

LEADERSHIP SKILLS

ICD-9-CM vs. ICD-10-CM Codes Used in Quality Measures

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A change from ICD-9-CM to the clinically richer ICD-10-CM/PCS in 2013 will affect quality measures. Full compliance with ICD-10-CM/PCS codes is expected on October 1, 2013. However, in order to take full advantage of the increased specificity available in the new code set, physician documentation will need to be available for coding professionals to report the more specific codes. For this reason, it's important for coding and quality professionals to work together to educate physicians to reap the benefits of the new codes.

Here are National Quality Forum (NQF) measures that will be affected along with examples of the corresponding ICD-9-CM and ICD-10-CM codes:

NQF Serious Reportable Events in Healthcare: *Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.*

ICD-9-CM

999.1 Complications of medical care, not elsewhere classified, air embolism

996.74 Other complications, due to vascular device, implant, and graft

ICD-10-CM

T80.0xxA Air embolism following infusion, transfusion, and therapeutic injection, initial encounter

T82.818A Embolism of vascular prosthetic devices, implants, and grafts, initial encounter

The ICD-9-CM code 996.74 includes embolism, fibrosis, hemorrhage, pain, and stenosis in the same code. This code would require manual review of the documentation to determine the specific complication. On the other hand, the ICD-10-CM not only specifically identifies air embolism as a problem but also distinguishes between air embolism following infusion, transfusion, and therapeutic injection versus embolism of vascular prosthetic devices, implants, and grafts. In addition, based on the seventh-character extension, one is able to continue to report the same code for follow-up visits (by changing the last character from "A" to "D"), thereby allowing the tracking of the problem from the initial encounter to any subsequent visits or even any sequela.

NQF—Accidental Puncture or Laceration

ICD-9-CM

998.2 Accidental puncture or laceration during a procedure

ICD-10-CM

D78.11 Accidental puncture and laceration of spleen during a procedure on the spleen

D78.12 Accidental puncture and laceration of spleen during other procedure

The ICD-9-CM code does not provide information regarding the site of the accidental puncture or what type of procedure was involved. ICD-10-CM has 21 codes indicating accidental puncture and laceration specifying organ or body system and whether the incident occurred

during a procedure on the organ affected or during another procedure.

NQF Serious Reportable Events in Healthcare: *Unintended retention of a foreign object in a patient after surgery or other procedure.*

ICD-9-CM

998.4 Foreign body accidentally left during a procedure

ICD-10-CM

T81.525D Obstruction due to foreign body accidentally left in body following heart catheterization, subsequent encounter

T81.532A Perforation due to foreign body accidentally left in body following kidney dialysis, initial encounter

The ICD-9-CM code includes a single code (998.4) code that includes a foreign body being accidentally left during a procedure. This code also includes adhesions, obstruction, or perforation due to foreign body accidentally left during surgery. There are 50 unique ICD-10-CM codes specifying complications due to foreign body (splitting out obstruction, adhesions, perforations, and other complications) and some common procedures like heart catheterizations, kidney dialysis, surgical operation, endoscopic procedures, removal of catheter, and infusion.

The ICD-9-CM code would be applied ONLY to the encounter/stay when the foreign body was found, but the ICD-10-CM code using the seventh-character extension would show whether this is the initial encounter, subsequent encounter, or sequela. The increased specificity in the clinical codes reflected in these examples will impact the quality and patient safety initiatives of providers.

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