ICD-10: DOCUMENTATION AND CODING TIPS FOR RHEUMATOLOGY

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Presented in Partnership with NORM and Crescendo Bioscience
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Agenda

- Identify the importance of physician documentation and coding
- Review examples of the impact in the changes in ICD-10
- Discuss and recap changes in the coding system

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Why ICD-10 Matters?

ICD-10 affects Payment

- Diagnosis code informs payers the reason for services
- Payment determination often depends on Medical Necessity
- May affect patients coverage in the future

Quality, Cost and ICD-10

- Many PQRS codes are diagnosis specific
- In order to report them the patient must have the specified diagnosis.

PQRS Example

- Patient sample criteria for the RA Measures Group are patients aged 18 years and older with a specific diagnosis of RA accompanied by a specific patient encounter:
- **One of the following diagnosis codes indicating rheumatoid arthritis:**

  ICD-10-CM: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032,
- M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069,
- M05.071, M05.072, M05.079, M05.09, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129,
- M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161,
- M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221,
- M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252,
- M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312,
- M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349,
- M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40,
- M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441,
- M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472,
- M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532,

Proper Use

Signs and Symptoms

- The use of codes that describe signs and symptoms are acceptable when the provider has not established a related, definitive diagnosis.
- Never extrapolate or assume information. Select the codes only from what is apparent in the available documentation.

First Listed Diagnosis

- Always read entire report
- If the problem is different from the definitive diagnosis, select the definitive diagnosis as your first listed diagnosis.

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Unsubstantiated Diagnosis

- The ICD-10 Guidelines state DO NOT CODE a diagnosis as probable, suspected, questionable, rule out or even a working diagnosis
- Code the highest level of certainty through known signs and symptoms
- Educate your providers to include patients signs and symptoms in their patients medical record documentation.

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Unsubstantiated Diagnosis Example:

- The patients X-rays are suggestive of RA with juxta-articular osteopenia and loss of joint space, Blood was drawn for a rheumatoid factor, sed rate and c-reactive protein. Also testing to rule out hemochromatosis.
- DO NOT use Rheumatoid Arthritis – Suggestive
- DO NOT use Hemochromatosis – Rule Out
- Review patients medical record for signs and symptoms which are not included in this documentation. You can report the findings on X-ray, Osteopenia M85.80

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ICD-10 Codes

- Don't limit yourself
- Report all diagnosis codes that pertain to the patients encounter
- If a patients disease is going to impact any treatment or medical decision making for that encounter. Report it.

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2017 ICD-10 Guidelines

Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

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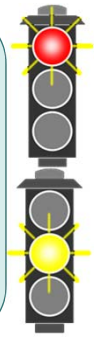
Two Types of "Excludes" Notes

- **Excludes1** note: Indicates "**not coded here**". The code being excluded is never used with this code. The two conditions cannot occur together. Example: B06, Rubella (German measles) has an Excludes 1 of congenital rubella (P35.0).
- **Excludes2** note: Indicates "**not included here**". The excluded condition is not part of the condition represented by the code. It is acceptable to use both codes together if the patient has both conditions. Example: J04.0, Acute laryngitis has an Excludes 2 of chronic laryngitis (J37.0).



An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other.

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Etiology/Manifestation Convention

- Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first**, if applicable,** followed by the manifestation. Wherever such a combination exists, there is a "use additional code" note at the etiology code, and a "code first" note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.

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"With"

- The word "with" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The classification presumes a causal relationship between the two conditions linked by these terms in the Alphabetic Index or Tabular List. **These conditions should be coded as related even in the absence of provider documentation explicitly linking them, unless the documentation clearly states the conditions are unrelated.** For conditions not specifically linked by these relational terms in the classification, provider documentation must link the conditions in order to code them as related.

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Code Assignment and Clinical Criteria

- The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. **The provider's statement that the patient has a particular condition is sufficient.** Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

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Laterality

- 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 (e.g., cataract surgery performed on each eye in separate encounters). 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.

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Zika Virus

- Code only a confirmed diagnosis of Zika virus (A92.5, Zika virus disease) as documented by the provider.
- In this context, “confirmation” does not require documentation of the type of test performed; the physician’s diagnostic statement that the condition is confirmed is sufficient. This code should be assigned regardless of the stated mode of transmission.
- If the provider documents "suspected", "possible" or "probable" Zika, do not assign code A92.5. Assign a code(s) explaining the reason for encounter (such as fever, rash, or joint pain) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

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Revisions and Additions to Chapter 4 Guidelines

- If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned. Code Z79.4, Long-term (current) use of insulin, **or Z79.84, Long term (current) use of oral hypoglycemic drugs, should also be assigned to indicate that the patient uses insulin or hypoglycemic drugs.** Code Z79.4 should not be assigned if insulin is given temporarily to bring a type 2 patient’s blood sugar under control during an encounter.

