Dynamic Chiropractic

Careful Coding: Spinal Anomalies

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Congenital anomalies of the spine are common radiographic findings – common enough, in fact, that the developers of the *ICD-9-CM* coding system thought it necessary to assign diagnosis codes to a small group of them. This select list of anomalies is found in the *ICD-9-CM* under congenital disorders and codes 756.10 through 756.19. (Table 1)[1]

Most doctors of chiropractic are familiar with these codes. This is evident by the frequency with which the codes appear in chiropractic records and on chiropractic claim forms. Unfortunately, some doctors are not aware that the use of these codes can be problematic. Congenital anomalies are not the best diagnoses to list as the reason(s) for care.

Use of the *ICD-9-CM* for even a short period of time brings most practitioners to the realization that some conditions have not been assigned codes. Facet syndrome is an example. While the condition is clinically significant and frequently identified, it does not have an assigned code. The practitioner is thus forced to use a code with a description close to facet syndrome or an unspecified code, usually 724.9. The code 724.2 could also be used. (Table 2)[1] An accurate diagnosis is often communicated inaccurately.

Table 1: *ICD-9-CM* Diagnosis Codes for Anomalies of the Spine

Code	Description
756.10	Anomaly of the spine, unspecified
756.11	Spondylosis, lumbosacral region
756.12	Spondylolisthesis
756.13	Absence of vertebra, congenital
756.14	Hemivertebra
756.15	Fusion of spine (vertebra),congenital
756.16	Klippel-Feil syndrome
756.17	Spina bifida occulta
756.19	Other (platyspondylia,supernumerary vertebra)

The opposite of the above problem also occurs: Some conditions with low clinical significance or low rates of occurrence have been assigned diagnosis codes. The list of spinal anomalies provides examples.

If conditions can be included or excluded from the system, it would seem reasonable to base the decision upon clinical significance and frequency of occurrence. It would also seem reasonable that a system intended to increase communication among health care providers and related third parties would seek accuracy.

While the anomalies listed in the *ICD-9-CM* can alter biomechanics, they are not typically symptomatic. They are also structural and cannot be treated with an expectation of correction. In most cases, this leaves congenital anomalies to be of note only as radiographic findings.

The best example of this is spina bifida occulta. Yochum and Rowe[2] state: "The defect is invariably clinically silent without pain or neurological complication. It is often noticed serendipitously when the patient or physician detects a noticeable step defect at the site of spinous agenesis." They also state: "SBO is a radiographic diagnosis and the only physical clues are a palpable depression or occasionally a sacral dimple."

An anomaly that is a radiographic diagnosis and rarely symptomatic is not a primary diagnosis. Listing an anomaly as a primary diagnosis indicates that treatment is for a congenital pre-existing condition that cannot be corrected. These situations are problematic with any third-party payer, but they are especially problematic in personal-injury and workers' compensation cases, in which the origin of the patient's current condition may be contested.

Table 2: *ICD-9-CM* Codes
That May be Used for Facet Syndrome

Code	Description
724.2	Lumbago
724.9	Otherunspecified back disorders

Spina bifida occulta and other anomalies should be listed as radiographic findings, impressions and when appropriate, as complicating factors. They should not be listed as primary diagnoses unless they are proven to be the source of the patient's pain and/or dysfunction.

In addition to problems with clinical significance and frequency of occurrence, questions can be raised regarding the accuracy of the classifications. Several studies cited by Yochum and Rowe[2] failed to identify spondylolysis in fetal spines or the spines of stillborn and neonatal cadavers. Yochum and Rowe also note that the youngest patient identified as having spondylolysis was 4 months old. Obviously, the classification of spondylolysis as congenital in the *ICD-9-CM* is inaccurate.

The code 738.4 is listed in the *ICD-9-CM* for acquired spondylolysis. This code, which is also used for the acquired form of spondylolisthesis, is the appropriate code for spondylolysis. The congenital code, 756.11, should be dropped from the system. Spondylolisthesis is also included in the *ICD-9-CM* list of congenital anomalies. While a congenital origin of the condition is possible due to elongation of the pars, it is not the most common etiology.

As stated above, the code 738.4 for acquired spondylolysis is also used for acquired spondylolisthesis. The code covers degenerative and traumatic origins of spondylolisthesis, and is the appropriate code in most cases. The congenital code, 756.12, should be used cautiously.

While we have covered the most pertinent problems with the spinal anomaly list, caution is also recommended when considering the use of the remaining spinal anomaly codes. Thankfully, the list is short, which indirectly limits the number of possible coding mistakes.

Proper coding is not easy, but it is a vital part of patient care and must be studied. Efforts should be made to know the codes, the conditions they represent, and the supportive findings that justify their use. This must be done while keeping in mind that the *ICD-9-CM* is less than perfect. In other words, doctors must become well-versed in the use of an imperfect system.

References

1. *International Classification of Diseases, 9th revision, Clinical Modification, 6th Edition, 2011 Office Edition, Volumes 1 &2*. Practice Management Information Corporation (PMIC), Los Angeles, 2010.
2. Yochum T, Rowe L. *Essentials of Skeletal Radiology, 3rd Edition*. Lippincott, Williams and Wilkins, Philadelphia, 2005.

As the *ICD-10* is scheduled for release in 2013 and contains substantially more codes than the *ICD-9*, providers should make sure they are current on any and all code changes when the new version is released for use.

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