DeCoDing ICD-10

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ARAPB

ICD-10 HISTORY FACTS

- ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994.
- Most countries (117) use the system to report mortality data, a primary indicator of health status.
- The release date for ICD-11 is 2017.

ICD-10 FEE FOR SERVICE

- Never designed with the intention of fee for service coding
  - Lack of single payer system
    - No conformity with ICD-10 codes
  - No consensus between Medicare carriers
  - Not EMR friendly

THE IDEA of ICD-10

- More specificity in coding will lead to easier and more accurate data mining
  - Disease burden
  - Disease prevalence
  - Disease cost
- Accurately reflect the medical encounter
  - Embraced by physicians
  - Nightmare for managers

ICD-10 RHEUMATOLOGY

- MORE than 7000 applicable diagnostic codes in rheumatology alone
  - Add another 3000 for non-rheumatology codes that rheumatologists use
- Mandatory ***non-rheumatology*** codes
- Does not affect CPTs (injections and x-rays)
- Does not affect E&M visits

ICD-10 KEY POINTS

- Identity
  - Location/Site
  - Laterality
- Specificity
  - RA
    - With or without **RF**
    - With or without major **organ** involvement
  - Gout
    - With or without **tophi**
  - Osteoporosis
    - With or without current **fracture**

Specify

- Include **mandatory** codes
  - **HIV positive**
  - **Current or former smoker**
  - **Current pregnancy**
- '**Drug-induced**' codes must be **coupled** with a **T-code** (drug name)

ICD-10 EHR CHALLENGE

- Code crosswalk doesn’t always work
  - Not specific enough
  - The number of code options is too vast to list in a problem template
    - Adult Rheumatoid Arthritis --> 500 different codes

RA 714.0 → **M06.0 RA Unspecified**

Gout 274.9 → **M10.9 Gout Unspecified**

Lupus 710.0 → **M32.10 Lupus Unspecified**

Section I. Conventions, general coding guidelines and chapter specific guidelines

The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

A. Conventions for the ICD-1Ø-CM

The conventions for the ICD-1Ø-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-1Ø-CM as instructional notes.

1. **The Alphabetic Index and Tabular List**
   The ICD-1Ø-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a structured chronological list of codes divided into chapters based on body system or condition. The Alphabetic Index consists of the following parts: the Index of Diseases and Injury, the Index of External Causes of Injury, the Table of Neoplasms and the Table of Drugs and Chemicals.
   See Section I.C2. General guidelines
   See Section I.C.19. Adverse effects, poisoning, underdosing and toxic effects
2. **Format and Structure**
   The ICD-1Ø-CM Tabular List contains categories, subcategories and codes. Characters for categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.
   The ICD-1Ø-CM uses an indented format for ease in reference.
3. **Use of codes for reporting purposes**
   For reporting purposes only codes are permissible, not categories or subcategories, and any applicable 7th character is required.
4. **Placeholder character**
   The ICD-1Ø-CM utilizes a placeholder character "X". The "X" is used as a placeholder at certain codes to allow for future expansion. An example of this is at the poisoning, adverse effect and underdosing codes, categories T36-T5Ø.
   Where a placeholder exists, the X must be used in order for the code to be considered a valid code.
5. **7th Characters**
   Certain ICD-1Ø-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.
6. **Abbreviations**
   a. **Alphabetic Index abbreviations**
      NEC "Not elsewhere classifiable"
      This abbreviation in the Alphabetic Index represents "other specified". When a specific code is not available for a condition, the Alphabetic Index directs the coder to the "other specified" code in the Tabular List.
      NOS "Not otherwise specified"
      This abbreviation is the equivalent of unspecified.
   b. **Tabular List abbreviations**
      NEC "Not elsewhere classifiable"
      This abbreviation in the Tabular List represents "other specified". When a specific code is not available for a condition the Tabular List includes an NEC entry under a code to identify the code as the "other specified" code.
      NOS "Not otherwise specified"
      This abbreviation is the equivalent of unspecified.
7. **Punctuation**
   [ ] Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.
   ( ) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers. **The nonessential modifiers in the Alphabetic Index to Diseases apply to subterms following a main term except when a nonessential modifier and a subentry are mutually exclusive, the subentry takes precedence. For example, in the ICD-1Ø-CM Alphabetic Index under the main term Enteritis, "acute" is a nonessential modifier and "chronic" is a subentry. In this case, the nonessential modifier "acute" does not apply to the subentry "chronic".**
   : Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.
8. **Use of "and"**
   See Section I.A.14. Use of the term "And"
9. **Other and Unspecified codes**
   a. **"Other" codes**
      Codes titled "other" or "other specified" are for use when the information in the medical record provides detail for which a specific code does not exist. Alphabetic Index entries with NEC in the line designate "other" codes in the Tabular List. These Alphabetic Index entries represent specific disease entities for which no specific code exists so the term is included within an "other" code.
   b. **"Unspecified" codes**
      Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified.
      See Section I.B.18 Use of Signs/Symptom/Unspecified Codes
10. **Includes Notes**
    This note appears immediately under a three character code title to further define, or give examples of, the content of the category.
11. **Inclusion Terms**
    List of terms is included under some codes. These terms are the conditions for which that code is to be used. The terms may be synonyms of the code title, or, in the case of "other specified" codes, the terms are a list of the various conditions assigned to that code. The inclusion terms are not necessarily exhaustive. Additional terms found only in the Alphabetic Index may also be assigned to a code.
12. **Excludes Notes**
    The ICD-1Ø-CM has two types of excludes notes. Each type of note has a different definition for use but they are all similar in that they indicate that codes excluded from each other are independent of each other.
    a. **Excludes1**
       A type 1 Excludes note is a pure excludes note. It means "NOT CODED HERE!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.
    b. **Excludes2**
       A type 2 Excludes note represents "Not included here". An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.
13. **Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)**
    Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-1Ø-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation.

