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Informative and educational updates for physicians

NEW CODES FOR 2010¹

Each year ICD-9-CM is updated to reflect new codes, deleted codes and revised codes in which the descriptors have changed. The codes become effective October 1st of each year. This year, ICD-9-CM has implemented over 300 new codes. This newsletter highlights a few of the new code sets.

A new code has been created to track the incidence of this emergent disease which is also known as H1N1 influenza:

- **488.1 Swine Flu**

Late effects of stroke has been expanded to include two new codes:

- **438.13 Late effects of cerebrovascular disease, dysarthria**
- **438.14 Late effects of cerebrovascular disease, fluency disorder (stuttering)**

The acute and chronic venous embolism and thrombosis codes offer new site specificity and new differentiation between deep and superficial vessels:

- **453.50–453.52; 453.6; 453.71–453.79; 453.81–453.89**

Three pre-existing codes have been revised regarding their description. Each involves the addition of the word “acute”:

- **453.40 Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity**
- **453.41 Acute venous embolism and thrombosis of deep vessels of proximal lower extremity**
- **453.42 Acute venous embolism and thrombosis of deep vessels of distal lower extremity**

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This information is for informational purposes only and does not replace the professional judgment and expertise of the individual performing coding based on numerous factors including, but not limited to, documentation in the medical record and other industry recognized coding guidance. Because codes, coding requirements and standards can and do change, the individual assigning codes is reminded to verify the accuracy, specificity, currency and acceptability of such codes and coding methods used.

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Example of Progress Note & Coding

Assessment: Patient with acute deep vein thrombosis involving the right femoral vein

- **Code: 453.41**

Always...

- Assess each chronic condition every year; conditions assessed in 2009 will need to be reassessed in 2010.
- Code to the highest level of specificity.
- Ensure that chart documentation supports ICD-9-CM coding.
- Make sure progress notes include the patient's name and date of service. Notes should be signed and dated by the provider and include his/her credentials. Signature stamps are not accepted by CMS.
- For practices with electronic health records, entries must be electronically signed to be valid (e.g. “electronically signed by”). The electronic signature must be password protected and used exclusively by the individual provider.

Guidelines for Documentation of Chronic Conditions

It is important for providers to always remember that CMS requires at least annual documentation of all chronic conditions. According to CMS, any condition that is taken into account, or affects patient care, treatment or management, should be documented and ultimately coded. Important points to be aware of:

- Always use the most recent coding resources. ICD-9-CM codes are revised annually and new information must be used beginning October 1st of each year.
- For each visit, code first the reason that the patient was seen and also other conditions assessed at the time of the visit—any that require or affect the care and treatment of the patient that day.
- A list of chronic conditions (e.g. problem list) cannot be used as a basis for submission of ICD-9-CM codes. CMS requires that the documentation show evaluation, monitoring or treatment of the conditions documented.
- Documentation must be clear, concise, legible, consistent and complete. For example, it is not appropriate to use an up or down arrow (e.g. in combination with a chemical symbol or laboratory result) as the basis of coding a condition.

¹ World Health Organization, “International Classification of Diseases, Ninth Revision, Clinical Modification, 6th Ed.” National Center for Health Statistics 2009 1-112. Web. 2 Dec 2009. http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm