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

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ICD-10-CM/PCS
THE NEXT GENERATION OF CODING

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This publication provides the following information on the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS):

- ICD-10-CM/PCS compliance date;
- ICD-10-CM/PCS – an improved classification system;
- ICD-10-CM/PCS examples;
- Structural differences between International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) and ICD-10-CM/PCS;
- Use of external cause and unspecified codes in ICD-10-CM;
- Continued use of Current Procedural Terminology (CPT) codes; and
- Resources.

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

ICD-10-CM/PCS COMPLIANCE DATE

The compliance date for implementation of ICD-10-CM/PCS is October 1, 2014, for all Health Insurance Portability and Accountability Act (HIPAA)-covered entities. ICD-10-CM/PCS will enhance accurate payment for services rendered and help evaluate medical processes and outcomes. A number of other countries have already moved to ICD-10, including:

- United Kingdom (1995);
- France (1997);
- Australia (1998);
- Germany (2000); and
- Canada (2001).

ICD-10-CM/PCS – AN IMPROVED CLASSIFICATION SYSTEM

Drawbacks of the current system, ICD-9-CM, include:

- It does not provide the necessary detail for patients' medical conditions or the procedures and services performed on hospitalized patients;
- It is 34 years old;
- It uses outdated and obsolete terminology;
- It uses outdated codes that produce inaccurate and limited data; and
- It is inconsistent with current medical practice as it cannot accurately describe the diagnoses and inpatient procedures of care delivered in the 21st century.

ICD-10-CM/PCS consists of two parts:

- ICD-10-CM – The diagnosis classification system developed by the Centers for Disease Control and Prevention for use in all United States (U.S.) health care treatment settings. Diagnosis coding under this system uses 3–7 alpha and numeric digits and full code titles, but the format is very much the same as ICD-9-CM; and
- ICD-10-PCS – The procedure classification system developed by the Centers for Medicare & Medicaid Services (CMS) for use in the U.S. for inpatient hospital settings **only**. The new procedure coding system uses 7 alpha or numeric digits while the ICD-9-CM coding system uses 3 or 4 numeric digits.

The new classification system provides significant improvements through greater detailed information and the ability to expand to capture additional advancements in clinical medicine. ICD-10-CM/PCS improvements include:

- Much greater specificity and clinical information, which results in:
  - Improved ability to measure health care services;

- Increased sensitivity when refining grouping and reimbursement methodologies;
- Enhanced ability to conduct public health surveillance; and
- Decreased need to include supporting documentation with claims;

❖ Updated medical terminology and classification of diseases;

❖ Codes that allow comparison of mortality and morbidity data; and

❖ Better data for:

- Measuring care furnished to patients;
- Designing payment systems;
- Processing claims;
- Making clinical decisions;
- Tracking public health;
- Identifying fraud and abuse; and
- Conducting research.

ICD-10-CM/PCS EXAMPLES

The examples below show that ICD-10-CM/PCS codes are more precise and provide better information.

ICD-9-CM
Mechanical complication of other vascular device, implant and graft
1 code (996.1)

ICD-10-CM
Mechanical complication of other vascular grafts
49 codes

T82.311A – Breakdown (mechanical) of carotid arterial graft (bypass), initial encounter
T82.312A – Breakdown (mechanical) of femoral arterial graft (bypass), initial encounter
T82.329A – Displacement of unspecified vascular grafts, initial encounter
T82.330A – Leakage of aortic (bifurcation) graft (replacement), initial encounter
T82.331A – Leakage of carotid arterial graft (bypass), initial encounter
T82.332A – Leakage of femoral arterial graft (bypass), initial encounter
T82.524A – Displacement of infusion catheter, initial encounter
T82.525A – Displacement of umbrella device, initial encounter

ICD-9-CM
Pressure ulcer codes
9 location codes (707.00 – 707.09)
Show broad location, but not depth (stage)

ICD-10-CM
Pressure ulcer codes
150 codes
Show more specific location as well as depth, including:
L89.131 – Pressure ulcer of right lower back, stage 1
L89.132 – Pressure ulcer of right lower back, stage 2
L89.133 – Pressure ulcer of right lower back, stage 3
L89.134 – Pressure ulcer of right lower back, stage 4
L89.139 – Pressure ulcer of right lower back, unspecified stage

