ICD-10-CM Updates for Radiology

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ICD-10-CM Updates for Radiology  
June 16, 2016

• Agenda
  • Review the impact of diagnosis codes on reimbursement
  • Highlight the known changes to the code set
  • Ask the right questions to monitor quality of the production

• Diagnosis Codes Impact Reimbursement
  • The data submitted in 2014 determines the financial adjustment in 2016; 2015 determines 2017 and so on
  • ICD-10-CM is a responsive code set
    • 2,000 +/- new codes effective 10/1/16
    • Details and impact on documentation moving target
    • Grace period for “unspecifed” ending in 5 months
    • Impacts value-based modifiers, MIPS, PQRS
  • Code Freeze is Over
    • Some of the code change proposals are still open for public comment at the time it was released.
    • Nearly 2,000 known new codes.
    • The official 2017 ICD-10-CM Addenda and Guidelines will be posted sometime in June to the following location on the NCHS website:
      • http://www.cdc.gov/nchs/icd/icd10cm.htm
  • Medical Necessity
    • ICD-10-CM Remains the primary tool to communicate medical necessity
    • “… support (of) the intensity and frequency of the service met but that it did not exceed the patient’s clinical needs.”
    • “…the patient’s condition is the key factor in determining medical necessity.”
  • Common Ground
    • PQRS – Quality Reporting
    • MIPS – Merit-Based
    • VM – “Value”
    • Alternative Payment Models
    • Medical Necessity Denials
• **Categories to Explore in Detail**
  - **Updates Focus on Key Details**
    - **Location**
      - Specific site
      - Laterality
      - Individual vessel (graft vs. native)
    - **Severity**
      - Acute vs. chronic
      - Traumatic vs. non traumatic
      - With/without …
    - **Context**
      - Primary vs. secondary
      - s/p relevant procedures
      - History of …
      - Due to …
    - **Story**
      - Initial vs. subsequent
      - How/where/why
  - **Neoplasms**
    - **New Codes:**
      - Gastrointestinal stromal tumor (GIST) subcategory C49.A-
      - Neoplasm of unspecified behavior of specific genitourinary organs such as the kidneys (subcategory D49.5-)
      - Castleman disease, a type of lymphoproliferative disorder (D47.Z2)
    - In category C81 (*Hodgkin lymphoma*), the term “classical” has been deleted from the code definitions to be consistent with current usage.
    - The code for elevation of prostate specific antigen (PSA) has been replaced with two new codes:
      - Elevated PSA (R97.20) and “Rising PSA following treatment for malignant neoplasm of prostate” (R97.21).
    - Two new codes have been created for “Hormone sensitive malignancy status” (Z19.1) and “Hormone resistant malignancy status” (Z19.2)
      - Report in addition to the neoplasm code to indicate whether the cancer responds to hormone therapy.
  - **Endocrine**
    - New code (Z79.84) has been established for long-term use of oral hypoglycemic drugs.
    - Numerous diabetes codes have been revised and expanded to provide additional information about proliferative diabetic retinopathy and diabetic macular edema.
    - DM “WITH” Other Conditions
      - Alphabetic Index –
      - “with” means due to, associated with
      - does not have to be documented as such in the medical record
• Cardiovascular
  • New/Revised codes:
    • Hypertensive urgency (I16.0)
    • Hypertensive emergency (I16.1)
    • Unspecified hypertensive crisis (I16.9)
    • Infarction due to occlusion of bilateral precerebral/cerebral arteries (I63.-)
    • Nontraumatic subarachnoid hemorrhage from the anterior communicating artery (I60.2)
    • Precerebral/peripheral artery aneurysm and dissection (I72 / I77.7)

• Respiratory
  • New code for mediastinitis (J98.51).

• Gastrointestinal
  • New codes have been established for:
    • Necrotizing enterocolitis outside of the neonatal period (K55.3-)
    • Irritable bowel syndrome with constipation (K58.1) and other irritable bowel syndrome (K58.8)
    • Drug-induced constipation (K59.03) and chronic idiopathic constipation (K59.04)
    • Exocrine pancreatic insufficiency (K86.81)
    • Microscopic colitis (K52.83-)
    • Indeterminate colitis (K52.3)
    • Toxic megacolon (K59.31) and other megacolon (K59.39)
  • More specificity needed for:
    • Category K85 (Acute pancreatitis) - capture the specific type of acute pancreatitis, such as biliary or alcohol-induced, and whether there is necrosis or infection.
    • Subcategory K55.0- (Acute vascular disorders of intestine) will be expanded to include specific and detailed codes for various types of intestinal ischemia and infarction.

• Musculoskeletal
  • New codes
    • Bunion and bunionette (M21.6-)
    • Pain in the joints of the hands (M25.541 – M25.549)
    • Mid-cervical disc disorders (M50)
    • Atypical femoral fractures (M84.75-)
  • Reclassification(s)
    • Periprosthetic fractures are currently classified as mechanical complications (subcategory T84.0-) moved to M97
      • The new codes will require a 7th character for the encounter.
    • There are numerous revisions to subcategory M26.6- (Temporomandibular joint disorders) to reflect laterality.
• **Genitourinary**
  - New codes have been added for:
    - Testicular pain (N50.81-), scrotal pain (N50.82), and chronic bladder pain (R39.82)
    - Hydronephrosis with ureteropelvic junction obstruction (N13.0)
    - Bacteriuria (R82.72) and other abnormal microbiological findings in urine (R82.79)
    - Voiding difficulties (R39.19-)
    - Specific types of dysplasia of the prostate (N42.3-)
    - Asymptomatic microhematuria (R31.21) and other microscopic hematuria (R31.29)
    - Erectile dysfunction following radiation therapy and other treatments (N52.3-)
    - Pre-pubertal vaginal bleeding (N93.1)
  - Increased specificity
    - Inflammatory disorders of the breast (N61)
      - mastitis without abscess (N61.0)
      - abscess of breast and nipple (N61.1).
    - Noninflammatory disorders of ovary, fallopian tube and broad ligament (N83) replaced with specific codes for laterality.
      - For example, there is now a specific code for a corpus luteum cyst of the left ovary (N83.12)

• **Obstetrics**
  - Location …
    - Scar from previous cesarean delivery
      - low transverse (O34.211),
      - vertical (O34.212), or
      - unspecified (O34.219)
  - Context …
    - New codes (Z31.7 and Z33.3) have been established for services provided to a gestational carrier

• **Neurologic**
  - New codes:
    - For patient’s score on the NIH Stroke Scale (NIHSS), (R29.700-R29.742)
    - Total Glasgow coma scale score codes (R40.24-) now require a 7th character to indicate when the score was recorded (i.e., in the field, on arrival in the emergency department)

• **Injury**
  - Deleted codes for concussion with LOC more than 30 minutes; now only 3 choices for concussion
    - Concussion w/o loss of consciousness (S06.0X0-),
    - Concussion w/ LOC 30 minutes or less (S06.0X1-); and
    - Concussion w/ LOC of unspec.duration (S06.0X9-).
  - Still adding codes for specific laterality
    - Fracture of the skull base (S02.1-),
    - Orbital floor (S02.3-),
    - Maxilla (S02.4-),
    - Mandible (S02.6-),
    - Jaw dislocation (S03.0-)
• Complications
  • Revisions for reporting more specificity
    • Postprocedural hemorrhage (ongoing) vs. postprocedural hematoma (stopped)
    • These changes affect multiple categories (D78, E89, G97, H59, H95, I97, J95, K91, L76, M96, and N99).
  • Revision(s) to report the complication is caused by the device.
    • For example, code T82.817 has been revised from “Embolism of cardiac prosthetic devices, implants and grafts” to “Embolism due to cardiac prosthetic devices, implants and grafts.”
  • Revision(s) to report the specific device
    • For example, category T85 now allows specific reporting of complications affecting a neurostimulator generator vs those affecting an electrode (lead).

• Z Codes
  • Four codes have been established for minimally invasive procedures converted to open procedures:
    • laparoscopic (Z53.31),
    • thoracoscopic (Z53.32),
    • arthroscopic (Z53.33), and
    • other procedures (Z53.39).
• **Guidelines**
  - Changes to the actual guidelines
    - We do not have the official guidelines changes (YET)
    - They are due out any day
    - We will provide you a special update on the guidelines shortly after we receive them
  
• **AHA Coding Clinic Q&A**
  - **AHA Coding Clinic Q3 2015**
    - Q: Non-union, requiring additional surgery to remove the prior fixation device
      - Subsequent encounter?
      - Initial encounter due to new treatment plan?
    - A: Care of complications of fractures, such as malunion and nonunion should be reported with the appropriate 7th character for subsequent care with non/malunion.
    - Q: 3 days post-discharge, imaging done for pain at the fracture site. X-ray shows improper alignment. Is improper alignment synonymous with nonunion?
    - A: An improper alignment of the fracture is not a nonunion of the fracture. This is still active treatment. The 7th character would be “A” initial encounter.
  
• **AHA Coding Clinic Q1 2016**
  - Q: Instructional note at category M50 (Cervical disc disorders) states “Code to the most superior level of disorder.” Does this directive apply only to adjacent levels? If several regions, different levels, are affected, is the code for only the most superior level assigned or can both levels be coded?
  - A: The intent of the note is to code each disorder at the most superior (highest) level. For example, if several regions are affected (e.g., C3-C4 and C5-C6) that are classified to the same subcategory (e.g., M50) assign only code M50.01 (cervical disc disorder with myelopathy, high cervical region) as C3-C4 is the most superior level.

• **Don’t Forget Orders**
  - Providing Diagnostic Information
    - Referring physicians are required to provide diagnostic information at the time the exam is ordered
    - Coding Clinic 1st Quarter 2012
    - Coding Clinic 1st Quarter 2014
    - Cannot use codes in lieu of a written diagnostic statement.
  
