Proper Utilization of ICD-10 Codes in the Chiropractic Office

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ICD-10-CM

ICD-10-CM

- The **increased specificity of the ICD-10 codes** requires more detailed clinical documentation in order to code some diagnoses to the **highest level of specificity**
- There are "unspecified" codes in ICD-10-CM for those instances when the health record documentation is not available to support more specific codes
- The benefits of ICD-10 cannot be realized if non-specific codes are used rather than taking advantage of the specificity ICD-10 offers

ICD-10 Pro Tips:

- Be as specific as possible in coding
- Documentation must support the ICD-10 codes
- Avoid unspecified codes such as lumbalgia and cervicalgia

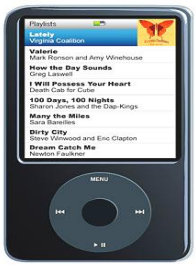
ICD-10 Specificity Update Example

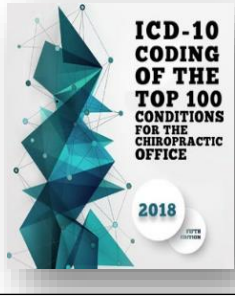
- M48.061 Spinal stenosis, lumbar region without neurogenic claudication
- M48.062 Spinal stenosis, lumbar region with neurogenic claudication

What are your local carriers telling you?

ICD-10 Step to UPDATE

1. Gather your last 40 new patient's charts
2. Make a list of the ICD-10 diagnoses
3. You have your "Top 40 Playlist"
4. Check your EOBs
5. Identify Unspecified Codes and Deleted Codes
6. Convert to 2018 Code Usage





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General ICD-10 Coding Guidelines:

1. ICD-10-CM codes should be listed at their highest level of specificity and characters.

   a. ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters. Use three-character codes only if there are no four-character codes within the coding category. These are the heading of a category of codes.

   You will rarely use a three-character code, if ever.

   b. Diagnosis codes are to be used and reported at their highest number of characters available. Use the 4, 5, 6, or 7-digit code to the greatest degree of specificity available. These provide further detail.

2. Codes that describe symptoms and signs are only acceptable if that is the highest level of diagnostic certainty documented by the doctor. No other diagnosis has been established (confirmed) by the provider. 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.

3. Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

   a. As an example, you would not use a code for muscle spasm along with a strain code, since the finding of spasms are routinely associated with a strain.

4. Additional signs and symptoms that are not routinely associated with a disease may be reported.

5. Coding for diagnoses that are probable, suspected, likely or questionable are not to be coded, because they indicate uncertainty.

   - **"Code what you know"**
   - Rule out and working diagnosis are not to be coded.

6. Code all documented conditions that coexist at the time of the visit that REQUIRE OR AFFECT patient care. (complicating factors) Do not code conditions that no longer exist.

7. Coding for diagnoses that are probable, suspected, rule out, etc. are not allowed for outpatients. *You can write that you suspect a certain condition in your notes, but the code for it will not go on the claim form.*

8. The term "first-listed" diagnosis is now to be used instead of the term "principle" diagnosis. "Code first" notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause. When there is a "code first" note and an underlying condition is present, the underlying condition should be sequenced first.

   "Code, if applicable, any causal condition first" notes indicate that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable. If a causal condition is known, then the code for that condition should be sequenced as the principal or first-listed diagnosis.

9. Multiple codes may be needed for sequela, complication codes and obstetric codes to more fully describe a condition. See the specific guidelines for these conditions for further instruction.

10. The acute condition should always be listed first.

    a. **The worst goes first!**

10. Each unique ICD-10 diagnostic code may be reported only once. If you use a left and right code, you only list the diagnosis with these sides once.

11. If the condition is bilateral and there is no bilateral code, then you have to list the left and right code separately.

12. If a condition is borderline, then it is listed as confirmed.

13. An unspecified code should be reported only when it is the code that most accurately reflects what is known about the patient's condition at the time of that particular encounter.

14. It is inappropriate to select a specific code that is not supported by the health record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

The ICD-10 Characters

Placeholder "X" character - The ICD-10-CM utilizes a placeholder character "X" The "X" is used as a 5th and /or 6th character placeholder at certain 6 and/or 7-character codes to allow for future expansion.

What is the phase of care?

S13.4xxA

Sprain of neck, initial encounter

7th Characters

Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct. The 7th character must always be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.

Ordinality

- Is this the initial or subsequent visit for the complaint?
- Are these symptoms the sequela of the initial event?

7th Character Basic ICD-10 Coding Guidelines:

A – Initial encounter
D – Subsequent encounter
S – Sequela

1. 7th character A:
    - Initial encounter (Medicare says to use this during active care)
    - Used when the patient is **receiving ***active*** treatment** for the condition
        - CMS says this is used as long as the patient is under active care (-AT modifier)

    While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

2. 7th character D:
    - Subsequent encounter
    - After treatment in the active phase of care and the patient is in the **healing or recovery phase of care**
    - Examples of this care are cast change, medication adjustment, or other aftercare following treatment of the injury or condition.
    - In chiropractic, this may be used in the phase when the patient is in **rehabilitation.**

3. 7th character S:
   - Sequela also known as “late effects”
   - For complication or conditions that arise as a direct result of a condition, such as deconditioning of muscle after an injury.
   - When using the Sequela codes, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself.
   - The “S” is added to the injury code only, not the sequela code.
   - The 7th character “S” identifies the injury responsible for the sequela.
   - The specific type of sequela is sequenced first on the claim form, followed by the injury code.