L89.141 – Pressure ulcer of left lower back, stage 1
L89.142 – Pressure ulcer of left lower back, stage 2
L89.143 – Pressure ulcer of left lower back, stage 3
L89.144 – Pressure ulcer of left lower back, stage 4
L89.149 – Pressure ulcer of left lower back, unspecified stage
L89.151 – Pressure ulcer of sacral region, stage 1
L89.152 – Pressure ulcer of sacral region, stage 2

ICD-9-CM
Angioplasty
1 code (39.50)

ICD-10-PCS
Angioplasty codes
854 codes

Specifying body part, approach, and device, including:
047K04Z – Dilation of right femoral artery with drug-eluting intraluminal device, open approach
047K0DZ – Dilation of right femoral artery with intraluminal device, open approach
047K0ZZ – Dilation of right femoral artery, open approach
047K34Z – Dilation of right femoral artery with drug-eluting intraluminal device, percutaneous approach
047K3DZ – Dilation of right femoral artery with intraluminal device, percutaneous approach

STRUCTURAL DIFFERENCES BETWEEN ICD-9-CM AND ICD-10-CM/PCS

The examples below show the structural differences between ICD-9-CM and ICD-10-CM/PCS.

ICD-9-CM Diagnoses Codes:

- 3–5 digits;
- First digit is alpha (E or V) or numeric;
- Digits 2–5 are numeric; and
- Decimal is after third digit.

Examples:

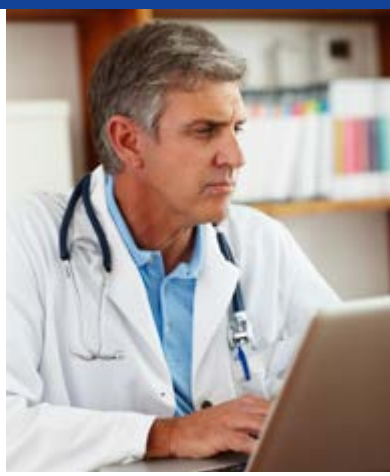
- 496 – Chronic airway obstruction, Not Elsewhere Classified (NEC);
- 511.9 – Unspecified pleural effusion; and
- V02.61 – Hepatitis B carrier.

ICD-10-CM Diagnoses Codes:

- 3–7 digits;
- Digit 1 is alpha;
- Digit 2 is numeric;
- Digits 3–7 are alpha or numeric (alpha digits are not case sensitive); and
- Decimal is after third digit.

Examples:

- A78 – Q fever;



- A69.21 – Meningitis due to Lyme disease; and
- S52.131a – Displaced fracture of neck of right radius, initial encounter for closed fracture.

ICD-9-CM Procedure Codes:

❖ 3–4 digits;

❖ All digits are numeric; and

❖ Decimal is after second digit.

Examples:

- 43.5 – Partial gastrectomy with anastomosis to esophagus; and
- 44.42 – Suture of duodenal ulcer site.

ICD-10-PCS Procedure Codes:

❖ 7 digits;

❖ Each digit is either alpha or numeric (alpha digits are not case sensitive and letters O and I are not used to avoid confusion with numbers 0 and 1); and

❖ No decimal.

Examples:

- 0FB03ZX – Excision of liver, percutaneous approach, diagnostic; and
- 0DQ10ZZ – Repair upper esophagus, open approach.

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

Similar to 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, 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 about 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 specific diagnosis codes should be reported when they are supported by the 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. Each health care encounter should be coded 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, unspecified codes should be reported when they are the codes that 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 conduct medically unnecessary diagnostic testing to determine a more specific code.

CONTINUED USE OF CPT CODES

When ICD-10-CM/PCS is implemented on October 1, 2014, it will not affect physicians', outpatient facilities', and hospital outpatient departments' use of CPT codes on Medicare Fee-For-Service claims. Providers should continue to use CPT codes to report these services.

RESOURCES

For more information about ICD-10-CM/PCS, visit http://www.cms.gov/Medicare/Coding/ICD10/index.html on the CMS website. For more information about all available Medicare Learning Network® (MLN) products, refer to the "Medicare Learning Network® Catalog of Products" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right.

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