Draffin & Tucker, LLP
CERTIFIED PUBLIC ACCOUNTANTS

IT'S ALL ABOUT YOU! – PART 2

Departmental Responsibilities for the Charge Description Master

The Charge Description Master

The CDM is an electronic file in the hospital's billing system

Department	CDM Code	CDM Description	Charge	Rev Code	M/CARE CP
400	4004545	AMPUTATION TOE	1,144.00	360	28810
400	4004546	AMPUTATION, TOE	865.00	360	28820
400	4006825	AMPUTATION,INTERPHAL	1,223.00	360	28825
400	4006885	ANORECTAL EXAM,SURGC	275.00	360	45990
400	4006610	ANOSCOPY W LES REMOV	518.00	360	46610
400	4004658	ANOSCOPY;DIAGNOSTIC	88.00	360	46600
400	4004544	ARTHROCLESIS;GREAT T	1,484.00	360	28750
400	4005100	BIOPSY ANORECTAL WLL	759.00	360	45100
400	4001910	BIOPSY BREAST	407.40	360	19100
400	4006816	BIOPSY BREAST PERCUT	187.00	360	19100
400	4001900	BIOPSY BREAST, ADDTL	77.00	360	19001
400	4005750	BIOPSY CERVIX SGL OR	362.00	360	57500

The CDM contains a comprehensive list of supplies and services with corresponding charges for each of those items.

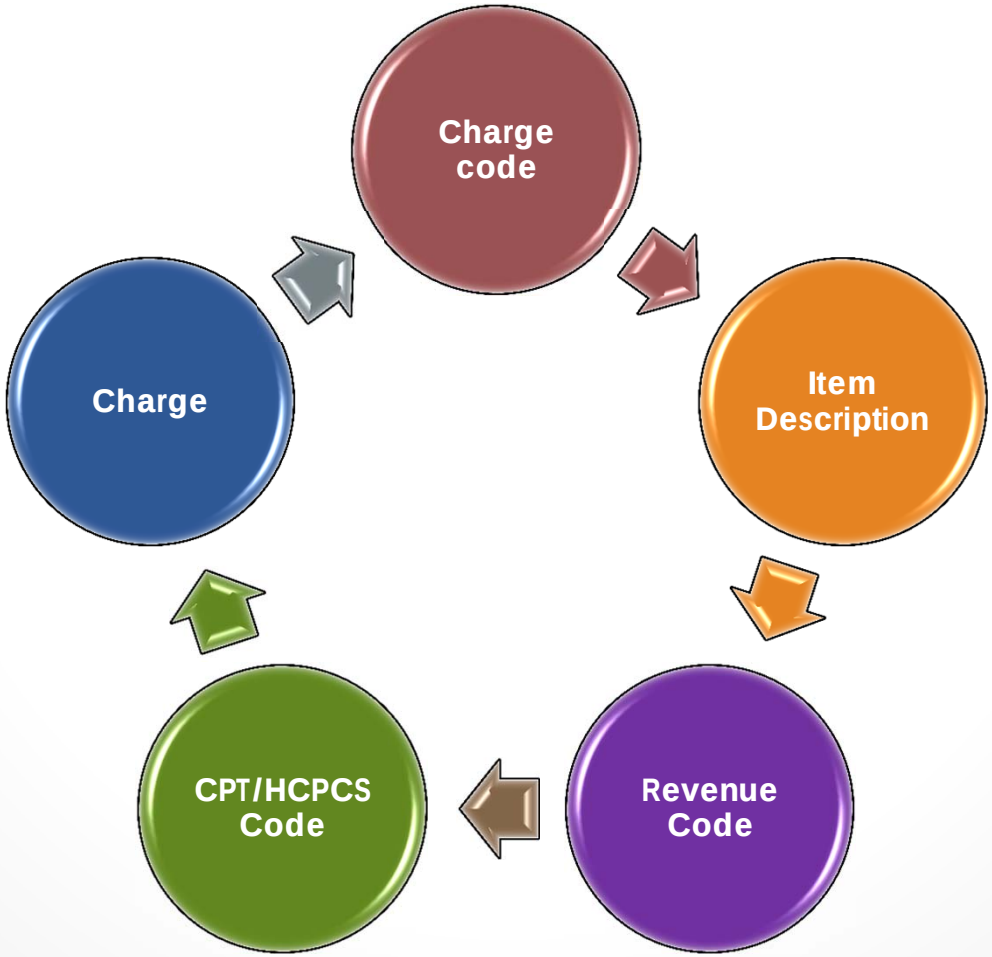
Items are grouped together by the departments and nursing units of the healthcare facility.

Does the size of your CDM matter?

No! The size of your CDM depends on the services provided by your hospital.

The purpose of a CDM is to accurately list every item and service your hospital provides for charging and statistical uses.

Elements of the CDM



Charge Code: Unique numerical identification of the service or supply.

Department	CDM Code	CDM Description	Charge	Rev Code	M/CARE CP
400	4004545	AMPUTATION TOE	1,144.00	360	28810
400	4004546	AMPUTATION, TOE	865.00	360	28820
400	4006825	AMPUTATION,INTERPHAL	1,223.00	360	28825
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400	4001900	BIOPSY BREAST, ADDTL	77.00	360	19001
400	4005750	BIOPSY CERVIX SGL OR	362.00	360	57500

Item Description: Actual name of the service or supply.

Department	CDM Code	CDM Description	Charge	Rev Code	M/CARE CP
400	4004545	AMPUTATION TOE	1,144.00	360	28810
400	4004546	AMPUTATION, TOE	865.00	360	28820
400	4006825	AMPUTATION,INTERPHAL	1,223.00	360	28825
400	4006885	ANORECTAL EXAM,SURGC	275.00	360	45990
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400	4001900	BIOPSY BREAST, ADDTL	77.00	360	19001
400	4005750	BIOPSY CERVIX SGL OR	362.00	360	57500

Descriptions should not be identical. They should accurately reflect each item, and should be easily recognizable to staff, especially those responsible for entering charges.

Department	CDM Code	CDM Description	Charge	Rev Code	M/CARE CP
400	4004545	AMPUTATION TOE	1,144.00	360	28810
400	4004546	AMPUTATION, TOE	865.00	360	28820
400	4006825	AMPUTATION,INTERPHAL	1,223.00	360	28825
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400	4001900	BIOPSY BREAST, ADDTL	77.00	360	19001
400	4005750	BIOPSY CERVIX SGL OR	362.00	360	57500

Revenue Code: Three-digit number used for Medicare billing.

