provide more specific information. The V and E codes have been incorporated into the main classification system. Now letters begin each numerical code.

Here’s a quick summary of the similarities and differences between ICD-9-CM and ICD-10-CM codes.

Similarities include the following.
- Both use three digits before the decimal point.
- Both include subcategory and subclassification codes after the decimal point. Together, the codes describe the clinical condition of a patient.

Differences for ICD-10-CM include the following.
- The codes provide more information.
- The first character is a letter, followed by digits.
- Characters three through seven can be numbers or letters.

To see how these differences play out, below are comparisons of the same condition, coded using ICD-9-CM and ICD-10-CM.

- ICD-9-CM code: 250.41
  - 250 = Diabetes mellitus
  - 250.4 = Diabetes with renal manifestations
  - 250.41 = Diabetes with renal manifestations, type 1, not stated as uncontrolled

When coded with the ICD-10-CM system, here’s what the same condition looks like.
- E10.2 = Type 1 diabetes mellitus with kidney complications
- E10.21 = Type 1 diabetes mellitus with diabetic nephropathy
  - Type 1 diabetes mellitus with intercapillary glomerulosclerosis
  - Type 1 diabetes mellitus with intracapillary glomerulonephritis
  - Type 1 diabetes mellitus with Kimmelstiel-Wilson disease

And there’s a second coding set for chronic kidney disease. Here’s how that looks.
- E10.22 = Type 1 diabetes mellitus with diabetic chronic kidney disease
  - Type 1 diabetes mellitus with chronic kidney disease due to conditions classified to 0.21 and 0.22
  - Use additional code to identify stage of chronic kidney disease (N18.1-N18.6)

For other kidney complications, this code should be used.
- E10.29 = Type 1 diabetes mellitus with other diabetic kidney complication
  - Type 1 diabetes mellitus with renal tubular degeneration
Procedure Codes

According to the NCHS, ICD-10-CM replaces Volumes 1 and 2 of ICD-9-CM. Because the new classification system does not include a procedure volume, CMS created new procedure codes, called ICD-10-PCS. The goals of the revision are the following.

- To improve accuracy and efficiency of coding
- To reduce training effort
- To improve communication with physicians.

Differences between ICD-9-CM, Volume 3 and ICD-10-PCS

ICD-9-CM, Volume 3, for facility coding procedures is made up of three to four digits, all of which are numbers. The decimal point is after the second digit.

For example, take the code 36.03.

- 36 = Operations on heart vessels
- 36.0 = Removal of coronary obstruction and insertion of stent(s)
- 36.03 = Open chest coronary artery angioplasty

ICD-10-PCS codes are made up of seven digits using numbers and 24 letters (A-H, J-N, and P-Z). The letters are not case-sensitive, and O and I are not used to avoid confusion with the numbers zero and one. No decimal points are used.

Procedures are divided into 16 sections related to whether it is a medical, surgical, imaging, or other kind of procedure. All procedure codes have seven characters. The first digit always corresponds to the section where the procedure is indexed. The second through seventh characters have specific meanings, which are identified below.

- 1 = Section of the ICD-10-PCS system where the code is indexed
- 2 = The body system
- 3 = Root operation, such as excision or incision
- 4 = Specific body part
- 5 = Approach used
- 6 = Device used to perform the procedure
- 7 = Qualifier to provide additional information about the procedure (diagnostic vs. therapeutic)

Here’s an example of an ICD-10-PCS code and how to interpret it.

Code: 097F7DZ

- Section: Medical and surgical 0
- Body system: Ear, nose, sinus 9
- Root operation: Dilation 7
- Body part: Eustachian tube, right F
- Approach: Via natural or artificial opening 7
- Device: Intraluminal (done with tubes) D
- Qualifier: No qualifier Z