The Role of Radiology in Diagnosis

What is YOUR Policy?

Sequencing of ICD-10 Codes

- Numbers are reported on the insurance claim form because you are communicating to a computer.
- Be sure to use the correct numbers, to the highest degree of specificity. This must be supported by the chart documentation.
- The diagnosis you provide directly relates to the level of care permitted by the third-party payers.

Proper Sequencing of Codes in ICD-10

Medicare Subluxation Complex – Segmental and somatic dysfunction
M99.01 ... segmental and somatic dysf.- cervical region
M99.02 ... segmental and somatic dysf.- thoracic region
M99.03 ... segmental and somatic dysf.- lumbar region
M99.04 ... segmental and somatic dysf.- sacral region
M99.05 ... segmental and somatic dysf.- pelvic region

Optimal sequencing of the codes:

- Neurological diagnosis
  -
  -
  -
- Structural descriptor diagnosis
  -
  -
  - t
  -
- Functional diagnosis
  -
- Soft tissue
  -
  -
- Extremity

Simple Coding Examples:
ICD-10 Cervicalgia M54.2

Combination Coding Examples
M54.30 Sciatica unspecified side
M54.31 Sciatica Right
M54.32 Sciatica Left
M54.40 Sciatica with lumbago unspecified
M54.41 Sciatica with lumbago right
M54.42 Sciatica with lumbago left

ICD-10-CM Specificity
Laterality

- ICD-10 codes include right or left designations. The right side is usually designated with the character 1, and the left side is designated with the character 2. In cases where a

bilateral code is designated, the character 3 may be designated. An unspecified side is either a character 0 or 9 depending on whether it is a fifth or sixth character.

Right Side Ends in Number _____
Left Side Ends in Number _____

- When a patient has a bilateral condition and each side is treated during separate encounters, assign the "bilateral" code (as the condition still exists on both sides), including for the encounter to treat the first side.
- For the second encounter for treatment after one side has previously been treated and the condition no longer exists on that side, assign the appropriate unilateral code for the side where the condition still exists.
- The bilateral code would not be assigned for the subsequent encounter, as the patient no longer has the condition in the previously-treated site.
- If the treatment on the first side did not completely resolve the condition, then the bilateral code would still be appropriate.

Spine is specified by _____

Spinal Coding
0 Multiple sites in spine
1 Occipito-atlanto-axial region Occ-C1-C2
2 Cervical region C3-C6 Deleted
    21 C4-5
    22 C5-6
    23 C6-7
3 Cervicothoracic region C7-T1
4 Thoracic region T2-T11
5 Thoracolumbar region T12-L1
6 Lumbar region L2-L4
7 Lumbosacral region L5-S1
8 Sacral and sacrococcygeal region
9 Site unspecified

M50.320 Other cervical disc degeneration, mid-cervical region, unspecified level(M50.32)
M50.321 Other cervical disc degeneration at C4-C5 level (was M50.32)
M50.322 Other cervical disc degeneration at C5-C6 level (was M50.32)
M50.323 Other cervical disc degeneration at C6-C7 level (was M50.32)

Headache

- Classic Migraine – Migraine with aura
- Common Migraine – Migraine without aura
- Status Migrainosus – Severe migraine that lasts > 72 Hours
- Chronic Migraine – Migraine that occurs > 15 days per month for at least 3 months
- Persistent Migraine – lasts more than 3 months and daily
- Opthalmoplegic Migraines – around the eyes

Headache Consultation

- Aura?
- Onset?
- Frequency and duration?
- Vomiting?
- Palliatives?

Helpful Tips for Survival in the *NEW* World of Coding

- Cervicalgia and Lumbalgia codes are a last resort!
- Disc Disorder vs. Disc Displacement
- Radiculopathy vs. Myelopathy
- What documentation is needed for the following:
  - Postlaminectomy Syndrome
  - Disc Displacement
  - Degenerative Disc Disease
  - Spinal Stenosis
  - Scoliosis
  - Disuse Atrophy

For More Information see the book:
ICD-10 Coding of the Top 100 Conditions for the Chiropractic Office
by Dr. Mario Fucinari www.Askmario.com

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Medicare can now ask for records from up to FIVE years ago. Are you complaint? The OIG stated that a compliance plan (different from HIPAA) is a mitigating factor against fines and/or jail time. If you have a Compliance Plan done in keeping with the OIG Recommendations, it may be your bullet-proof vest!

For a *professionally* created Compliance manual, unique to your office or chart audits contact Mario Fucinari DC, CCSP, CPCO, a **Certified Professional Compliance Officer** for further information.

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Thank You!!