ICD-10 and Quality Measures

Frequently Asked Questions

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General Information

1. Where can I find general ICD-10 information?

   The main ICD-10 web page with general ICD-10 information is located on the CMS website at: https://www.cms.gov/medicare/coding/icd10/index.html. This website provides the most current information related to ICD-10.

2. Where is more detailed information regarding the CMS Quality Measures by program?

   For further information on the CMS Quality Measures by program, see the CMS Quality Measures web page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/index.html?redirect=/qualitymeasures/03_electronicspecifications.asp. This web page also contains links to other important Quality Measure Resources. Other Quality Measure program information can be found on the *QualityNet* website: https://www.qualitynet.org.

Medicare Spending Per Beneficiary (MSPB) Measures

3. How will ICD-10 affect the MSPB measures?

   The MSPB measures assess payments for services provided to a Medicare beneficiary during an MSPB episode, which spans from three days prior to an inpatient hospital admission to 30 days after discharge. An MSPB episode includes payments made by Medicare and the beneficiary (i.e., allowed charges) that are price-standardized for geographic payment differences and risk-adjusted for age and severity of beneficiary illness.

   The hospital MSPB measure was finalized in the FY 2012 Inpatient Prospective Payment System (IPPS) Final Rule for use in the Hospital Inpatient Quality Reporting (IQR) Program. The hospital MSPB measure was also finalized in the FY 2013 IPPS Final Rule for use in the efficiency and cost reduction domain of the Hospital Value-Based Purchasing (VBP) Program. For more information about the hospital MSPB measure and resources, including detailed measure calculation methodology, see the MSPB page on the *QualityNet* website: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772053996.

   The physician MSPB measure, or MSPB-TIN (Taxpayer Identification Number), was finalized for use in the Physician Value-Based Payment Modifier (VM) program in the CY 2014 Physician Fee Schedule Final Rule. The MSPB-TIN measure has also been included in Quality Resource Use and Reports (QRURs) physician feedback reports. More information on the VM program and QRURs can be found on this CMS webpage.

   The impact of the transition to ICD-10 codes on the MSPB measures is minimal. The only update in 2016 was to the MSPB risk adjustment model, which broadly follows a newer version of the CMS-Hierarchical Condition Category (HCC) risk adjustment methodology used in the Medicare Advantage program.

   The MSPB risk adjustment model uses the HCCs specified in the CMS-HCC risk adjustment model. The HCCs, which are mapped from ICD codes, were calculated using the HCC Version 22 (V22) model posted on this CMS webpage. The HCC V22 model includes

programming code that first maps ICD-9 codes to condition categories (CCs) and ICD-10 codes to CCs before mapping the CCs to HCCs. The HCC V22 risk adjustment model was used in the MSPB calculations or the 2016 Hospital Specific Reports and the 2015 Annual QRURs, which were calculated using January – December 2015 claims data. Below is a list of the versions of the HCC V22 model that were used in MSPB calculations:

- 2015 HCC V22 model to calculate CCs for claims billed in 2014 that are included in the MSPB calculation
- 2016 HCC V22 model to calculate CCs for claims billed in 2015 that are included in the MSPB calculation
- 2017 HCC V22 model to calculate CCs for claims billed in 2016 that are included in the MSPB calculation

The 2015 and 2016 HCC V22 model can be found on this CMS download page.

Skilled Nursing Facility 30- Day All-Cause Readmission Measure

4. How will ICD-10 impact the Skilled Nursing Facility 30-Day All-Cause Readmission Measure?

The Skilled Nursing Facility Readmission Measure (SNFRM) is an NQF-endorsed (#2510) measure adopted for the Skilled Nursing Facility Value-Based Purchasing Program. The SNFRM estimates the risk-standardized readmission rate of all-cause, unplanned hospital readmissions for SNF Medicare fee-for-service beneficiaries within 30 days of discharge from their prior proximal short-stay acute hospital discharge.

The SNFRM was developed using diagnosis codes and procedure codes from ICD-9-CM. This measure uses diagnosis codes for identifying planned readmissions and for risk adjustment. More information on the measure methodology for planned readmissions can be found on the CMS Methodology page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html. The individual codes that comprise each diagnosis group and procedure group were mapped from ICD-9-CM to their closest ICD-10-CM equivalent, or equivalents. CMS intends to monitor the impact of the transition to ICD-10 for this measure.

Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) Measures

5. Where can I find information about the ICD-10 codes for the CDC/NHSN surgical site infection (SSI) measures?

General resources for SSI events can be found on the NHSN web page: https://www.cdc.gov/nhsn/acute-care-hospital/ssi/index.html. The most current lists of procedure codes are found on the NHSN Surveillance for Surgical Site Infection (SSI) Events webpage in the "Supporting Materials" section of both Acute Care Facilities and Ambulatory Surgery Centers:

http://www.cdc.gov/nhsn/acute-care-hospital/ssi/index.html

http://www.cdc.gov/nhsn/ambulatory-surgery/ssi/index.html

Note: NHSN recently issued an email correction involving certain codes for COLO and HYST procedures applicable only to operative procedures performed on or after January 1, 2017. This email blast is posted here: https://www.cdc.gov/nhsn/pdfs/commup/nhsn-email-colo-hyst-codes.pdf.

Please contact nhsn@cdc.gov with any questions related to the CDC/NHSN Measures.

CMS Hospital Outcome and Payment Measures

6. Where can I find the ICD-10 codes for the CMS outcome and payment measures for fiscal year 2018?

Readmission measures

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) codes used to define the acute myocardial infarction (AMI), coronary artery bypass grafting (CABG), chronic obstructive pulmonary disease (COPD), heart failure (HF), pneumonia, stroke and total hip/knee arthroplasty (THA/TKA) readmission measure cohorts are posted on the QualityNet website (www.qualitynet.org), under Hospitals – Inpatient > Claims-Based Measures > Readmission Measures > Measure Methodology. Specifically, the ICD-10 codes used to define the cohort inclusions are located as follows:

- Tables D.1.1, D.2.1, D.3.1, D.4.1, and D.5.1 in Appendix D of the 2017 Condition-Specific Readmission Measures Updates and Specifications Report list the codes for the AMI, COPD, HF, pneumonia, and stroke measures, respectively.
- Table D.1.1, D.2.1 in Appendix D of the 2017 Procedure-Specific Readmission Measures Updates and Specifications Report lists the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) codes used to define a CABG and THA/TKA procedure, respectively.

Additionally, in terms of cohort definitions:

- The 2017 Condition-Specific Readmission Measures Updates and Specifications Report - Supplemental ICD-10 Code Lists, posted on the aforementioned webpage, outline the cohort exclusion codes for the HF measure (left ventricular assist device implantation (LVAD) and heart transplantation).
- Admissions with a procedure code for a concomitant valve or other major cardiac, vascular, or thoracic procedure are not included in the CABG readmission cohort. The ICD-10-PCS codes used to identify these procedures in claims are posted on the aforementioned webpage in the 2017 Procedure-Specific Readmission Measures Updates and Specifications Report - Supplemental ICD-10 Code Lists.
- The 2017 Procedure-Specific Readmission Measures Updates and Specifications Report - Supplemental ICD-10 Code Lists, posted on the aforementioned webpage, outline the codes that identify and disqualify index admissions with a non-elective or non-primary THA/TKA procedure from cohort inclusion.

In terms of risk adjustment:

- The ICD-10 codes used in risk adjustment for these measures (for example, history of percutaneous transluminal coronary angioplasty [PTCA]) are listed in the Supplemental ICD-10 Code List documents described above.

- If you are interested in identifying which ICD-10 codes are included in each of the condition categories (CCs) used for risk adjustment, these crosswalks are available on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Readmission Measures > Resources.

In terms of the planned readmission algorithm:

- The ICD-10 codes used in the planned readmission algorithm for these measures (for example, history of PTCA) are listed in the 2017 Updates and Specifications Reports discussed above.

- If you are interested in identifying which ICD-10 codes are included in the Agency for Healthcare Research and Quality (AHRQ) Clinical Classifications Software (CCS) categories used in the algorithm, these crosswalks are available at: (www.hcup-us.ahrq.gov) under the Tools & Software menu.

The cohort for the Hospital-Wide Readmission Measure is defined using the clinically meaningful AHRQ CCS diagnosis and procedure categories. The AHRQ CCS Diagnosis and Procedure Crosswalks show the assignment of ICD-9/ICD-10 codes to the CCS diagnosis and procedure categories. These are available at: (www.hcup-us.ahrq.gov) under the Tools & Software menu.

- Information on the assignment of patients to specialty cohort groups for discharges that include ICD-10 codes is available in Appendix D of the 2017 Hospital-wide Readmission Measure Updates and Specifications Report, posted on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Readmission Measures > Measure Methodology.

Mortality measures

The ICD-10-CM codes used to define the cohort inclusions for the AMI, COPD, HF, pneumonia, stroke and CABG mortality measures are posted on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Mortality Measures > Measure Methodology. Specifically, the ICD-10 codes used to define the cohort inclusions are located as follows:

- Tables D.1.1, D.2.1, D.3.1, D.4.1, and D.5.1 of Appendix D of the 2017 Condition-Specific Mortality Measures Updates and Specifications Report lists the codes for the AMI, COPD, HF, pneumonia, and stroke measures, respectively.

- Table D.1.1 of Appendix D of the 2017 Procedure-Specific Mortality Measure Updates and Specifications Report lists the codes for the CABG mortality measure.

Additionally, in terms of cohort definitions:

- The 2017 Condition-Specific Mortality Measures Updates and Specifications Report - Supplemental ICD-10 Code Lists and the 2017 Procedure-Specific Mortality Measure Updates and Specifications Report - Supplemental ICD-10 Code Lists posted on

the aforementioned webpage, include the cohort exclusion codes for the HF measure (LVAD implantation and heart transplantation) and the CABG measure (concomitant valve or other major cardiac, vascular, or thoracic procedure), respectively.

In terms of risk adjustment:

- The ICD-10 codes used in risk adjustment for these measures are listed in the Supplemental ICD-10 Code List documents described above.
- If you are interested in identifying which ICD-10 codes are included in each of the CCs used for risk adjustment, these crosswalks are available on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Mortality Measures > Resources.

Complication measures

The ICD-10-PCS codes used in the THA/TKA complication measure are posted on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Complication Measure > Measure Methodology. Specifically, the ICD-10 codes used to define a THA/TKA procedure in claims are located as follows:

- Appendix D, in Table D.1.1, of the 2017 Procedure-Specific Complication Measure Updates and Specifications Report.

Additionally, in terms of cohort definitions:

- THA/TKA procedures that are non-elective or non-primary are not included in the cohort. The ICD-10 codes used to identify these procedures on posted on the aforementioned webpage in the 2017 Procedure-Specific Complications Measure Updates and Specifications Report - Supplemental ICD-10 Code Lists.

In terms of risk adjustment:

- The ICD-10 codes used in risk adjustment for these measures are listed in the Supplemental ICD-10 Code List documents described above.
- If you are interested in identifying which ICD-10 codes are included in each of the CCs used for risk adjustment, these crosswalks are available on the QualityNet website (www.qualitynet.org) under Complication Measures > Resources.

Payment measures

The ICD-10-CM codes used to define the cohort inclusions for the payment measures are posted on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Payment Measures > Measure Methodology. Specifically, the ICD-10 codes used to define the cohort inclusions are located as follows:

- Tables D.1.1, D.2.1, D.3.1, and D.4.1 in Appendix D of the 2017 Payment Measures Updates and Specifications Report lists the codes for AMI, HF, pneumonia, and THA/TKA measures respectively.

Additionally, in terms of cohort definitions:

- The 2017 Payment Measures Updates and Specifications Report - Supplemental ICD-10 Code Lists, posted on the aforementioned webpage, outline the cohort exclusion

codes for the HF measure (LVAD implantation and heart transplantation) and the THA/TKA measure (THA/TKA procedures that are non-elective or non-primary).

- THA/TKA procedures that are non-elective or non-primary are not included in the cohort. The ICD-10 codes used to identify these procedures on posted on the aforementioned webpage in the 2017 Procedure-Specific Complications Measure Updates and Specifications Report - Supplemental ICD-10 Code Lists.

In terms of risk adjustment:

- The ICD-10 codes used in risk adjustment for these measures are listed in the Supplemental ICD-10 Code List documents described above.
- If you are interested in identifying which ICD-10 codes are included in each of the CCs used for risk adjustment, these crosswalks are available on QualityNet, under Payment Measures > Resources.

