DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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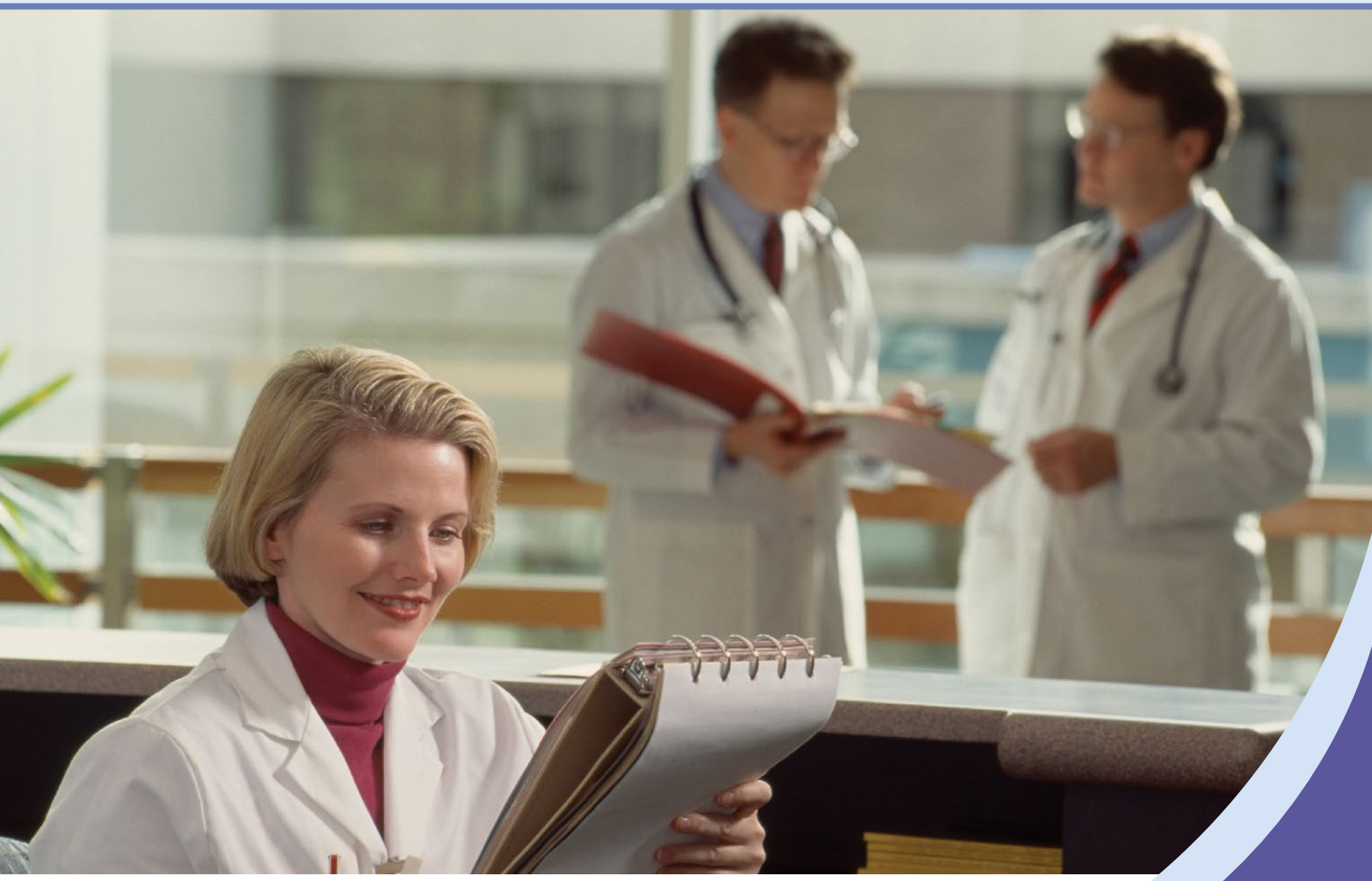
ICD-10-CM/PCS MYTHS AND FACTS



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The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

International Classification of Diseases, 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) was implemented on October 1, 2015, for all Health Insurance Portability and Accountability Act (HIPAA)-covered entities.

Learn about these ICD-10-CM/PCS topics:

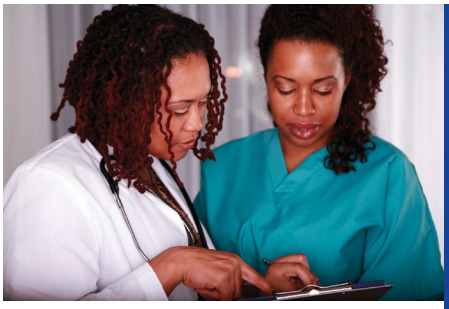
- Use of external cause and unspecified codes in ICD-10-CM
- Responses to myths on ICD-10-CM/PCS
- Resources

When "you" is used in this publication, we are referring to health care providers.

USE OF EXTERNAL CAUSE AND UNSPECIFIED CODES IN ICD-10-CM

Similar to International Classification of Diseases, 9th Revision, Clinical Modification (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 on 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.

In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While you should report specific diagnosis codes when they are supported by available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. You should code each health care encounter to the level of certainty known for that encounter.



If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient's condition at the time of that particular encounter. It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code.

RESPONSES TO MYTHS ON ICD-10-CM/PCS

MYTH

Non-covered entities, which are not covered by HIPAA such as Workers' Compensation and auto insurance companies, that use ICD-9-CM may choose not to implement ICD-10-CM/PCS.