Department	CDM Code	CDM Description	Charge	Rev Code	M/CARE CP
400	4004545	AMPUTATION TOE	1,144.00	360	28810
400	4004546	AMPUTATION, TOE	865.00	360	28820
400	4006825	AMPUTATION,INTERPHAL	1,223.00	360	28825
400	4006885	ANORECTAL EXAM,SURGC	275.00	360	45990
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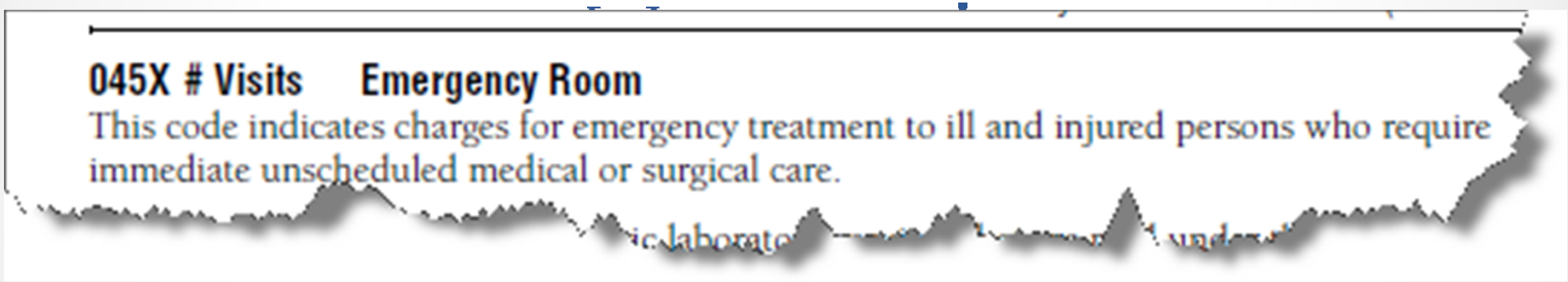
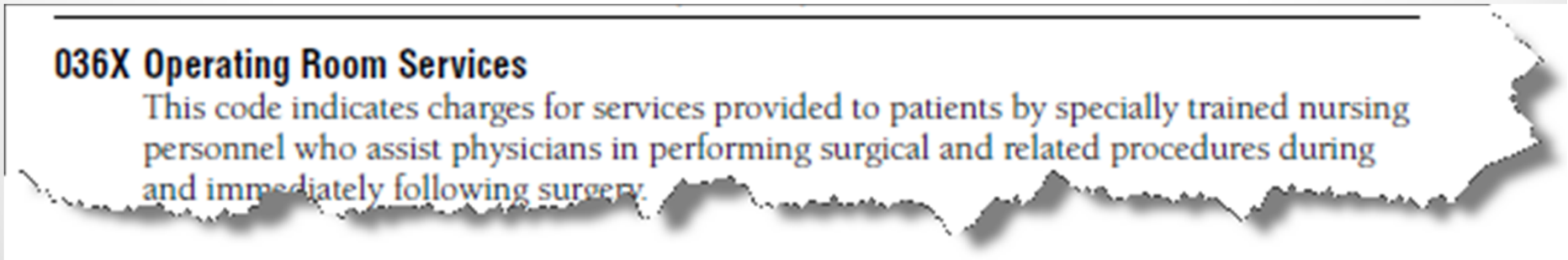
Revenue codes are listed in the Uniform Billing Editor



045X # Visits Emergency Room

This code indicates charges for emergency treatment to ill and injured persons who require immediate unscheduled medical or surgical care.



036X Operating Room Services

This code indicates charges for services provided to patients by specially trained nursing personnel who assist physicians in performing surgical and related procedures during and immediately following surgery.

Revenue codes appear on the patient's bill.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
250	PHARMACY			3	325 00		
270	MED-SUR SUPPLIES			5	137 50		
272	STERILE SUPPLY			1	50 00		
300	CKMB	82553	01/01/10	1	80 00		
300	TROPONIN	84484	01/01/10	1	120 00		
300	CPK	82550	01/02/10	1	40 00		
320	DX XRAY	74020	01/01/10	1	150 00		
450	EMERGENCY ROOM	99214	01/01/10	1	300 00		
637	SELF ADMINISTERED DRUGS			4	20 00	20 00	

Revenue codes tell a payer **WHERE** or in what department a services was provided to a patient.

CPT/HCPCS Code: Uniform numeric and alpha numeric codes used for Medicare billing.

Department	CDM Code	CDM Description	Charge	Rev Code	M/CARE CP
400	4004545	AMPUTATION TOE	1,144.00	360	28810
400	4004546	AMPUTATION, TOE	865.00	360	28820
400	4006825	AMPUTATION,INTERPHAL	1,223.00	360	28825
400	4006885	ANORECTAL EXAM,SURGC	275.00	360	45990
400	4006610	ANOSCOPY W LES REMOV	518.00	360	46610
400	4004658	ANOSCOPY;DIAGNOSTIC	88.00	360	46600
400	4004544	ARTHROCLESIS;GREAT T	1,484.00	360	28750
400	4005100	BIOPSY ANORECTAL WLL	759.00	360	45100
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400	4005750	BIOPSY CERVIX SGL OR	362.00	360	57500

OPPS hospitals are paid for outpatient services under a fee system called APCs (ambulatory payment classification).

APCs apply to OPPS hospitals only.

CPT/HCPCS codes are used to group services into APCs.

APCs are groups of services with similar clinical characteristics with similar costs based on the CPT/HCPCS codes assigned.

CPT/HCPCS codes drive outpatient APC reimbursement. If no CPT/HCPCS codes are reported, there is no separate payment to the APC hospital for the UB line item.

Different APC categories pay different amounts.

Verify service rendered is consistent with service reported.

Department	CDM Code	CDM Description	Charge	Rev Code	M/CARE CP
400	4004545	AMPUTATION TOE	1,144.00	360	28810
400	4004546	AMPUTATION, TOE	865.00	360	28820
400	4006825	AMPUTATION,INTERPHAL	1,223.00	360	28825
400	4006885	ANORECTAL EXAM,SURGC	275.00	360	45990
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400	4001900	BIOPSY BREAST, ADDTL	77.00	360	19001
400	4005750	BIOPSY CERVIX SGL OR	362.00	360	57500

Charge: Dollar amounts owed by patients to the facility for specific services or supplies.

Department	CDM Code	CDM Description	Charge	Rev Code	M/CARE CP
400	4004545	AMPUTATION TOE	1,144.00	360	28810
400	4004546	AMPUTATION, TOE	865.00	360	28820
400	4006825	AMPUTATION,INTERPHAL	1,223.00	360	28825
400	4006885	ANORECTAL EXAM,SURGC	275.00	360	45990
400	4006610	ANOSCOPY W LES REMOV	518.00	360	46610
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PPS and CAH CDMs are very similar, but the review is different.

The PPS CDM review should focus on areas unique to DRG and APC payments.

The CAH CDM focus will be on areas related to cost-based reimbursement.

However the compliance focus of the CDM review will be similar for both types of hospitals.

