Core measures are standardized sets of valid, reliable and evidence based criteria for documentation of specific conditions or procedures. The information allows minimum data collection of evidence-based performance measurement for the purpose of improving the health care delivery process.

JCAHO and CMS have combined their efforts to identify specific conditions/treatments that will be monitored for accreditation and reimbursement initiatives. These conditions/treatments have both clinical and reimbursement implications.
Medical Record Documentation

- The information should be documented during the patient’s visit.
  - Some late entry documentation may be acceptable.
  - Information added more than 30 days post-discharge cannot be used to ensure that all required documentation criteria is met.
  - The 30-day from discharge date is used relative to the Medicare Conditions of Participation for Medical Records – 42CFR482.24(c)(3)(viii). Any allowable variation must be specifically stated in the data element explanation.

Coding Requirements

- In order to ensure consistent collection of data on these initiatives, a required set of general data elements must be submitted for each initiative. For the purposes of our discussion today, we will be focusing on ICD-9-CM principal diagnosis and procedures to identify the effect of ICD-10 code changes.

Code Assignment

- Until October 1, 2014, the ICD-9-CM diagnosis and procedure system will be utilized to submit all required code elements.
  - ICD-9 codes are broader in definition and lack specific detailed information that will be available in ICD-10
- Unless further delayed, October 1, 2014, ICD-10-CM (diagnosis) and on inpatient cases ICD-10-PCS will be used for all inpatient procedure codes.
The expansion of detailed information in ICD-10 will allow improvement in data collection for assessing severity, quality of care and outcomes. Example:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
<th>Diagnosis Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Displaced Intertrochanteric Fracture</td>
<td>820.21</td>
<td>S72.141A</td>
<td>Displaced intertrochanteric fx., right femur, initial encounter for closed fracture</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure</th>
<th>ICD-9-CM</th>
<th>ICD-10-PCS</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open reduction of fx. with internal fixation femur</td>
<td>79.35</td>
<td>0QS604Z</td>
<td>Open reduction of fracture with internal fixation, right upper femur</td>
</tr>
</tbody>
</table>

Note in the diagnosis sample we now show: laterality (right) and the treatment phase (initial encounter).

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Diagnosis Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S72.141A</td>
<td>Displaced intertrochanteric fx., right femur, initial encounter for closed fracture</td>
</tr>
</tbody>
</table>

In the procedure code, we now know the laterality, the section of the femur that was involved and that no device was needed.

<table>
<thead>
<tr>
<th>ICD-10-PCS</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0QS604Z</td>
<td>Open reduction of fracture with internal fixation, right upper femur</td>
</tr>
</tbody>
</table>

Initially, ICD-9-CM and ICD-10 data will be co-mingled as comparative and trended data and will cross calendar and fiscal years.

Definition changes between the 2 groups will need to be evaluated and an impact determination made.

Baseline statistics may need to be created using ICD-10 information to allow appropriate correlation.
Example: Pressure ulcers:

- ICD-9:
  - Require 2 codes – one indicating the location of the ulcer (9 choices) and the 2nd code identifies the stage.
- ICD-10:
  - Requires 1 code to indicate the location (many more choices) and stage
  - Laterality is also included where appropriate

Example: Myocardial Infarction (MI):

- ICD-9:
  - The age of an acute MI is up to 8 weeks
- ICD-10:
  - The age of an acute MI is up to 4 weeks (28 days)
  - There is an additional code for a subsequent MI within the initial 4-week period.
  
  A comparison of volumes of acute MI’s may actually show a decrease since the time period is shorter than in the I-9 statistics.

Surgical procedures will contain additional information such as the approach, the specific location and whether a device was used.

This information could impact quality measures by providing more detailed information that impact infections and mortality.
Specifications Manual for National Hospital Inpatient Quality Measures Discharges 01-01-14 (1Q14) through 09-30-14 (3Q14) has a preview list for anticipated ICD-10 codes. This list will be updated for diagnosis assignment and published in May 2014 for use on and after October 1, 2014.

The table manual provides lists of diagnoses of items currently under review with potential ICD-10 codes to be assigned. We will perform a partial comparison during this presentation.

There are additional ICD-10 codes in each of the above categories with a 5th digit which specifies whether or not the respiratory failure is with hypoxia or hypercapnia. These codes are not listed in the preview.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J96.00</td>
<td>Acute respiratory failure, unspecified, whether with or without hypoxia or hypercapnia</td>
</tr>
<tr>
<td>J96.10</td>
<td>Chronic respiratory failure, unspecified, whether with or without hypoxia or hypercapnia</td>
</tr>
<tr>
<td>J96.20</td>
<td>Acute and chronic respiratory failure, unspecified, whether with or without hypoxia or hypercapnia</td>
</tr>
</tbody>
</table>
Table 5.03 Colon Surgery

<table>
<thead>
<tr>
<th>ICD-10 CODE</th>
<th>ICD-10 DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0BBK0ZZ</td>
<td>Excision of Right Lung, Open Approach</td>
</tr>
<tr>
<td>0BBK7ZZ</td>
<td>Excision of Right Lung, Via Natural or</td>
</tr>
<tr>
<td></td>
<td>Artificial Opening</td>
</tr>
<tr>
<td>0BBL0ZZ</td>
<td>Excision of Left Lung, Open Approach</td>
</tr>
<tr>
<td>0BBL7ZZ</td>
<td>Excision of Left Lung, Via Natural or</td>
</tr>
<tr>
<td></td>
<td>Artificial Opening</td>
</tr>
<tr>
<td>0D190Z9</td>
<td>Bypass Duodenum to Duodenum, Open Approach</td>
</tr>
<tr>
<td>0D190ZA</td>
<td>Bypass Duodenum to Jejunum, Open Approach</td>
</tr>
</tbody>
</table>

As you look at the codes from the table, the excision of the right or left lung is included in this category. Verification of codes listed should be performed and questioned where appropriate.

Pregnancy and complications of pregnancy codes have changed definitions. Antepartum and delivered terms are eliminated. Trimesters are used to describe pre-birth time periods and when delivery occurs.
### Code Assignment

**Example:**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anemia, in mother, complicating pregnancy, delivered</td>
<td>648.21</td>
<td>O99.013</td>
<td>Anemia complicating pregnancy, third trimester</td>
</tr>
<tr>
<td>Iron deficiency anemia</td>
<td>280.9</td>
<td>D50.9</td>
<td>Unspecified iron deficiency anemia</td>
</tr>
<tr>
<td>Mother with multiple births, some liveborn</td>
<td>V27.6</td>
<td>Z37.61</td>
<td>Triplets, some liveborn</td>
</tr>
</tbody>
</table>

The identification of the trimester will allow more specific time frames to be applied to core measures to capture significant events.

Outcome of delivery codes identify the number of births (up to sextuplets) and whether all or only some expired.

### Preview Table Review

The Specifications Manual for National Hospital Quality Initiatives – Appendix P lists proposed codes which have been suggested for use at the implementation of ICD-10-CM/PCS.

CMS has published a comparison table of 5 of the initiatives.
Acute Myocardial Infarction (AMI) – Table 1.1

- ICD-10 adds specificity for laterality and specific arteries involved can be assigned:
  - Example: Left main coronary artery
  - Left anterior descending coronary artery
  - Right coronary artery
- MI’s are also categorized as initial or subsequent
  - The subsequent definition is for another MI that occurs within 4 weeks of the initial MI

Percutaneous Coronary Intervention –

- Percutaneous coronary angioplasty (PTCA) will have the code definitions expanded in ICD-10-CM to include:
  - The specific artery, the type of device, the type of stent (drug-eluting, non-drug eluting) and the approach
  - Example: Dilation of Coronary artery, two sites, bifurcation, radioactive intraluminal device, percutaneous approach

Heart Failure – Table 2.1

- In ICD-10, there is no designation for malignant hypertensive heart disease. Hypertensive heart disease does have corresponding codes
- ICD-9-CM has separate codes for malignant hypertensive disease, benign hypertensive disease and unspecified hypertensive disease.
I would put this bullet first and then the I-10 bullet with less specificity.
Left Ventricular Assist Device (LVAD) and Heart Transplant – Table 2.2
- Expanded codes include information identifying:
  - Insertions, replacement and the type of approach
  - For transplants – the type of transplant such as allogeneic, synergetic or zooplastic
  - Assistance with cardiac output identifies
    - Type of pump – Impeller or other
    - Whether output is continuous or intermittent

Pneumonia (PN)– Table 3.1
- The majority of codes have a 1 to 1 correlating code that specifies the type of pneumonia.
  - Lobar pneumonia without a specific organism named is assigned to a code for Lobar pneumonia (J18.1), unspecified.
  - In ICD-9-CM, lobar pneumonia is assigned to the code for pneumococcal pneumonia which is assigned to J13 in ICD-10.
  - Legionnaires’ disease is now classified to the infections disease chapter of ICD-10 – not the respiratory chapter.

