

ADT – Edit – Convert ICD-9 to ICD-10

This tool is meant to assist you, *not* to do the coding for you. It is based upon GEMs documentation from CMS. “The purpose of the GEMs is to create a *useful, practical* code to code translation reference dictionary for both code sets, and to offer acceptable translation alternatives *wherever possible*. Therefore, the GEMs *do* include target system alternatives that are more specific than the source system when better alternatives are not available.”

If you wish to read more, see:

<http://www.cms.gov/Medicare/Coding/ICD10/2015-ICD-10-CM-and-GEMs.html>

IT IS NOT A SUBSTITUTE FOR YOUR SPECIFIC KNOWLEDGE OF THE RESIDENT AND THE MEDICAL RECORDS FOR THE RESIDENT.

Often the first choice in a list will be the least specific option when there is insufficient information in the ICD-9 code to select otherwise. We caution you – the first one is not necessarily the most accurate. Again, this is a *guide* to get you to the general code (a ball park code) so that you can then determine the specific code. Use your clinical records to do the actual coding!

An example would be ICD-9 code 707.01 “Pressure Ulcer Elbow”. The closest ICD-10 match will show as L89.009 “Pressure ulcer of unspecified elbow, unspecified stage”. However, your documentation in the medical record for the resident should clearly show which elbow and the stage of the wound. You would not simply select L89.009 but would scroll through the list of right/left and various stages until you found the diagnosis/diagnoses that most closely relate to the records. Also, that single diagnosis could cover several scenarios under ICD-9. Now with ICD-10 you need separate codes for right vs left or in the case of multiple pressure ulcers of different stages on the same elbow. This example is illustrated further below.

As Theresa Lang on the AANAC website, May 6, 2015, says: “As an example ICD-9 has 17 codes for pressure ulcers; ICD-10 has 126 - IT IS IMPOSSIBLE FOR A COMPUTER TO CONVERT THIS. A person still needs to manually know how to code to choose the proper code in ICD-10. GEMs . . . were never indented [sic] (intended) to be used to convert medical records.”

How to use this Conversion Assistance Tool:

The screen is divided into an upper area and a lower area. The top left corner is the Census History. You will select the record in the census for which you wish to dual code. When you do so, the ICD-9 codes will display in the lower left. If you have already started to code the ICD-10, you may also see corresponding codes on the lower right side of the screen.

AHSPRING JR, CHARLES R.

Soc Sec: 0001CN0001 Med Rec: CRA050124
Current Status: In-House 01 / 502B

Click HERE to
Change
Resident

History Records Which Effect Diagnoses

Date	Time	Transaction Type
04/16/2014	14:30	INITIAL ADMISSION

Possible ICD-10 Mapping

ICD-10	Description
L89.009	Pressure ulcer of unspecified elbow, unspecified stage
-- OTHER POSSIBILITIES --	
L89.000	Pressure ulcer of unspecified elbow, unstageable
L89.001	Pressure ulcer of unspecified elbow, stage 1
L89.002	Pressure ulcer of unspecified elbow, stage 2
L89.003	Pressure ulcer of unspecified elbow, stage 3
L89.004	Pressure ulcer of unspecified elbow, stage 4
L89.010	Pressure ulcer of right elbow, unstageable
L89.011	Pressure ulcer of right elbow, stage 1
L89.012	Pressure ulcer of right elbow, stage 2
L89.013	Pressure ulcer of right elbow, stage 3

ICD-9-CM	Description	ICD-10	Description
707.01	PRESSURE ULCER ELBOW		
294.20	DEMENTIA UNSPEC WO BEHAV DISTURB		
414.00	CORONARY ATHRSCLER UNS VESSEL		

These ICD-9 codes correspond to the census record highlighted above.

SELECTING ICD-10 CODES

When you highlight an ICD-9 code in the lower left, a corresponding list of ICD-10 codes will display in the upper right corner. The closest potential match will be listed first. Often this is the least specific option and may not be the best option. ICD-10 codes are color coded.

Green – indicates an exact match

Teal (almost green) – indicates that from the information available in the ICD-9 code, this is a possible match. You may see multiple options that are teal. Keep in mind that just because the wording in the description is identical, does not mean that the meaning is identical. For example, ICD-9 contains 040.1 “Rhinoscleroma” and 040.89 “Other specified bacterial diseases”. The meaning of “Other” here is excluding Rhinoscleroma since that has its own code. In ICD-10 there is only one code A48.8 “Other specified bacterial diseases”. Since there is a single code, the meaning of “Other” here includes Rhinoscleroma. Not identical but they are approximate.