Excess Days in Acute Care (EDAC) measures

The ICD-10-CM codes used to define the cohort inclusions for the AMI and HF EDAC measure are posted on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Excess Days in Acute Care (EDAC) Measures > Measure Methodology. Specifically, the ICD-10 codes used to define the cohort inclusions are located as follows:

- Tables D.1.1 and D.2.1 in Appendix D of the 2017 condition-specific EDAC measures updates and specifications report list the codes for the AMI and HF measures, respectively.

Additionally, in terms of cohort definitions:

- The 2017 Condition-Specific Excess Days in Acute Care Measures Updates and Specifications Report - Supplemental ICD-10 Code Lists, posted on the aforementioned webpage, outline the cohort exclusion codes for the HF measure (LVAD implantation and heart transplantation).

In terms of risk adjustment:

- The ICD-10 codes used in risk adjustment for these measures are listed in the Supplemental ICD-10 Code List documents described above.
- If you are interested in identifying which ICD-10 codes are included in each of the CCs used for risk adjustment, these crosswalks are available on the QualityNet website (www.qualitynet.org), under Hospitals – Inpatient > Claims-Based Measures > Excess Days in Acute Care (EDAC) Measures > Resources.

7. Who do I contact if I have questions related to the use of ICD-10 codes in the outcome and payment measures?

Questions related to the use of ICD-10 codes in the CMS outcome and payment measures can be submitted to:

- cmsmortalitymeasures@yale.edu for questions related to the mortality measures;

- cmsreadmissionmeasures@yale.edu for questions related to the readmission measures;
- cmscomplicationmeasures@yale.edu for questions related to the complication measure;
- cmsepisodepaymentmeasures@yale.edu for questions related to the payment measures; and
- cmsedacmeasures@yale.edu for questions related to the EDAC measures.

8. When will the SAS package for use with the ICD-10 codes become available?

The 2017 SAS packages for use with the ICD-10 codes in the outcome and payment measures will be available in summer 2017. For copies of the SAS packages once they become available, please contact:

- cmsmortalitymeasures@yale.edu for the SAS packages for the mortality measures;
- cmsreadmissionmeasures@yale.edu for the SAS packages for the readmission measures;
- cmscomplicationmeasures@yale.edu for the SAS packages for the complication measure;
- cmsepisodepaymentmeasures@yale.edu for the SAS packages for the payment measures; and
- cmsedacmeasures@yale.edu for the SAS packages for the EDAC measures.

9. Do I need to convert ICD-9 codes to ICD-10 codes in order to run internal reports?

After the implementation of the ICD-10 codes in the measures, hospitals will not need to convert ICD-9 codes to ICD-10 codes to run internal reports. If hospitals require reports that span the use of both coding systems (i.e., before and on/after October 1, 2015), the following resources can be accessed:

- Condition Category crosswalks for both ICD-9 and ICD-10 codes are available on the QualityNet website (www.qualitynet.org), under Hospitals – Inpatient > Claims-Based Measures > Mortality (or Readmission, Complication, Payment, or Excess Days in Acute Care) Measures > Resources.
- The ICD-9 codes used to identify the cohort, risk variables and planned readmission reduction algorithm are available on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Mortality (or Readmission, Complication, Payment, or Excess Days in Acute Care) Measures > Resources.
- The ICD-10 codes used to identify the cohort, risk variables and planned readmission reduction algorithm can be found in the 2017 Annual Updates and Specification Reports and the 2017 Annual Updates and Specification Reports – Supplemental ICD-10 Code Lists available on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Mortality (or Readmission, Complication, Payment, or Excess Days in Acute Care) Measures > Measure Methodology.

10. Has the measure cohort volume significantly increased since the transition from ICD-9-based to ICD-10-based measure specifications?

Tests of model performance and the frequencies of the cohorts, exclusion codes, and risk-variables demonstrate similar results and indicate no unexpected substantial increases in the measure cohort sizes in the transition from ICD-9 to ICD-10-based specifications. Questions related to the use of ICD-10 codes in the CMS outcome and payment measures can be submitted to the applicable measure email inbox as listed under Question 7 above.