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7th Character (A and D)

- 7th character "A", initial encounter is used **for each encounter where** the patient is receiving active treatment for the condition.
- 7th character "D" subsequent encounter is used for encounters after the patient has **completed** active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

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Poisoning

- If the intent of the poisoning is unknown or unspecified, code the intent as accidental intent. The undetermined intent is only for use if the documentation in the record specifies that the intent cannot be determined.

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Coding of Pathological Fractures

7th character D is to be used for encounters after the patient has completed active treatment. The other 7th characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for **routine care of fractures during the healing and recovery phase as well as** treatment of problems associated with the healing, such as malunions**,** nonunions, and sequelae.

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ICD-10 Snap Shot of Changes

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Pain

G56.03	Add	Carpal tunnel syndrome, bilateral upper limbs
G56.13	Add	Other lesions of median nerve, bilateral upper limbs
G56.23	Add	Lesion of ulnar nerve, bilateral upper limbs
G56.33	Add	Lesion of radial nerve, bilateral upper limbs
G56.43	Add	Causalgia of bilateral upper limbs
G56.83	Add	Other specified mononeuropathies of bilateral upper limbs
G56.93	Add	Unspecified mononeuropathy of bilateral upper limbs
G57.03	Add	Lesion of sciatic nerve, bilateral lower limbs
G57.13	Add	Meralgia paresthetica, bilateral lower limbs
G57.23	Add	Lesion of femoral nerve, bilateral lower limbs
G57.33	Add	Lesion of lateral popliteal nerve, bilateral lower limbs
G57.43	Add	Lesion of medial popliteal nerve, bilateral lower limbs
G57.53	Add	Tarsal tunnel syndrome, bilateral lower limbs
G57.63	Add	Lesion of plantar nerve, bilateral lower limbs
G57.73	Add	Causalgia of bilateral lower limbs
G57.83	Add	Other specified mononeuropathies of bilateral lower limbs
G57.93	Add	Unspecified mononeuropathy of bilateral lower limbs
G61.82	Add	Multifocal motor neuropathy

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External Causes – Additions

X50.0XXA	Add	Overexertion from strenuous movement or load, initial encounter
X50.0XXD	Add	Overexertion from strenuous movement or load, subsequent encounter
X50.0XXS	Add	Overexertion from strenuous movement or load, sequela
X50.1XXA	Add	Overexertion from prolonged static or awkward postures, initial encounter
X50.1XXD	Add	Overexertion from prolonged static or awkward postures, subsequent encounter
X50.1XXS	Add	Overexertion from prolonged static or awkward postures, sequela
X50.3XXA	Add	Overexertion from repetitive movements, initial encounter
X50.3XXD	Add	Overexertion from repetitive movements, subsequent encounter
X50.3XXS	Add	Overexertion from repetitive movements, sequela
X50.9XXA	Add	Other and unspecified overexertion or strenuous movements or postures, initial encounter
X50.9XXD	Add	Other and unspecified overexertion or strenuous movements or postures, subsequent encounter
X50.9XXS	Add	Other and unspecified overexertion or strenuous movements or postures, sequela

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ICD-10 Reminders

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Osteoporosis

- If the physician does not document that there is a current pathological fracture, choose a code from M81 (osteoporosis w/o current pathological fracture).
- Remember that M80 (osteoporosis with current pathological fracture) is not reported when the patient has a prior, healed fracture.
- Use additional code to identify major osseous defect, if applicable (M89.7-)
- Remember to include a 7th digit for codes in category M80.

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Osteoarthritis

- Coding Hip Osteoarthritis – In categories M16 through M18, the fifth character, when required, addresses laterality. For example, when coding hip OA (M16), the fourth character describes the type of hip OA and whether it is bilateral or unilateral, and the fifth character indicates laterality. Within the M16 category, specific codes also describe OA due to hip dysplasia and posttraumatic OA; in both cases, a fifth character is required to address the issue of laterality.
- Coding Knee Osteoarthritis – The architecture describing OA of the knee under category M17 is similar of that to OA of the hip, minus the section on dysplasia. Assign a 5th character for laterality
- Coding Thumb (CMC Joint) Osteoarthritis – Category M18 covers OA of the first carpometacarpal (CMC) joint; and will require a fifth character to specify laterality in situations where only one hand is affected.
- Osteoarthritis in Other Joints – The codes under block M19 describe primary (M19.0), post-traumatic (M19.1), secondary (M19.2) and unspecified (M19.9-) OA in joints other than the hip, knee and first CMC joint. In this block, the fifth character is used to describe the location of the other joint (such as shoulder, elbow or wrist) and the **sixth** character describes laterality.

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Coding Tips

- Make sure that your coding is as specific as the supporting documentation allows.
- Take proper steps to increase accuracy
- Consistency and communication between providers, coders and billing staff are the keys to success.
- Make denials a main area of focus.

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References:

- https://www.cms.gov/
- http://www.cdc.gov/
- http://www.ama-assn.org/ama

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