Red – There simply is not enough information in the ICD-9 code to draw any type of conclusion. Do NOT simply disregard these codes because they are red. Again, we refer you to the Pressure Ulcer scenario described above. The system cannot always point you to either right or left, the correct body part, or the correct staging when it was not contained in the ICD-9 code. Given your knowledge of the resident and the medical record, the best answer may be one of the red options.

Blue – is the highlighted record.

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Soc Sec: 0001CN0001 Med Rec: CRA050124
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Possible ICD-10 Mapping

ICD-10	Description
L89.009	Pressure ulcer of unspecified elbow, unspecified stage
--- OTHER POSSIBILITIES ---	
L89.000	Pressure ulcer of unspecified elbow, unstageable
L89.001	Pressure ulcer of unspecified elbow, stage 1
L89.002	Pressure ulcer of unspecified elbow, stage 2
L89.003	Pressure ulcer of unspecified elbow, stage 3
L89.004	Pressure ulcer of unspecified elbow, stage 4
L89.010	Pressure ulcer of right elbow, unstageable
L89.011	Pressure ulcer of right elbow, stage 1
L89.012	Pressure ulcer of right elbow, stage 2
L89.013	Pressure ulcer of right elbow, stage 3

ICD-9-CM	Description	ICD-10	Description
707.01	PRESSURE ULCER ELBOW		
294.20	DEMENTIA UNSPEC WO BEHAV DISTURB		
414.00	CORONARY ATRHSCLER UNS VESSEL		

In the illustration above, to associate L89.012 with 707.01, double click the ICD-10 code, L89.012. You will then see it display in the lower grid to the right of the ICD-9 code as shown below. In this example, the red option is a better choice than the teal option listed first.

ICD-9-CM	Description	ICD-10	Description
707.01	PRESSURE ULCER ELBOW	L89.012	Pressure ulcer of right elbow, stage 2
294.20	DEMENTIA UNSPEC WO BEHAV DISTURB		
414.00	CORONARY ATRHSCLER UNS VESSEL		

If you need to add a second code corresponding to Pressure Ulcer Elbow, please do so through the Census module. This would include ulcer of left elbow if they had wounds on both, or ulcer of right elbow stage 1 if they had multiple ulcers of varying stages at the same site.

Click on the second ICD-9 code and a new list of ICD-10 mappings will display in the upper right corner. Read through the possibilities until you find the most appropriate match. Again, don't forget to reference all documentation in the medical record for support of your choice. Double click to select it

and associate it with the ICD-9 code in the bottom portion of the screen. Continue in the same manner for all ICD-9 codes.

WHEN AN ICD-9 CODE REQUIRES MULTIPLE ICD-10 CODES

Some ICD-9 codes may actually need a combination of two or more ICD-10 codes. As an example, ICD-9 code 115.11 “Histoplasma duboisii meningitis” will require two ICD-10 codes, B39.5 “Histoplasmosis duboisii” AND G02 “Meningitis in other infectious and parasitic diseases classified elsewhere. The lower portion of the screen will appear as below so that you can see that ICD-9 code is made up of the two pieces of ICD-10 code.

115.11	HISTOPLASMA DUB MENINGITIS *	B39.5	Histoplasmosis duboisii *
115.11	HISTOPLASMA DUB MENINGITIS *	G02	Meningitis in oth infec/parastc diseases classd elswhr *

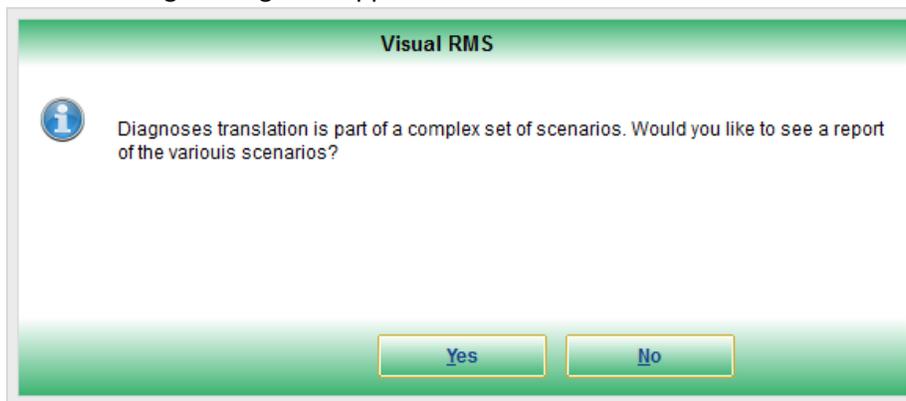
* - Denotes that is a complex scenario not covered by this utility and must be manually coded.