Septicemia – Table 3.2
- Severe sepsis will have two possible codes in ICD-10
  - With septic shock
  - Without septic shock
  - Three codes were added in ICD-10 (sepsis, severe sepsis and septic shock)
  - Strep Sepsis has separate codes for the type of Strep organism – 15 in ICD-10 and 1 in ICD-9

Respiratory Failure – Table 3.3
- 3 respiratory failure codes are listed identifying the stage of respiratory failure – acute, unspecified and acute and chronic.
Should this be "are used" or is this sentence about I-9?
Richard Kantner, 3/31/2014
Respiratory Failure – Table 3.4

- 3 respiratory failure codes are listed identifying the stage of respiratory failure – acute, unspecified and acute and chronic.
- Codes to identify whether the patient had hypoxia or hypercapnia with the respiratory failure are not included.

What will be the impact on the data when more specific codes are assigned?

Colon Surgery – Table 5.03

- Separate codes for drainage or partial removal of tissue will be in ICD-10.
- Site specific
- Approach

Total Abdominal Hysterectomy – Table 5.06

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>Description</th>
<th>ICD-10-PCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.49</td>
<td>TAH</td>
<td>0UTC0ZZ</td>
<td>Resection of Uterus, open approach</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0UTC0ZZ</td>
<td>Resection of Cervix, Open Approach</td>
</tr>
</tbody>
</table>

In order to capture the entire procedure, 2 codes are needed in ICD-10. If captured and counted separately, this will double your volume.
### Asthma – Table 6.1

- Extrinsic and intrinsic asthma are assigned different codes in ICD-9, however, in ICD-10, the same code is assigned for unspecified asthma.
- Additional codes are assigned to allow the specification of the acuity:
  - Mild, moderate and severe
  - Intermittent or persistent descriptors have also been added within these categories.

### Table 7.02

#### Obstetrics - Table 7.02

- **Threatened Abortion**
  - ICD-9-CM - One code for antepartum and one for when the delivery occurred on the current admission.
  - ICD-10-CM - One code has been established. This code has an Excludes note indicating it not assigned when a spontaneous abortion occurs in conjunction with the diagnosis.

- **Coagulation defects during pregnancy** have codes which specify the type of defect:
  - Afibrinogenemia
  - Disseminated intravascular coagulation
  - Other
  - Unspecified
Influenza Immunization - Table 12.9

- There are 2 procedure codes listed in this table. The location where the injection is given includes the subcutaneous tissue level or muscle level that determines which code is assigned.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3E0134Z</td>
<td>Introduction of Serum, Toxoid and Vaccine into Subcutaneous Tissue, Percutaneous Approach</td>
</tr>
<tr>
<td>3E0234Z</td>
<td>Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach</td>
</tr>
</tbody>
</table>

Specific diagnosis codes identifying the type of injection was available in ICD-9-CM.

In ICD-10-CM, there is a single code for immunization encounters.

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Description</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>V04.81</td>
<td>Need for prophylactic vaccination and inoculation against influenza</td>
<td>Z23</td>
</tr>
<tr>
<td>V03.82</td>
<td>Need for prophylactic vaccination against streptococcus pneumoniae</td>
<td>Z23</td>
</tr>
</tbody>
</table>

When submitting data for these immunizations, identify a mechanism that will allow identification of the "influenza vaccine", otherwise when the procedure code listed is pulled, all cases with vaccines will be listed.

Establish a report validation process to ensure only the specific information required is pulled into the report.
Next Steps

Planning
- Establish a measure review team
- Identify measures to be reviewed
  - Data definitions
  - Code set conversions
  - Effect of ICD-10 on selected measure
    - Designate specific core measure cases to allow dual/double coding as a trial to see how the information will look and if it is codeable.
- Educate stakeholders regarding the measures which will impact your facility

Educate stakeholders regarding the measures which will impact your facility

Next Steps

- Determine which changes in ICD-10 will impact your facility the most.
- Prepare an assessment report that identifies and analyzes the changes.
- Ensure that reports that contain volumes continue to count cases as a single item when multiple ICD-10 codes are required to report a procedure.
- Ensure all internal and external reports have the right code parameters.

Next Steps

- Prepare educational and action plans to address each problem item identified.
- Monitor the case mix index to see if major changes occur in November and December.
- Analyze and remediate any major changes in data.