Common CDM “Hot Spots”

Revenue codes are required for Medicare billing in both CAH and PPS hospitals, and are uniformly used by all payers.

Revenue codes are usually "hard-coded" in the hospital charge master and are automatically assigned when a charge is entered.

Applies to CAH and PPS.

CMS uses a revenue code to cost center crosswalk to estimate the cost of services.

This data is then used to set future hospital outpatient Ambulatory Payment Classification (APC) payment rates.

If you are in a PPS type hospital, inaccurate revenue codes will negatively impact future DRG and APC payment rates but not current.

In a CAH, incorrect revenue codes can impact current payments.

In either case, it is extremely important to ensure that all hospital systems are working properly to assign the appropriate revenue code to the claim form.

But the major Medicare concern in the CAH CDM is the revenue codes.

Erroneous revenue codes are often encountered when supplies are charged by various ancillary departments.

In the CDM the supply charges may be directly assigned to the operating room department.

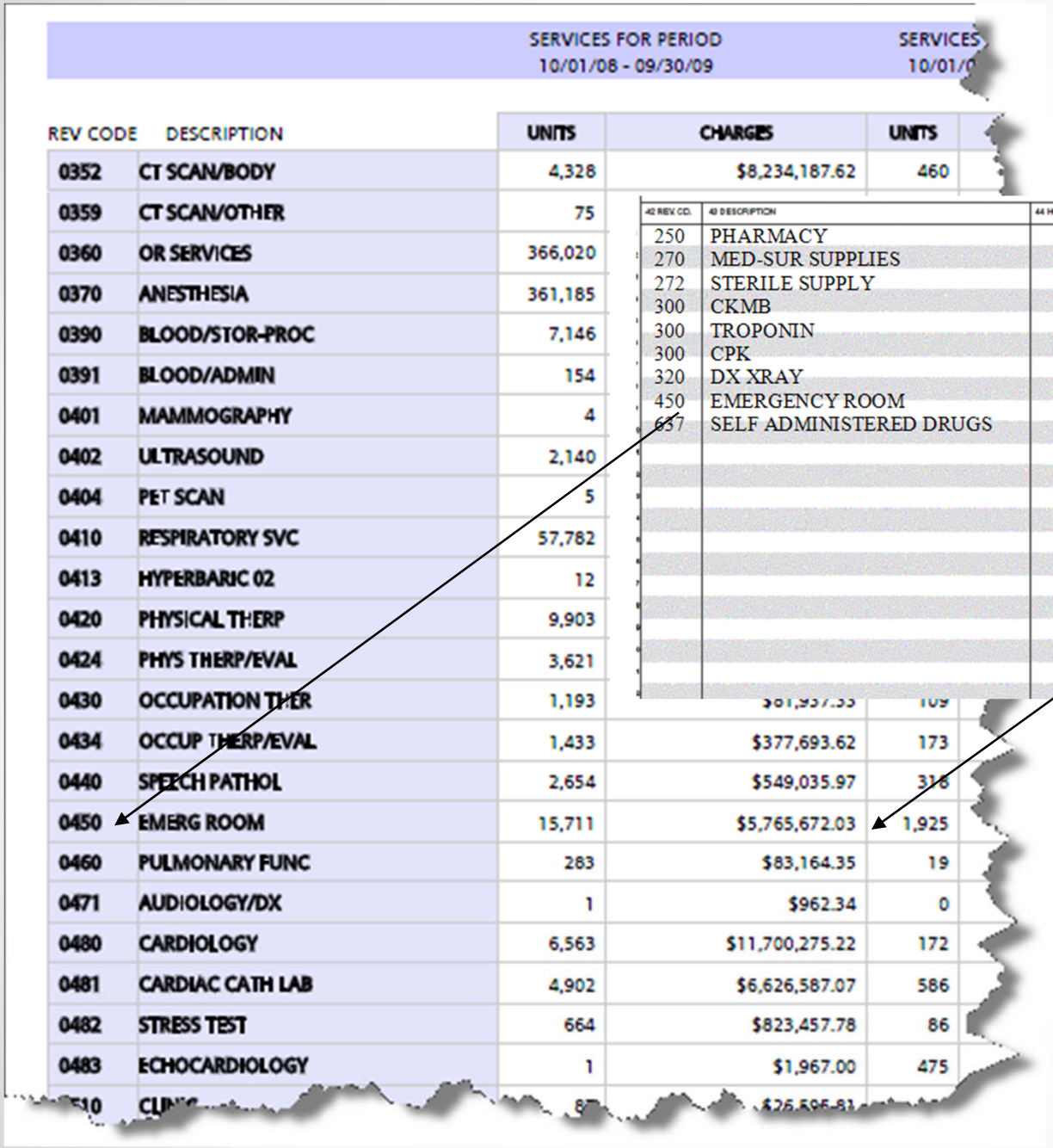
The operating room department will then receive credit for this revenue in the monthly financial reports.

However, this is erroneous. Even if the supply is used in the OR it should be assigned a supply revenue code of 270.

The revenue code will determine to which cost center (ER, operating room, physical therapy etc.) both the charges and costs will be assigned.

Revenue codes and charges from each Medicare are summarized into a special report.

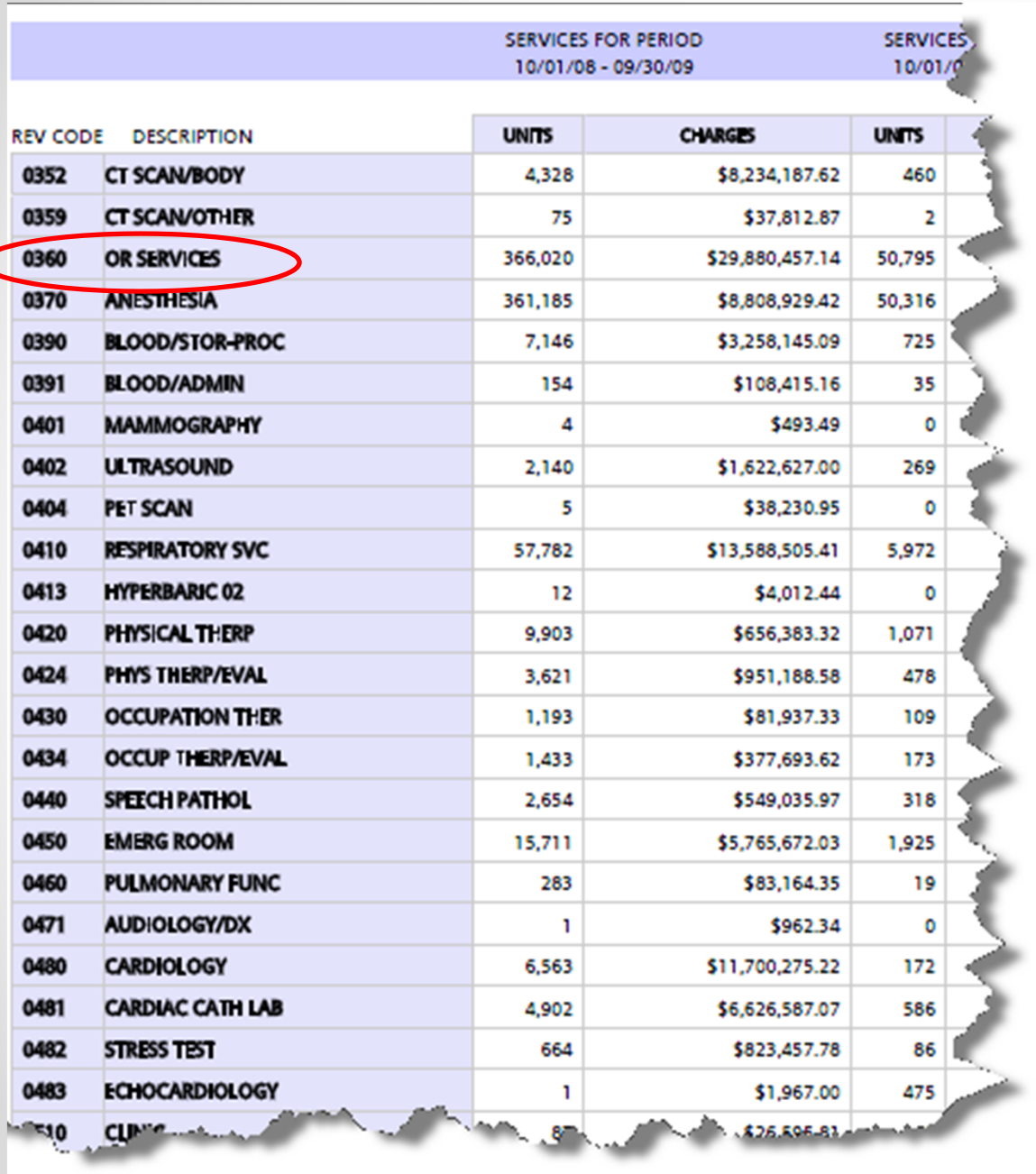
This summary report is called the Provider Statistical and Reimbursement (PS&R) report.



		SERVICES FOR PERIOD 10/01/08 - 09/30/09		SERVICES 10/01/0	
REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS	
0352	CT SCAN/BODY	4,328	$8,234,187.62	460	
0359	CT SCAN/OTHER	75			
0360	OR SERVICES	366,020			
0370	ANESTHESIA	361,185			
0390	BLOOD/STOR-PROC	7,146			
0391	BLOOD/ADMIN	154			
0401	MAMMOGRAPHY	4			
0402	ULTRASOUND	2,140			
0404	PET SCAN	5			
0410	RESPIRATORY SVC	57,782			
0413	HYPERBARIC 02	12			
0420	PHYSICAL THERP	9,903			
0424	PHYS THERP/EVAL	3,621			
0430	OCCUPATION THER	1,193		109	
0434	OCCUP THERP/EVAL	1,433	$377,693.62	173	
0440	SPEECH PATHOL	2,654	$549,035.97	316	
0450	EMERG ROOM	15,711	$5,765,672.03	1,925	
0460	PULMONARY FUNC	283	$83,164.35	19	
0471	AUDIOLOGY/DX	1	$962.34	0	
0480	CARDIOLOGY	6,563	$11,700,275.22	172	
0481	CARDIAC CATH LAB	4,902	$6,626,587.07	586	
0482	STRESS TEST	664	$823,457.78	86	
0483	ECHOCARDIOLOGY	1	$1,967.00	475	
510	CLINIC	87	$26,595.81		

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
250	PHARMACY			3	325 00
270	MED-SUR SUPPLIES			5	137 50
272	STERILE SUPPLY			1	50 00
300	CKMB	82553	01/01/10	1	80 00
300	TROPONIN	84484	01/01/10	1	120 00
300	CPK	82550	01/02/10	1	40 00
320	DX XRAY	74020	01/01/10	1	150 00
450	EMERGENCY ROOM	99214	01/01/10	1	300 00
637	SELF ADMINISTERED DRUGS			4	20 00

The PS&R is a summary of the UB-04s.



		SERVICES FOR PERIOD 10/01/08 - 09/30/09		SERVICES 10/01/0
REV CODE	DESCRIPTION	UNITS	CHARGES	UNITS
0352	CT SCAN/BODY	4,328	$8,234,187.62	460
0359	CT SCAN/OTHER	75	$37,812.87	2
0360	OR SERVICES	366,020	$29,880,457.14	50,795
0370	ANESTHESIA	361,185	$8,808,929.42	50,316
0390	BLOOD/STOR-PROC	7,146	$3,258,145.09	725
0391	BLOOD/ADMIN	154	$108,415.16	35
0401	MAMMOGRAPHY	4	$493.49	0
0402	ULTRASOUND	2,140	$1,622,627.00	269
0404	PET SCAN	5	$38,230.95	0
0410	RESPIRATORY SVC	57,782	$13,588,505.41	5,972
0413	HYPERBARIC 02	12	$4,012.44	0
0420	PHYSICAL THERP	9,903	$656,383.32	1,071
0424	PHYS THERP/EVAL	3,621	$951,188.58	478
0430	OCCUPATION THER	1,193	$81,937.33	109
0434	OCCUP THERP/EVAL	1,433	$377,693.62	173
0440	SPEECH PATHOL	2,654	$549,035.97	318
0450	EMERG ROOM	15,711	$5,765,672.03	1,925
0460	PULMONARY FUNC	283	$83,164.35	19
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0482	STRESS TEST	664	$823,457.78	86
0483	ECHOCARDIOLOGY	1	$1,967.00	475
510	CLIN	8	$26,595.81	

Medicare "assumes" if a **charge** is billed with certain revenue code that this code also represents where the related **costs** are reported.

Just remember, in a CAH revenue code assignment in the CDM is very important!

Certain revenue codes indicate that payment should not be made.

Applies to CAH and PPS.

637 – Self-administered drugs are non-covered by Medicare

42 REV CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
250	PHARMACY			3	325 00	
450	EMERGENCY ROOM	99214	01/01/10	1	300 00	
637	SELF ADMINISTERED DRUGS			4	20 00	20 00

Bill as “non-covered” charges on UB-4 claim form.

Applies to CAH and PPS.

Non-covered charges with incorrect revenue codes may result in accusations of fraud and abuse.

Billing self-administered drugs as covered will result in Medicare overpayments. This applies to outpatient areas such as ED and observation.

Applies to CAH and PPS.

Incorrect assignment of CPT/HCPCS codes is a common CDM hot spot in PPS hospitals.

CPT is the abbreviation for Current Procedural Terminology.

CPT codes are numbers assigned to specific services or procedures a medical practitioner (and hospitals) may provide to a patient.

Most CPT/HCPCS codes have a payment assigned to them.

CPT/HCPCS codes play an important role in outpatient reimbursement for OPPS (non-CAH) hospitals.

OPPS hospitals are paid for outpatient services under a fee system called APCs (ambulatory payment classification).

APCs apply to OPPS hospitals only.

CPT/HCPCS codes are conditional for Medicare billing.

Conditional means that not every service rendered will be identified by a HCPCS code, but if there is a code available it should be reported.

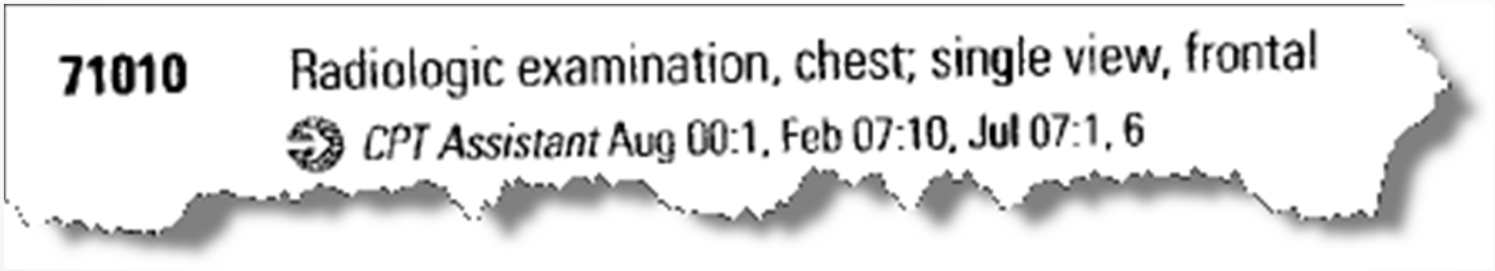
CPT/HCPCS codes should be reported in a CAH for non-Medicare payers.

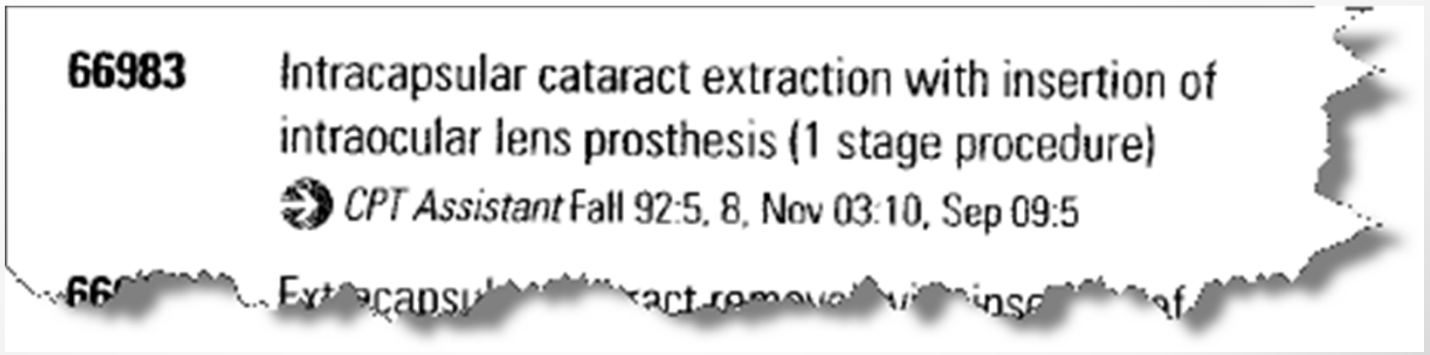
CPT/HCPCS should always be reported, when available, in a OPPS hospital.

Wrong CPT/HCPCS codes can mean the wrong payment.

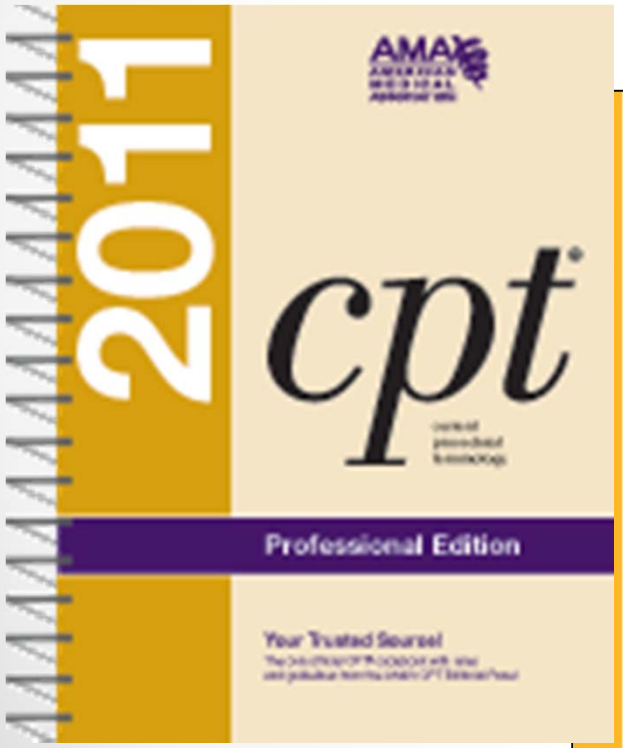
If there is not a code on your claims when a code exists, you will not be paid for services.