Do not panic, the ICD-9 code has not doubled in your census. It is shown this way so that you can see the association for this conversion purpose.

In other cases, the second code will depend on which of several options you select as the first. For example, ICD-9 code 806.4 has six different scenarios. One scenario says to pick S34.109A OR S34.119A OR S34.129A and then ADD S32.009A. The remaining five options similarly offer you multiple options for the first code and then a second code. The reverse may also be true – two ICD-9 codes may be combined into a single ICD-10 code.

CAUTION: We do NOT error check to be sure that you have combined codes in a logical manner for representing your original ICD-9. For example, if you pick one item from scenario 1 and one item from scenario 2, we do not alert you. We also do not alert you if you only select one item in the complex scenario. You must understand the medical record and carefully select codes based upon a review of the options.

If you highlight any one of the ICD-9 codes, i.e. code 806.4 described above, you will see the list of ICD-10 codes shown in the upper right Mapping display. Double click on any one of the codes as you have previously and the following message will appear:



Answer YES and a report will be displayed on the screen. The report will show you the correct coding for various scenarios. Below is a *snippet* (there are actually six different scenarios for 806.4) to show you the type of information that you will be given – either of the first three in combination with the fourth

could be appropriate. Use this information as a guide when evaluating the medical record to determine the combination of codes to assign.

COLLINS, SUSAN M

806.4 - Closed Fracture of Lumbar Spine with Spinal Cord Injury

Scenario # 1

S34.109A - Unspecified injury to unspecified level of lumbar spinal cord, initial encounter

- OR -

S34.119A - Complete lesion of unspecified level of lumbar spinal cord, initial encounter

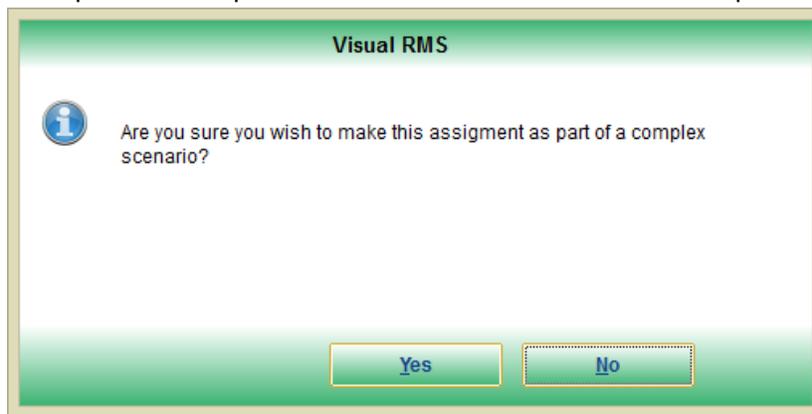
- OR -

S34.129A - Incomplete lesion of unspecified level of lumbar spinal cord, initial encounter

WITH

S32.009A - Unspecified fracture of unspecified lumbar vertebra, initial encounter for closed fracture

When you close this report or answer no and do not produce the report, you will be asked if you wish to add the ICD-10 code as part of a complex scenario. Answer Yes to add the first part of the code.



Select the second ICD-10 code. You will be asked if you wish to produce the report. If you do not need it a second time, answer no. You will then be asked if you wish to make the assignment. If you are sure you have the correct code, answer Yes. You will then be asked if you wish to replace the currently assigned ICD-10.

Yes, will overwrite the first code with this second code. Do this if the first was selected in error.

No, will keep the original code. If you answer No you will then be asked if you wish to add this additional code.

Yes, will assign the new code so that you will see two ICD-10 codes on the single ICD-9.

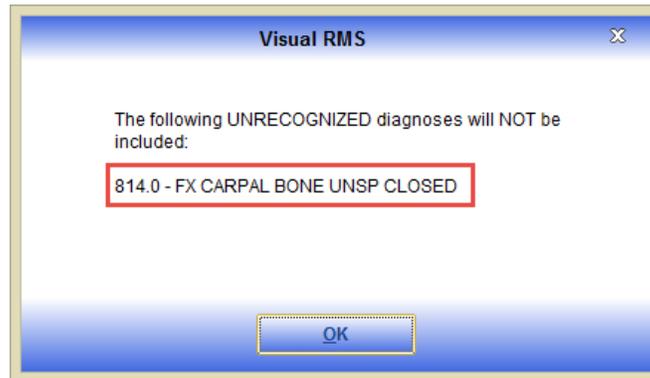
No, will return you to the selection screen.