11. Which documents should be used to define the cohort, risk factors, and planned readmission algorithm for the fiscal year (FY) 2018 Hospital Readmissions Reduction Program and Hospital Inpatient Quality Reporting Program, since the performance period spans the use of both ICD-9 and ICD-10 codes?

The ICD-10 codes used to identify the cohort, risk variables and planned readmission reduction algorithm for the outcome and payment measures for FY 2018 under the Hospital Readmissions Reduction Program and the Hospital Inpatient Quality Reporting Program can be found in the 2017 Annual Updates and Specification Reports and the 2017 Annual Updates and Specification Reports – Supplemental ICD-10 Code Lists. These reports can be found on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Mortality (or Readmission, Complication, Payment, or Excess Days in Acute Care) Measures > Measure Methodology

The ICD-9 codes used to identify the cohort, risk variables and planned readmission reduction algorithm for the outcome and payment measures for FY 2018 under the Hospital Readmissions Reduction Program and the Hospital Inpatient Quality Reporting Program can be found in the 2016 Annual Updates and Specification Reports. These reports can be found on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Mortality (or Readmission, Complication, Payment, or Excess Days in Acute Care) Measures > Resources.

12. Are the ICD-10 code lists still preliminary?

The preliminary ICD-10 code lists have been updated and are now complete. The final ICD-10 codes for use in the outcome and payment measures under the Hospital Readmissions Reduction Program and the Hospital Inpatient Quality Reporting Program in FY 2018 are available in the 2017 Annual Updates and Specification Reports and the 2017 Annual Updates and Specification Reports – Supplemental ICD-10 Code Lists. These reports can be found on the QualityNet website (www.qualitynet.org) under Hospitals – Inpatient > Claims-Based Measures > Mortality (or Readmission, Complication, Payment, or Excess Days in Acute Care) Measures > Measure Methodology.

As CMS routinely maintains and updates measure specifications, these measure lists may be refined in future fiscal years as CMS continues to examine the use of ICD-10 codes by hospitals.

Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) 90 Composite

13. Where can I find ICD-10 information related to the AHRQ (PSI) 90 composite?

The Patient Safety Indicator 90 (PSI 90) composite is the weighted average of the reliability-adjusted observed-to-expected ratios (indirect standardization of the smoothed rates) for 10 patient safety indicators. For more information on the all-payer version of the PSI 90 and the other patient safety indicators, visit http://www.qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10.aspx. The Agency for Healthcare Research and Quality (AHRQ) offers free software to help organizations use the AHRQ Quality Indicators (QIs) to generate results that are both accurate and actionable. AHRQ currently has software available to specify ICD-10 coded numerators and denominators for the PSIs. This software ensures a standard, trusted approach to quality measurement so more resources are available to support improvements in patient care. The AHRQ QI software uses readily available data, requiring only administrative data already collected and reported by hospitals in most States. Using administrative data for measurement promotes consistency when evaluating performance over time and across initiatives and reduces costs associated with data collection and reporting. The software is compatible with two commonly used platforms, SAS and Windows, and is updated on an annual basis. To learn more about the AHRQ QI software, visit http://www.qualityindicators.ahrq.gov/software/. If you have any questions, or would like to talk with a member of the AHRQ QI Support Team, please contact QISupport@ahrq.hhs.gov.

Provider Questions

14. How can providers correct coding errors?

CMS does not provide specific coding guidance. Several resources are listed below to assist you:

- **The ICD-10 code lookup tool:** https://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx
- **ICD-10 coding resources for Providers:** https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
- **Requests for updates** to the diagnosis and procedure code sets discussed at the ICD-10 Coordination and Maintenance Committee meetings: https://www.cms.gov/Medicare/Coding/ICD10/ICD-10-Coordination-and-Maintenance-Committee-Meetings.html
- **For specific coding questions:** Specific coding questions should be submitted to the American Hospital Association (the official US clearinghouse on medical coding) via http://www.codingclinicadvisor.com/
- **AHIMA** is now also providing coding advice for a fee through their Code Check service. You can learn more information at this link: http://www.ahima.org/topics/codecheck

General Equivalence Mappings (GEMs)

15. <u>What are General Equivalence Mappings (GEMs)?</u>

The Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) created the GEMs as a tool for the conversion of data from ICD-9-CM to ICD-10-CM and ICD-10-PCS and vice versa.

The GEMs can be used to:

- Assist with the conversion of ICD-9-CM codes to ICD-10-CM/PCS codes;
- Assist with the conversion of ICD-10-CM/PCS codes back to ICD-9-CM; and
- Ensure that consistency in national data is maintained.

The GEMs are also known as crosswalks as they provide important information linking codes of one system with codes in the other system. The GEMs are a comprehensive translation dictionary that can accurately and effectively translate any ICD-9-CM-based data, including:

- Tracking Quality
- Recording Morbidity/Mortality
- Calculating Reimbursement
- Risk Adjustment Logic
- Quality Measures
- A variety of research applications involving trend data

Mapping from ICD-10-CM and ICD-10-PCS codes back to ICD-9-CM codes is known as backward mapping. Mapping from ICD-9-CM codes to ICD-10-CM and ICD-10-PCS codes is known as forward mapping. The GEMs are complete in their description of all the mapping possibilities, as well as when new concepts in ICD-10 are not found in ICD-9-CM. **All** ICD-9-CM codes and **all** ICD-10-CM/PCS codes are included in the collective GEMs:

- All ICD-10-CM codes are in the ICD-10-CM to ICD-9-CM GEMs
- All ICD-9-CM diagnosis codes are in the ICD-9-CM to ICD-10-CM GEMs
- All ICD-10-PCS codes are in the ICD-10-PCS to ICD-9-CM GEMs
- All ICD-9-CM procedure codes are in the ICD-9-CM to ICD-10-PCS GEMs

CMS and CDC made a commitment to update the GEMs annually, along with the updates to ICD-10-CM/PCS during the transition period prior to ICD-10 implementation. The GEMs will be maintained for at least three years beyond October 1, 2015, which is the compliance date for implementation of ICD-10-CM/PCS for all Health Insurance Portability and Accountability Act (HIPAA)-covered entities. The last update to the GEMs will be for FY 2018.

Note: The GEMs are **not** a substitute for learning how to use ICD-10-CM and ICD-10-PCS. Providers' coding staff will assign codes describing patients' encounters from the ICD-10-CM and ICD-10-PCS code books or encoder systems. The GEMs will not be used to code patient encounters.

16. Where do I find GEMs?

You can download the 2017 GEMs on this website: https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-CM-and-GEMs.html.

17. Are there instances where there is not a translation from ICD-9 to an ICD-10 code? How does GEMs handle this situation?

Yes, there are instances where there is no translation between an ICD-9-CM code and an ICD-10 code. The “No Map” flag indicates there is no plausible translation from a code in one system to **any** code in the other system. For example, the following codes are marked “No Map”:

- ICD-10-CM code **Y71.3 – Surgical instruments, materials, and cardiovascular devices (including sutures) associated with adverse incidents**, which has no reasonable translation in ICD-9-CM
- ICD-9-CM procedure code **89.8 – Autopsy**, which has no reasonable translation in ICD-10-PCS.

18. Why do we need the GEMs?

We need the GEMs because:

- ICD-10 is currently used and much more specific. For diagnoses, there were 14,567 ICD-9-CM codes and there are 69,832 ICD-10-CM codes. For procedures, there were 3,882 ICD-9-CM codes and there are 71,924 ICD-10-PCS codes (in the 2015 versions of ICD-9-CM, ICD-10-CM, and ICD-10-PCS).
- One ICD-9-CM diagnosis code is represented by multiple ICD-10-CM codes.
- A few ICD-10-CM codes have no predecessor ICD-9-CM codes.
- One ICD-9-CM procedure code is captured by multiple ICD-10-PCS codes.

Additional Resources

- For more information on ICD-10, please see the CMS main ICD-10 website: https://www.cms.gov/medicare/Coding/ICD10/index.html.
- For more information on ICD-10-CM/PCS for Medicare Fee-For-Service Providers, visit: http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html.
- For ICD-10-CM/PCS Provider Resources, visit: http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html.
- For ICD-10 statutes and regulations, visit: http://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html.
- All Available Medicare Learning Network® (MLN) Products: “MLN Catalog” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf.

- For Provider-Specific Medicare Information, read the MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf.
- For general Medicare information for patients, see http://www.medicare.gov.