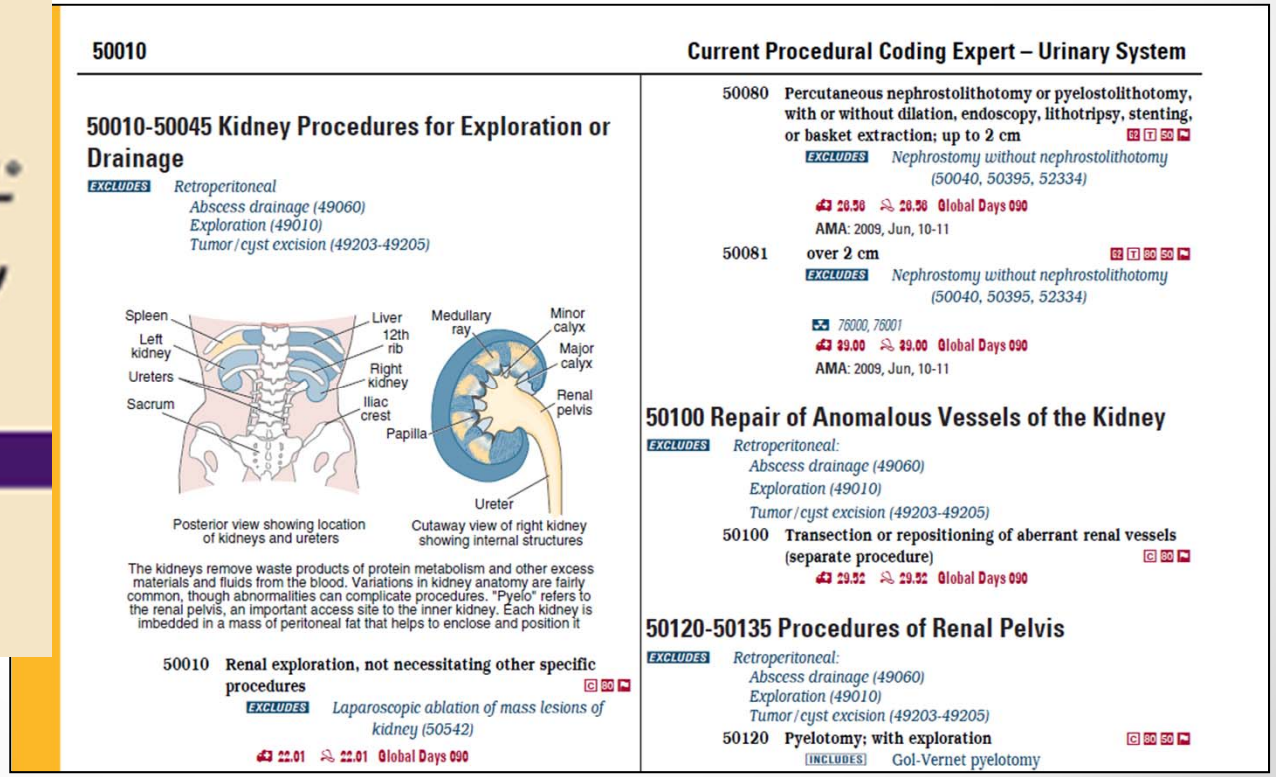
Since everyone uses the same codes to mean the same thing, they ensure uniformity.





CPT codes are published annually by the American Medical Association.





50010 Current Procedural Coding Expert – Urinary System

50010-50045 Kidney Procedures for Exploration or Drainage

EXCLUDES *Retroperitoneal*
Abscess drainage (49060)
Exploration (49010)
Tumor/cyst excision (49203-49205)

The kidneys remove waste products of protein metabolism and other excess materials and fluids from the blood. Variations in kidney anatomy are fairly common, though abnormalities can complicate procedures. "Pyelo" refers to the renal pelvis, an important access site to the inner kidney. Each kidney is imbedded in a mass of peritoneal fat that helps to enclose and position it

50010 **Renal exploration, not necessitating other specific procedures** C 80
EXCLUDES *Laparoscopic ablation of mass lesions of kidney (50542)*
22.01 22.01 Global Days 090

50080 **Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm** 62 T 50
EXCLUDES *Nephrostomy without nephrostolithotomy (50040, 50395, 52334)*
26.50 26.50 Global Days 090
AMA: 2009, Jun, 10-11

50081 **over 2 cm** 62 T 50
EXCLUDES *Nephrostomy without nephrostolithotomy (50040, 50395, 52334)*
76000, 76001
39.00 39.00 Global Days 090
AMA: 2009, Jun, 10-11

50100 Repair of Anomalous Vessels of the Kidney

EXCLUDES *Retroperitoneal:*
Abscess drainage (49060)
Exploration (49010)
Tumor/cyst excision (49203-49205)

50100 **Transection or repositioning of aberrant renal vessels (separate procedure)** C 80
29.52 29.52 Global Days 090

50120-50135 Procedures of Renal Pelvis

EXCLUDES *Retroperitoneal:*
Abscess drainage (49060)
Exploration (49010)
Tumor/cyst excision (49203-49205)

50120 **Pyelotomy; with exploration** C 80 50
INCLUDES Gol-Vernet pyelotomy

CPT codes change often throughout the year.

Deleted or expired CPT codes often remain in CDMs which can affect payments in a PPS hospital.

Department managers should review the CDM section related to his/her area often to ensure that necessary revisions are made.

So for PPS hospitals, accurate CPT/HCPCS codes are the main concern in a CDM review. If the CPT/HCPCS code is wrong, the payment is wrong.

There are some services in the CAH that continue to be paid under a fee schedule.

There may also be other payers (commercial, managed care etc.) that use CPT/HCPCS codes for paying the CAH.

For these reasons, the CAH CDM review should also focus on accurate CPT/HCPCS codes.

Hospitals and physicians both electronically submit data using CPT codes. However in a hospital, all services provided are not assigned CPT codes.

For example, most supply items used in a CAH hospital do not have a CPT code assigned. Typically CPT codes are used to describe procedures or visits.

Healthcare Common Procedure Coding System (HCPCS)

HCPCS Level II codes are a set of standardized alphanumeric codes that describe health care equipment and supplies that are not identified by CPT codes.

Ambulance services

Drugs

Durable Medical Equipment

Prosthetics

Orthotics

(DMEPOS)

HCPCS codes do not determine coverage or payment in neither a CAH or OPPS hospital.

Payment and coverage are determined by individual payers.

Since there are fixed payments assigned to some HCPCS codes, OPPS hospitals should assign these codes, when available.

HCPCS “J” codes related to drugs should be assigned by both OPPS and CAH hospitals.

Inaccurate HCPCS/CPT codes can result in erroneous payments for those items that may be paid under a fixed payment system (i.e. APC, lab fee schedule).

Missing HCPCS/CPT code will result in zero payments for items paid using a fixed payment system (APC, lab fee schedule).

Oftentimes CDM items that are no longer used remain in the CDM and only serve to “clutter” the CDM.

Items no longer used are not reviewed or updated for revenue code or CPT/HCPCS coding changes.

If someone decides to reactivate such an item, there is the possibility that the codes will be erroneous which can result in payment errors.

Duplicate billing is a common CDM hot spot.

Duplicate billing is especially common when hospital staff are answering a cardiac arrest code.

Since staff from multiple departments are responding to such codes, it may be unclear as to who is responsible for entering related charges.

In these cases, there is the potential for duplicate charging, or possibly missing charges.

There should be a clear understanding when developing “code response” charges in the CDM as to whose responsibility it will be to enter the charge.

Duplicated charge codes often lead to an increase in the size of and number of line items in a CDM.

Duplicated charge codes for a service or supply can often distort inventory/usage statistics.

No charge in CDM for service provided will result in lost charges and under payments.

Errors are often made related to the number of units billed for a service.

For example, only one blood administration charge can be billed to Medicare for the same date of service regardless of the number of units of blood transfused.

The CDM description for blood administration should clearly indicate this is a per day charge.

Oftentimes there is confusion related to the appropriate billing of drugs.

The HCPCS code descriptions are very specific as to the dosage of the drug.