Other vs Unspecified

Be as **specific** as possible

'**Other** specified' suggests the ***coding*** is not specific enough

"**Un**specified" suggests to the payer that the ***doctor*** is not specific enough

- Target for non-payment!
  - * These codes are acceptable <u>only</u> for symptoms without a diagnosis

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      Codes titled "unspecified" are for use when the information in the medical record is insufficient to assign a more specific code. For those categories for which an unspecified code is not provided, the "other specified" code may represent both other and unspecified.
      See Section I.B.18 Use of Signs/Symptom/Unspecified Codes

Avoid Repeat Coding

Exclusions

Purpose is to **avoid** redundancy

- ‘Acute gout’ ***with*** ‘chronic gout’
- ‘Herniated disc causing radiculopathy’ ***with*** ‘radiculopathy’
- ‘Osteoporosis and current fracture’ ***with*** ‘personal history of OP fracture’

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a. Excludes1

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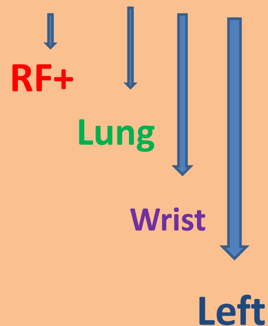
b. Excludes2

A type 2 Excludes note represents “Not included here”. An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

RHEUMATOID ARTHRITIS

- M05.132



ICD-10 RAPID FIRE

- ICD-10 code book
  - **Too big** and onerous
- ICD-10 app
  - Accurate but **time consuming**, especially with multiple code selections
  - Weak with verbal search
- EHR
  - What are its capabilities?
  - **What if you're not using one?**

POSSIBLE EHR/APP DESIGN

"CHRONIC TOPHACEOUS GOUT RIGHT KNEE"

Choose Your Diagnosis First Letter

- ABCDEFGHIJKLMNOPQRSTUVWXYZ

"G"

- Gangrene
- Giant Cell Arteritis
- Gonorrhea
- Gout
- Granulomatosis with Polyangiitis

"GOUT"

M10.0 Acute Gout

M1A.0 Chronic Gout

Chronic Gout Location

- M1A.01 Shoulder
- M1A.02 Elbow
- M1A.03 Wrist
- M1A.04 Hand
- M1A.05 Hip
- M1A.06 Knee
- M1A.07 Ankle/Foot
- M1A.08 Vertebra
- M1A.09 Multiple Joints

Chronic Gout Knee Laterality

M1A.061 **Right**

M1A.062 **Left**

Chronic Gout Right Knee
Does The Patient Have Tophi?

M1A.0611 **Tophi**

M1A.0612 **No Tophi**

CONGRATULATIONS!

YOU HAVE COMPLETED THE CODE!

M1A.0611

CHEAT SHEET

- 90% of rheumatologic diagnostic choices
- One page
- Easily select multiple diagnoses
- Non-EHR compatible

IDENTIFY
FIND COMMONALITIES

JOINT			EXTREMITY
Shoulder	1		
Elbow	2	⟵	Upper Arm
Wrist	3	⟵	Forearm
Hand	4	⟵	Hand
Hip	5	⟵	Thigh
Knee	6	⟵	Lower Leg
Ankle/Foot	7	⟵	Foot
Multiple	9		

IDENTIFY
FIND COMONALITIES

Laterality

- Right 1
- Left 2

Spine

- Cervical 2
- Thoracic 4
- Lumbar 6
- Lumbosacral 7

SPECIFY

- **RA**
  - With RF M05
  - Without RF M06
  - Any Organ involvement
- **OSTEOPOROSIS**
  - With fracture
    - Initial or subsequent encounter
      - Healing routinely or problem (delayed, nonunion, malunion)
  - Without fracture

START CHANGING YOUR HABITS NOW!!