FACT

Because ICD-9-CM is no longer being maintained, it is in non-covered entities' best interest to use the new coding system. The increased detail in ICD-10-CM/PCS is of significant value to non-covered entities.

MYTH

The increased number of codes in ICD-10-CM/PCS will make the new coding system impossible to use.

FACT

Just as an increase in the number of words in a dictionary does not make it more difficult to use, the greater number of codes in ICD-10-CM/PCS does not necessarily make it more complex to use. In fact, the greater number of codes in ICD-10-CM/PCS make it easier for you to find the right code. In addition, just as you do not have to search the entire list of ICD-9-CM codes for the proper code, you also do not have to conduct searches of the entire list of ICD-10-CM/PCS codes. The Alphabetic Index and electronic coding tools are available to help you select the proper code. The improved structure and specificity of ICD-10-CM/PCS will likely assist in developing increasingly sophisticated electronic coding tools that will help you more quickly select codes. Because ICD-10-CM/PCS is much more specific, is more clinically accurate, and uses a more logical structure, it is much easier to use than ICD-9-CM. Most physician practices use a relatively small number of diagnosis codes that are generally related to a specific type of specialty.

MYTH

ICD-10-CM/PCS was developed without clinical input.

FACT

The development of ICD-10-CM/PCS involved significant clinical input. A number of medical specialty societies contributed to the development of the coding systems.

MYTH

Unnecessarily detailed medical record documentation is required when using ICD-10-CM/PCS.

FACT

As with ICD-9-CM, ICD-10-CM/PCS codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation does not support a higher level of specificity. As demonstrated by the American Hospital Association/American Health Information Management Association field testing study, much of the detail contained in ICD-10-CM is already in medical record documentation and was not needed for ICD-9-CM coding.

MYTH

ICD-10-CM-based super bills are too long or too complex to be of much use.

FACT

Practices may continue to create super bills that contain the most common diagnosis codes used in their practice. ICD-10-CM-based super bills are not necessarily longer or more complex than ICD-9-CM-based super bills. Neither ICD-9-CM-based super bills nor ICD-10-CM-based super bills provide all possible code options for many conditions. The super bill conversion process includes:

- Conducting a review that includes removing rarely used codes
- Crosswalking common codes from ICD-9-CM to ICD-10-CM, which can be accomplished by looking up codes in the ICD-10-CM code book or using the General Equivalence Mappings (GEMs)

MYTH

The GEMs were developed to provide help in coding medical records.

FACT

The GEMs were not developed to provide help in coding medical records. Code books are used for this purpose. Mapping is not the same as coding because:

- Mapping links concepts in two code sets without consideration of patient medical record information
- Coding involves the assignment of the most appropriate code based on medical record documentation and applicable coding rules/guidelines

The GEMs can be used to convert these databases from ICD-9-CM to ICD-10-CM/PCS:

- Payment systems
- Payment and coverage edits
- Risk adjustment logic
- Quality measures
- A variety of research applications involving trend data

MYTH

Medically unnecessary diagnostic tests need to be performed to assign an ICD-10-CM code.

FACT

As with ICD-9-CM, ICD-10-CM codes are derived from documentation in the medical record. Therefore, if a diagnosis has not yet been established, you should code the condition to its highest degree of certainty (which may be a sign or symptom) when using both coding systems. In fact, ICD-10-CM contains many more codes for signs and symptoms than ICD-9-CM, and it is better designed for use in ambulatory encounters when definitive diagnoses are often not yet known. Nonspecific codes are still available in ICD-10-CM/PCS for use when more detailed clinical information is not known.

MYTH

ICD-10-PCS replaced Current Procedural Terminology (CPT).

FACT

ICD-10-PCS is only used for facility reporting of hospital inpatient procedures and does **not** affect the use of CPT.

MYTH

With the implementation of ICD-10-CM codes, how I report CPT and HCPCS codes has changed.

FACT

The implementation of ICD-10-CM codes does not impact how you report CPT and HCPCS codes, including CPT/HCPCS modifiers for physician services. While ICD-10-CM codes have expanded detail, including specification of laterality for some conditions, you should continue to follow CPT and CMS guidance when you report CPT/HCPCS modifiers for laterality.

RESOURCES

This chart provides resources for ICD-10-CM/PCS.

For More Information About…	Resource
ICD-10-CM/PCS	https://www.cms.gov/Medicare/Coding/ICD10/index.html
2017 ICD-10-CM and General Equivalence Mappings (GEMs) Updates	https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-CM-and-GEMs.html
2017 ICD-10-PCS and GEMs Updates	https://www.cms.gov/Medicare/Coding/ICD10/2017-ICD-10-PCS-and-GEMs.html
ICD-10-CM/PCS Information for Medicare Fee-For-Service Providers	https://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html
ICD-10-CM/PCS Provider Resources	https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
ICD-10-CM/PCS Statute and Regulations	https://www.cms.gov/Medicare/Coding/ICD10/Statute_Regulations.html
All Available Medicare Learning Network® (MLN) Products	"MLN Catalog"
Provider-Specific Medicare Information	"MLN Guided Pathways: Provider Specific Medicare Resources"
Medicare Information for Patients	https://www.medicare.gov

HYPERLINK TABLE

Embedded Hyperlink	Complete URL
"MLN Catalog"	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
"MLN Guided Pathways: Provider Specific Medicare Resources"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf

Check out CMS on: