

THE PULSE

Medical Unit Newsletter

Department of Business & Industry
Workers' Compensation Section

Division of Industrial Relations
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This newsletter is not intended to provide legal advice to the reader. Legal opinions or interpretations of statutes and regulations referenced should be sought from legal professionals.

ICD-10: COMING TO THE WORKERS' COMP NEAREST YOU

The Centers for Medicare and Medicaid Services (CMS) mandated use of the ICD-10 coding system beginning October 1, 2015. The State of Nevada, Division of Industrial Relations (DIR) will adopt CMS guidelines regarding ICD-10 implementation, also effective October 1, 2015. With this in mind, the following information may be helpful.

ICD-10 is divided into two components, similar to ICD-9. The diagnoses portion, ICD-10-CM, is required to be used by all HIPAA (Health Insurance Portability and Accountability Act) compliant health care providers. Although not under the HIPAA umbrella, workers' compensation will follow the same guidelines. Therefore, all health care providers providing services to Nevada's injured workers, must begin using ICD-10-CM diagnoses this fall.

The procedure portion of the new coding system, ICD-10-PCS, is for inpatient hospitalizations only initially. CMS has not released information regarding other health care providers transitioning to ICD-10-PCS. All outpatient providers will continue billing procedures using ICD-9-PCS, CPT codes, and Nevada Specific Codes as described in the Medical Fee Schedule.

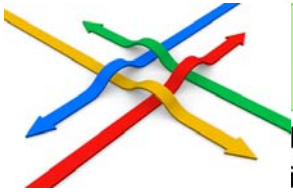
Coding errors will likely delay reimbursement. One potentially significant error will be using unspecified codes in ICD-10. ICD-10 codes are very specific. Non-specific codes should only be used when there are no other more appropriate codes. Correct coding will necessitate a greater level of detail documented in the medical record. Clinicians should become familiar with the increase in specificity required. Body part location, laterality and root causes are examples of three areas requiring improved documentation for accurate coding.

Another anticipated mistake is not adequately preparing staff. It is important that any staff person responsible for providing medical services, billing, reimbursement and/or medical records receive adequate training regarding the impact ICD-10 may have on their job duties. There are a plethora of resources available online, in books and at conferences. Be sure to match the appropriate staff member to the type of information being presented (aimed at professional coders vs clinicians). Practice managers should anticipate that staff may require additional time to apply ICD-10 codes. Routinely practicing these new skills now, easing clinician schedules during the initial transition and having back up plans as needed may avoid a great deal of frustration and possible reimbursement delays later. Some delays are inevitable. Planning ahead and patience may be the most valuable skills of all.

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Don't Miss The 5th Annual Nevada Workers' Compensation Educational Conference

The WCS will host the [5th Annual Nevada Workers' Compensation Educational Conference](#) on August 20-21, 2015 at the Tuscan Suites & Casino in Las Vegas. Attending the conference provides a variety of learning opportunities specifically aimed at Nevada's workers compensation professionals and extensive networking opportunities. This year's conference will include a legislative update regarding changes adopted by the latest legislative session. Fortunately, there is still time to register. The WCS website has all the necessary information including how to register and/or become a vendor or sponsor.



RATERS' CORNER: HEARING IMPAIRMENT

In the quarterly Review Panel meeting, a number of recurrent mistakes concerning the rating of hearing impairments has been observed. Listed below are some suggestions that might be helpful when performing PPD hearing impairments. Please note, all references to page numbers and tables refer to the AMA Guides to the Evaluation of Permanent Impairment, 5th edition.

1. Initially, calculate the decibel sum hearing loss (DSHL) by adding the decibel (dB) loss documented on the audiometric exam at 500, 1,000, 2,000 and 3,000 Hz. Add the dB loss for each ear separately. Use Table 11-1 on page 247 of the AMA Guides, to determine the percentages of **monaural hearing impairment** for each ear. This can be confusing because the percentages given represent monaural hearing impairment only and do not determine the binaural hearing impairment. Binaural hearing impairment is required to determine whole person impairment. According to Step #4 on page 247, consult Table 11-2 to **convert monaural hearing impairment to binaural hearing impairment**. Please note the very important statement in small italics on page 248, under Table 11-2, indicating which axis of the table represents the DSHL for each ear. **The left vertical axis is the sum for the DSHL of the four frequencies for the worst ear and the horizontal axis is the better ear.** This chart is valid only if both the worse and the better ear each have a hearing loss of greater than or equal to 100. If one ear has less than or equal to 100, please see #4 below.
2. Do not take the **monaural** hearing impairment from Table 11-1 on page 247 and transfer this number into Table 11-3 on page 250. Table 11-3 requires the **binaural** hearing impairment from Table 11-2.
3. Apply the binaural hearing impairment from Table 11-2 to determine the whole person impairment from Table 11-3.
4. The last two paragraphs of column one on page 250, include an equation to be used to calculate the percentage of binaural impairment (that is the impairment noted in the left column of table 11-3, page 250) when only one ear exhibits hearing impairment. Use the equation given, allowing 0% monaural **impairment (not DSHL)**, for the unimpaired ear (or the ear with better hearing). Therefore, if one ear has a DSHL greater or equal to 100, but the good ear is less than 100, use the equation given, inserting 0% for **monaural impairment (not DSHL)** of the better ear. Use Table 11-1 on page 247 to obtain the percentage of **monaural impairment (not DSHL)** for the ear with worse hearing. The value from this equation will be the **binaural** hearing impairment, which should then be transferred to Table 11-3 on page 250 to determine whole person impairment.

Lastly, note the tinnitus impairment on page 246 under Section 11.2a. The AMA Guides instructs raters to, "Add up to 5% for tinnitus in the presence of measureable hearing loss if the tinnitus impacts the ability to perform activities of daily living." It should be noted this is **not 5% whole person impairment**. Refer to the comments listed under Example 11-2 on page 251, which demonstrate the 5% added for tinnitus is not added to the whole person impairment percentage. The percent of impairment added for tinnitus is added to the percentage of binaural hearing impairment **before** converting it to whole person impairment. Raters should also note there is a range of possible impairment (0-5%) that may be added for tinnitus. Documentation regarding how the tinnitus impacts the person's activities of daily living is required.

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