Continue in the same manner to associate additional ICD-10 codes. You may also complete this process through the Census module.

UNRECOGNIZED CODES

When you select a census record to work with, if any of the ICD codes are unrecognizable – they were manually typed into the system and there is an error or they are from an old data table – you will see an alert. Pay attention to the code that is shown in the warning. You *will not* see it displayed as part of the tool and you *will* have to correct it through the Census

module if this is supposed to be a current diagnosis. The actual ICD-9 code for the example below is 814.00 – it had been manually typed into the census record and the second zero was inadvertently omitted.



REMOVING/REPLACING AN ICD-10 CODE

Option 1: Remove the currently assigned ICD-10 code.

In the lower grid where you can see the ICD-10 codes that are assigned to the ICD-9, highlight the pair where you wish to remove the ICD-10. Double left mouse click. An alert will come up and ask if you want to remove the assignment. Answer Yes to remove the ICD-10. Now you may select/assign another code.

Option 2: Overwrite an existing ICD-10 code.

If you select one ICD-10 code and then find a more accurate alternative, simply double click the better option from the list in the upper right Mapping box. You will be asked if you wish to replace the old code with the new one. YES will remove the previously chosen ICD-10 code from the lower box and replace it with this new code.

You may also edit diagnoses codes through Census – Edit History just as you always have done.

SAVING THE NEW CODES

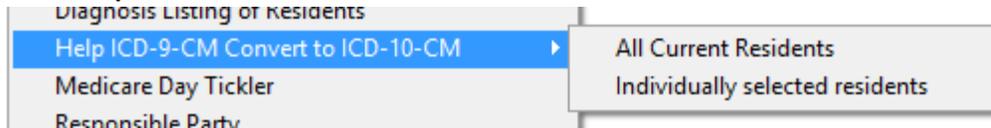
When you exit (click red X in upper right corner of the window) or select another resident or census record, you will be asked if you wish to save. YES will write the records and make them available in the Census module. They will maintain the same 1-A, 2-A, 1-C, etc. order and will retain the same dating information as their corresponding ICD-9 listing. If you need to change this order for any reason, you will do so through the Census module.

REMINDER

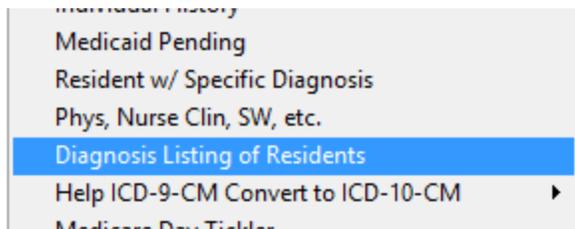
The color **RED** in this utility does *not* mean wrong or incorrect. It simply means that there is no methodology in place to tell you if it is a good match. The original code may not indicate laterality or may not contain sufficient information to be able to select a more specific diagnosis in the new coding system. A red choice may actually be the best choice in some instances. **You must rely on the medical record** to help you make selections.

OTHER REFERENCE INFORMATION

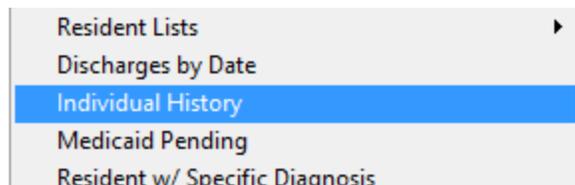
ADT – Reports



These reports will show you the ICD-9 code, the least specific ICD-10 code where insufficient information is included in the ICD-9 code, and additional information if multiple scenarios are possible. Keep in mind that these reports can be long if you have residents with many diagnoses. You may find it easiest to print or screen view a single resident at a time. Or, save the ALL report to pdf and then use the search function to locate individual residents.



This report will list each current resident and then each ICD-9 code followed by each ICD-10 code that is associated with the most current census record. It will also show the Acute/Chronic/Surgical designation as well as the sequence number (i.e. A01, A02, A03, C01, C02).



This report has been modified to also show you the Acute/Chronic/Surgical designation as well as the sequence number and the version number. It will display as A 1 (9) or A 1 (10).