- **RA**
  - **Always indicate RF status**
  - **Nodule – where on the body and what side**
  - **Mention organ involvement – 'with lung disease'**
- **GOUT**
  - **Always indicate if tophi present or not**
- **Laterality – 'OA of the RIGHT knee'**
- **Mandatory diagnostic code**
  - **Placed in problem list or assessment section so they can easily be identified**

ICD-10 CHEAT SHEET

- Note the Key
  - Use when faced with a bolded selection box
  - * options to the side or below
- Alphabetical
- Organized into disease categories
  - Connective Tissue Disease
  - Crystalline Disorders
- Mandatory Code Box
- Common Drugs Box
- Infusion Reaction Box

EXAMPLE CODING CASE

1. Pain in Left Hip

M25.552

2. Elevated Sed Rate

R79.89

The "X" Factor
Maintaining Structure

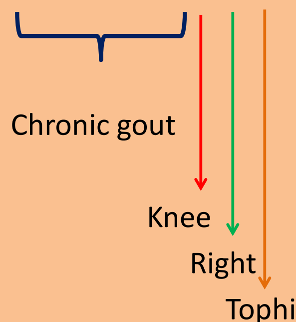
The ICD-10-CM uses the letter "X" as a place-holder. A placeholder "X" is used as a fifth character place-holder at certain six-character codes to allow for future expansion, without disturbing the sixth-character structure. For instance, an initial encounter for accidental poisoning by penicillin is coded to T36.0X1A. The "X" in the fifth character position is a place-holder, or filler character.

The "X" Factor
Maintaining Structure

I like it here!

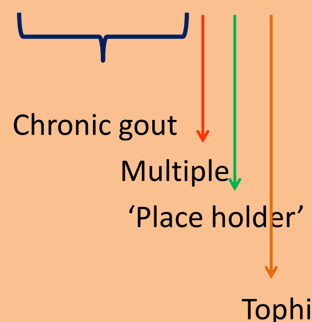
Tophaceous gout *one* site

M1A.0611



Tophaceous gout *multiple* sites

M1A.09X1



Coding Case 1

- 64 yo with RF positive rheumatoid lung disease presents with pain and swelling in the left shoulder. You determine that the shoulder pain is from RA. The patient is on MTX.

- M05.112
- Z79.899

Coding Case 2

- 83 yo male with right wrist pain. You determine the pain to be from osteoarthritis. Right wrist x-ray also showed chondrocalcinosis.

- M19.031 (OA right wrist)
- M11.31 (chondrocalcinosis right wrist)

Coding Case 3

- Patient consults you for posture change. Five years ago she suffered from a spinal fracture from coughing. Imaging showed findings c/w an osteoporotic compression fracture. You find her to be kyphotic.

➢ M40.04 (thoracic kyphosis)
➢ Z87.310 (personal history of osteoporotic fracture)

Coding Case 4

- 64 yo F, RF negative rheumatoid arthritis, well controlled on a TNF inhibitor, now presents with a diffuse rash and Lupus antibodies. You determine she has Drug-Induced Lupus from TNFi. She thinks all her problems started when she quit smoking.

➢ M06.09 (RF negative multiple joints)
➢ M32.0 (Drug-Induced Lupus)
➢ T50.905 (Adverse Reaction to Biologics)
➢ Z87.891 (Former smoker)

Coding Case 5

- 42 yo with Sarcoidosis manifesting as lung disease and uveitis. On high dose steroids.

- D86.0 (Sarcoid lung)
- D86.83 (Sarcoid eye)
- Z79.52 (long term meds – steroids)

Coding Case 6

- Patient presents with bilateral hand pain. You diagnose left sided carpal tunnel syndrome and right 4th trigger finger.

- G56.02 (left carpal tunnel)
- M65.341 (right 4th trigger finger)

Coding Case 7

Established osteoporosis patient presents with acute back pain. On bisphosphonate for 10 years.

You diagnose an acute spinal compression fracture. Labs last week show Vitamin D deficiency.

- M80.08XA (osteoporosis with spinal fracture initial encounter)
- E55.9 (vitamin D deficiency)
- Z93.83 (long term meds – bisphosphonates)

Coding Case 8

- 54 yo with Sjogrens Syndrome with typical sicca but no major organ involvement. The patient has secondary fibromyalgia.

- M35.01 (Sjogrens – eye)
- M79.7 (fibromyalgia)

Coding Case 9

- Your patient with stable Pagets of the left hemipelvis now presents with acute right lumbar radiculopathy.

➢ M88.88 (Pagets – pelvis)
➢ M54.16 (Right lumbar radiculopathy)

Coding Case 10

- Established patient on allopurinol for chronic tophaceous gout presents with a hot right great toe.

➢ M10.071 (acute Gout right foot)
➢ Z93.899 (long term meds – other)