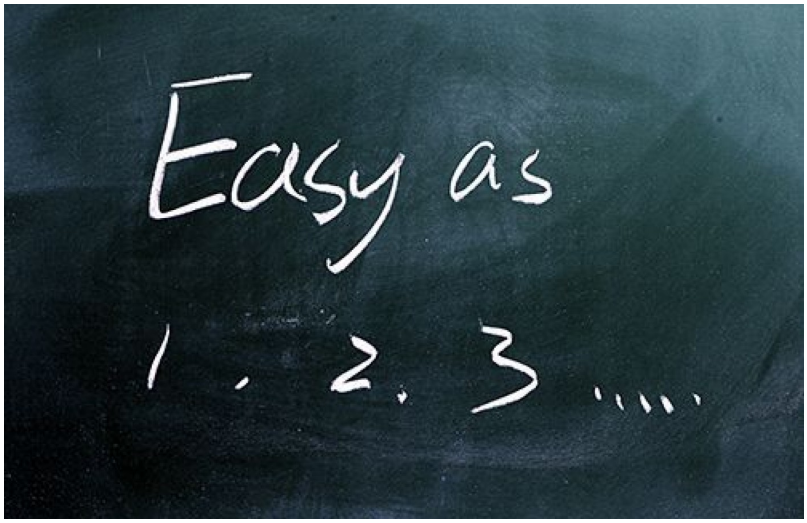
Dynamic Chiropractic



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ICD-10 Coding Tips: Lesson #1

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With the plethora of new codes available in ICD-10, some of the language can be downright overwhelming, and even in the best-case scenario, confusing to decipher. In this initial article in what will be an ongoing discussion of ICD-10 coding, here are some basic rules to keep in mind when choosing ICD-10 codes.

"Other" or "Unspecified"

When using codes that state "other" or "unspecified," note these have special meanings. "Other" or "other specified" codes are designated for use when the information in the medical record provides detail for which a specific code does not exist. For instance, consider a patient for whom the history and exam findings lead you to a diagnosis of facet syndrome. When you search in ICD-10, you cannot find a specific code for "facet syndrome." In this case, you would use the codes *M53.80 to M53.88,* which are noted as "other specified dorsopathies" extending from the occipito-atlanto-axial region to the sacral and sacrococcygeal region.

These codes should be used because you are specifying the diagnosis as "facet syndrome," which fits with the code for "other specified dorsopathies." In basic terms, this type of code is used when you can indicate or describe the specific diagnosis or causation of the condition, but no code corresponds to that precise diagnosis.

On the other hand, when the pain or dorsopathy is determined as sciatica, you can indicate *M54.30 to M54.32* for sciatic pain or *M54.40 to M54.42* for lumbago with sciatic pain, as ICD-10 includes codes specifically for that diagnostic conclusion.

Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. This means you have a patient with a dorsopathy, but cannot clearly determine the specific diagnosis or causation. Therefore, you would use the code *M53.9*, "dorsopathy unspecified," as there is no clear diagnostic conclusion.

Symptoms and Signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. In reality, this takes the place of a doctor wanting to use a "rule-out diagnosis."

For instance, consider a patient who presents with lower back that is severe and the provider is suspicious it may be a disc pathology. However, until a proper scan or other test can provide conclusive evidence of a disc pathology, the diagnosis will start as *back pain M54.5*. Once there is confirmation of the disc pathology, the disc codes may be utilized.

Be sure to code only what you can confirm based on your history, physical examination and testing. This means the initial diagnosis may indeed be pain, but later be amended to a specific condition once confirmed.

Sign(s) / symptom(s) and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances in which signs / symptoms or unspecified codes are the best choices for accurately reflecting the health care encounter.

Each encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.

Another coding conundrum is the use of signs and symptoms when they are routinely associated with a disease process. These codes should not be assigned as additional codes unless otherwise instructed by the classification.

A good example is when there is a diagnosis involving disc disorder; there would be no need to code pain, as the pain is inherent to the disc diagnosis. However, additional signs and symptoms that may not be associated routinely with a disease process should be coded when present. For instance, while a disc condition would be associated with pain, it may or may not include muscle spasm, as muscle spasm is not inherent and therefore should be coded separately, if present, with *M62.830,* which is the code for spasm of the back.

Coding for Spinal Disorders

The coding of spinal disc disorders also can be a bit confusing because ICD-10 provides many new choices that allow for greater specificity. First, consider when you see the code for disc disorder accompanied by other terms and conditions that may include bulges, herniations, protrusions, degeneration, etc. However, the disc descriptions also offer specificity to disc disorders with myelopathy or radiculopathy. Therefore, if the disc were causing myelopathy, the codes would be *M50.00 to M50.03*. However, if the disc were causing radiculopathy (neuritis), it would be coded with *M50.10 to M50.13*.

If the disc were displaced, but did not cause myelopathy or radiculopathy, it would be coded using *M50.20 to M50.23*. If it were degenerated, but not causing myelopathy or radiculopathy it would be coded with *M50.30 to M50.33*. And going a step further, if the disc disorder neither caused myelopathy or radiculopathy, nor were displaced or degenerated, but it can be "specified," then the "other specified" disc disorder could be used: *M50.80 to M50.83*. Finally, if disc pathology is present, but with none of the aforementioned specifics, and it could not be specifically identified, the "unspecified" disc disorder codes (*M50.90 to M50.93*) would be utilized.

As confusing as it may seem at first glance, this is simply a granulated method of description that can range from extremely specific to nonspecific, with separate codes for each derivation. Note spondylosis does much the same, as it has codes for with and without myelopathy or radiculopathy as well.

External Causes of Injury

I would be remiss if I didn't offer a few words about the codes designating external causes of injury. These are the codes that describe the causes of injury, such as the patient was a driver of a car and involved in an accident with a passenger van.

There is no national requirement for mandatory ICD-10-CM external-cause code reporting. Unless a provider is subject to a state-based external-cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required.

This means you may use the codes, but they are not required; nor do they change any factors for care of the patient. External-cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause); the intent (unintentional or accidental, or intentional, such as suicide or assault); the place where the event occurred; the activity of the patient at the time of the event; and the person's status (i.e., civilian vs. military).

If you choose to report them, the external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis. You may never have a patient visit you after being sucked into a jet engine, but if you do, the code is *V97.33XA* for the initial encounter and all visits with active care.

Editor's Note: Sam continues his discussion of ICD-10 coding throughout 2016 in the "Ask the Billing Expert" column To learn more about ICD-10 coding, access Sam's recent webinar ("Making the New Codes Work: A Look at ICD-10 After the Transition"), available in our online webinar archives.

Feel free to submit billing questions to Mr. Collins at sam@hjrossnetwork.com. Your question may be the subject of a future column.

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