Missing or inaccurate drug dosages in pharmaceutical description can lead to erroneous charges.

If the dosage of the facility's stocked drug is different from the HCPCS code dosage, over billing and under billing can occur.

Lack of understanding of CDM item description and CPT/HCPCS descriptions can lead to charging errors which can result in over billing or under billing.

Computer systems are often limited by the number of characters you can use to describe a CDM item.

The item description should closely match the CPT/HCPCS code description and be easily recognizable by staff as the service they rendered.

Item descriptions should be reviewed periodically to ensure they accurately describe the service delivered.

Use of “miscellaneous” charge codes should be kept to a minimum.

Use of miscellaneous-type charge codes may cause payments to be delayed or denied.

Inconsistent pricing between departments for “like” items should be kept to a minimum.

Third-party administrators frequently audit pricing inconsistencies and may deny payment.

Charges too low or too high?

Critical Access Hospitals (CAH) are paid based on a percentage of charges.

If charges are too low, this may result in lost of reimbursement for CAHs.

In a CAH, patient co-pays are based on the hospital charges.

If charges are increased in a CAH, this will increase the amount a patient will owe.

PPS hospitals are paid by Medicare using DRGs and APCs.

DRGs pay a flat dollar amount dependent upon a inpatient's illness or procedure.

APCs pay a flat dollar amount dependent upon an outpatient service or procedure.

Managed care contracts may also use

PPS hospitals should ensure outpatient charges are set at least to the fee schedule amounts.

Monitor CMS, MAC/FI, and Medicaid websites for coding and billing updates

When making decisions regarding pricing changes, hospitals should first analyze the financial impact!

Inaccurate charging documents can lead to inaccurate payments.

Verify a 1:1 relationship between the CDM and the charge form or electronic charge entry.

Hospitals should appoint a chargemaster coordinator or charge master team, to oversee the design and maintenance of the charge master.

Department managers from all revenue-producing departments should be involved with maintaining their departments' charge master.

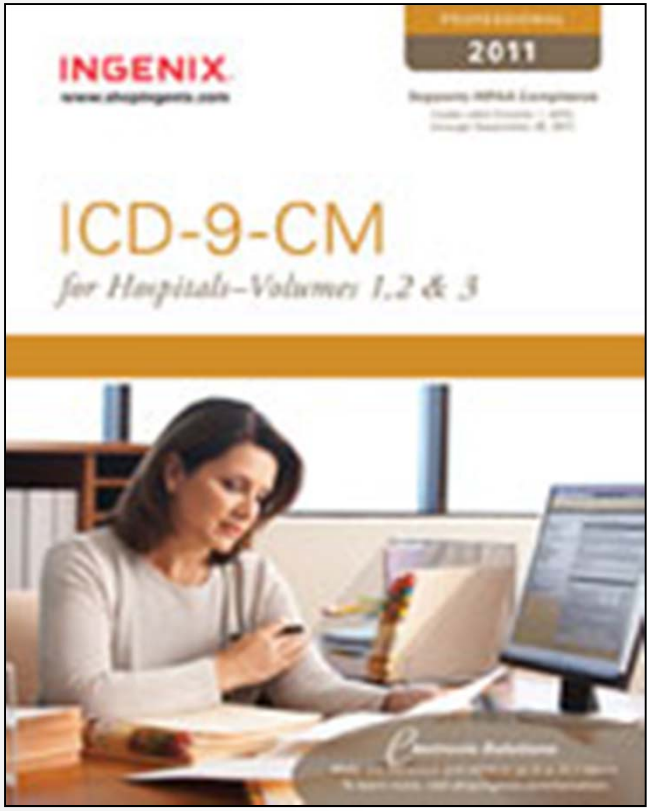
In summary, update the CDM annually.

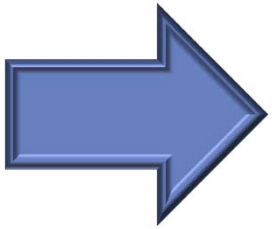
Review for BOTH compliance and reimbursement issues.

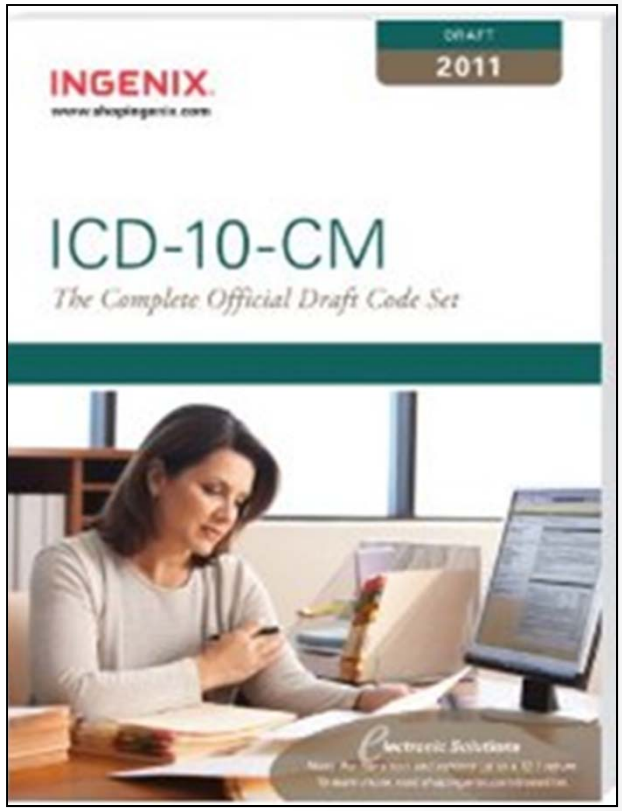
Continuously monitor the CMS, MAC/FI, and Medicaid websites for coding and other changes that may occur during the year.

Staff should analyze the financial impact related to changes that have been made in the charge master.

The future of coding







TODAY

OCTOBER 1, 2013

Preparation is the key!
Will you be ready?

Volumes 1 & 2 (diagnosis codes) applies to ALL settings.

Volume 3 (procedure codes) applies to inpatient hospital only.

ICD-9-CM diagnosis codes are required under HIPAA for uniform claim submission.

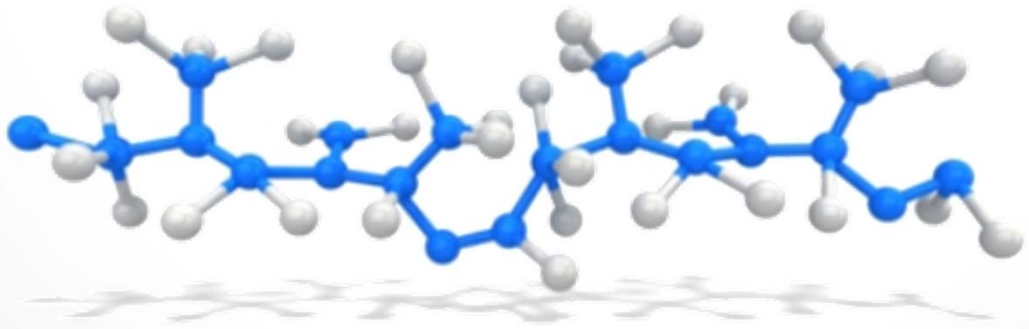
ICD-9 was developed in the 1970's and no longer fits our 21st century health care system.

The United States is one of the few industrial nations that has not upgraded its coding system to ICD-10.

ICD-9 is obsolete and does not reflect current disease processes, today's medical terminology, or the modern practice of medicine.

ICD-9 lacks the precision needed for a number of emerging uses such as value-based purchasing and bio-surveillance.

ICD-9 does not have the specificity and detail needed to identify all procedures.



ICD-9 does not use consistent terminology and lacks codes for preventive services.

ICD-9 is running out of space and its design cannot accommodate the fast paced advances in medicine.

Replacing ICD-9 with ICD-10 will provide clinical data that will be comparable to the rest of the world.

Diagnosis code set changes from ICD-9-CM (Vol. 1 & 2) to ICD-10-CM (all settings).

Hospital inpatient procedure code set changes from ICD-9-CM (Vol. 3) to ICD-10-PCS.

ICD-9-CM

- 3 - 5 digits or characters
- 1st character is numeric or alpha (E or V codes)
- 2nd – 5th characters are numeric
- Decimal placed after the first 3 characters
- 17 Chapters and V & E codes are ‘supplemental’

ICD-10-CM

- 3 - 7 digits or characters
- 1st character is alpha (all letters used except “U”)
- 2nd – 7th characters can be alpha or numeric
- Decimal placed after the first 3 characters
- 21 Chapters and V & E codes are ‘not’ supplemental

ICD - 9 – CM Diagnosis Codes

Approximately 14,000 codes

ICD - 10 – CM Diagnosis Codes

Approximately 69,000 codes

Why so many diagnosis codes?

To provide greater specificity and detail

34,250 (50%)
of all ICD-10-CM
codes are related to the
musculoskeletal system

17,045 (25%) of all ICD-10-CM codes are related to fractures

10,582 (62%) of fracture codes to distinguish ‘right’ vs. ‘left’

25,000 (36%)
of all ICD-10-CM codes
to distinguish
‘right’ vs. ‘left’

ICD-10-CM Structure Format

Category

Etiology
Anatomic site
Severity

Extension

S72 031 A Displaced mid-cervical fracture of right femur, initial encounter for closed fracture

New to ICD-10-CM

Injuries are grouped by anatomic site rather than by type of injury.

New to ICD-10-CM

Diseases of the sense organs (eyes & ears) have their own chapters, no longer part of Nervous System chapter.

New to ICD-10-CM

Inclusion of trimesters in obstetric codes (and elimination of 5th digits for episode of care)

New to ICD-10-CM

Change in timeframes specified in certain codes

New to ICD-10-CM

Acute myocardial infarction – time period changed from 8 weeks to 4 weeks.

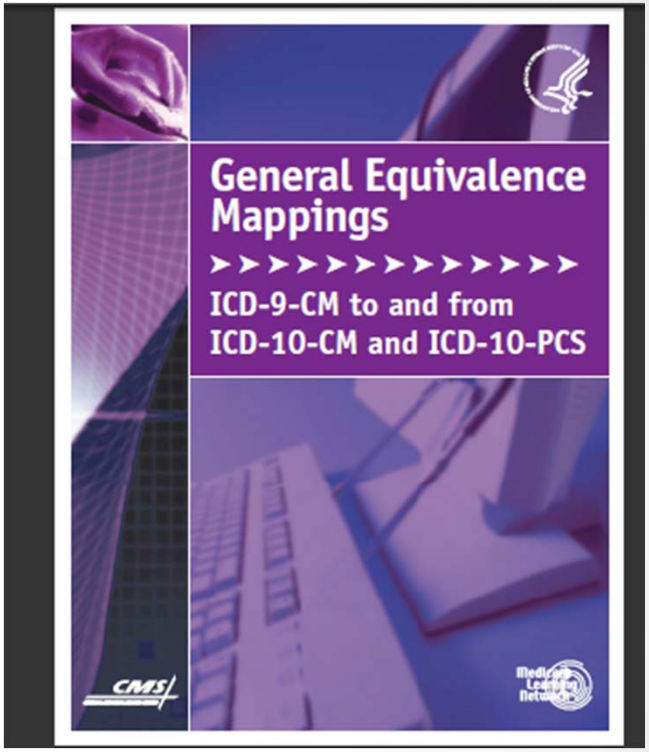
New to ICD-10-CM

Full code titles for ALL codes (no reference back to common fourth and fifth digits).

New to ICD-10-CM

Post-op complications have been moved to procedure specific body system chapters.

CMS has provided resources to aid in the transition. However there is not a one-to-one match for many ICD-9 codes.



http://www.cms.gov/ICD10/Downloads/ICD10GEMSFactSheet20100617.pdf

ICD-9 to ICD-10

82002 Fracture of midcervical section of femur, closed

1. 

Displaced mid-cervical fracture of right femur, initial encounter for closed fracture
2. **S72031G** Displaced mid-cervical fracture of right femur, subsequent encounter for closed fracture with delayed healing
3. **S72032A** Displaced mid-cervical fracture of left femur, initial encounter for closed fracture
4. **S72032G** Displaced mid-cervical fracture of left femur, subsequent encounter for closed fracture with delayed healing

ICD-9 to ICD-10

1. **25050** Diabetes with ophthalmic manifestations, type ll or specified type, not stated as uncontrolled
2. **36206** Severe non-proliferative diabetic retinopathy
3. **36207** Diabetic macular edema

E11341 Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema

ICD-9-CM (Volume 3) (Procedures)

- Min. characters: 3
- Max. characters: 4
- Numeric format (+ V code)
- Decimal point

ICD-10-PCS (Procedures)

- Min. characters: 7
- Max. characters: 7
- Alphanumeric format
- No decimal point

ICD-9-CM Procedure Codes

Approximately 3,800 codes

ICD-10-PCS Procedure Codes

Approximately 73,000 codes

ICD-10-PCS Structure Format

Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier

ICD-9-CM

Laparoscopic salpingo-oophorectomy, bilateral

Laparoscopic removal of both ovaries and tubes at same operative session

ICD-10-PCS Equivalent

Resection of bilateral ovaries, percutaneous endoscopic approach

Resection of bilateral fallopian tubes, percutaneous endoscopic approach

In summary, there are some significant changes and challenges ahead related to charging and billing in hospitals.

It will be important to track these changes to ensure that staff are trained to adapt to these changes.

What have we learned?