  • Question: …. Is there an official policy or guideline requiring providers to record a written diagnosis in lieu of an ICD-10-CM code number?
  • Answer: Yes, there are regulatory and accreditation directives that require providers to supply documentation in order to support code assignment. Providers need to have the ability to specifically document the patient’s diagnosis, condition and/or problem. Therefore, it is not appropriate for providers to list the code number or select a code number from a list of codes in place of a written diagnostic statement.
    - (AHA Q1 2012), (AHA Q4 2015)
• **New Policy Information**
  - Transmittal # 1630 updated diagnosis codes to various NCD (Effective date 07/01/2016 unless otherwise specified)
    - NCD150.3 Bone DEXA – add M85.8- series (10/1/15)
    - NCD210.3 Colorectal Cancer Screening – allow either Z12.12 or Z12.11 coverable
    - NCD2014.14 LDCT Screening – add F17.2- series
  - “Contractors shall be aware than any claims that are brought to their attention regarding any of the above noted NCD and associated edits shall be adjusted accordingly.”
  - Transmittal # 1630 updated diagnosis codes to various NCD (Effective date 10/1/2015)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M85.811</td>
<td>Other specified disorders of bone density and structure, right shoulder</td>
</tr>
<tr>
<td>M85.812</td>
<td>...left shoulder</td>
</tr>
<tr>
<td>M85.821</td>
<td>...right upper arm</td>
</tr>
<tr>
<td>M85.822</td>
<td>...left upper arm</td>
</tr>
<tr>
<td>M85.831</td>
<td>...right forearm</td>
</tr>
<tr>
<td>M85.832</td>
<td>...left forearm</td>
</tr>
<tr>
<td>M85.841</td>
<td>...right hand</td>
</tr>
<tr>
<td>M85.842</td>
<td>...left hand</td>
</tr>
<tr>
<td>M85.851</td>
<td>...right thigh</td>
</tr>
<tr>
<td>M85.852</td>
<td>...left thigh</td>
</tr>
<tr>
<td>M85.861</td>
<td>...right lower leg</td>
</tr>
<tr>
<td>M85.862</td>
<td>...left lower leg</td>
</tr>
<tr>
<td>M85.871</td>
<td>...right ankle and foot</td>
</tr>
<tr>
<td>M85.872</td>
<td>...left ankle and foot</td>
</tr>
<tr>
<td>M85.88</td>
<td>...other site</td>
</tr>
<tr>
<td>M85.89</td>
<td>...multiple sites</td>
</tr>
</tbody>
</table>

• **Bone Mineral Density Studies**
  - Note that CMS has **not** added the codes for unspecified site, such as M85.80 other specified disorders of bone density and structure, unspecified site).

• **Lung Cancer Screening**
  - CMS has added codes for current smoking, in addition to the codes for personal history of smoking that were previously covered.
  - Effective February 5, 2015, ICD-9-CM code **305.1** (Tobacco use disorder) is covered.
  - Additionally, the following ICD-10-CM codes are **covered** effective October 1, 2015:

<table>
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<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F17.210</td>
<td>Nicotine dependence, cigarettes, uncomplicated</td>
</tr>
<tr>
<td>F17.211</td>
<td>...in remission</td>
</tr>
<tr>
<td>F17.213</td>
<td>...with withdrawal</td>
</tr>
<tr>
<td>F17.218</td>
<td>...with other nicotine-induced disorders</td>
</tr>
<tr>
<td>F17.219</td>
<td>...with unspecified nicotine-induced disorders</td>
</tr>
</tbody>
</table>

• Note that Medicare covers LDCT only for current or past dependence on cigarettes, not other nicotine-containing products.
• The ICD-10 code for current smoking will not be implemented for LDCT till July 1, 2016
  • Some of last year’s claims will be beyond the timely filing deadline by then.
  • The ACR says CMS has advised them that until July 1, providers can report the dx code for history of smoking on the claim for a current smoker in order to get the claim processed.

• Diagnostic Mammograms
  • CMS is removing more than 20 nonspecific diagnosis codes from the covered list for diagnostic mammograms, retroactive to October 1, 2015. Examples include code N60.09 (Solitary cyst of unspecified breast) and C50.019 (Malignant neoplasm of nipple and areola, unspecified female breast).
  • Make sure you review all of the ICD-10-CM codes that are now covered for diagnostic mammograms.

• Don’t Forget Quality Measures
  • PQRS Challenges
    • What happens when there is no cross-over between an LCD and a PQRS measure for ICD-10 codes?
    • Example – Measure 418 (Osteoporosis management in women who had a fracture) - Pathological fracture ICD-10-CM codes not included

• Known Challenges
  • Delays in updating the coverage edits
  • Pending claims to avoid reprocessing hassles
  • Denials with unspecified codes
  • Denials with status codes (history of, s/p, etc.)
  • Ask the right questions
    • More than lag days
    • More than days in AR
    • Review diagnosis codes by provider/modality
  • Compare codes
    • Unspecified?
    • 2ndry codes?
    • Degree of severity
• **Examples:**
  • Example 1 -
    - **Impression:**
      - 1.8 cm anterior-posterior full-thickness tear of the supraspinatus tendon with 1.5 cm of medial retraction. Mild volume loss of the supraspinatus muscle
      - M75.102 vs **M75.122**
  • Example 2 –
    - **Impression:**
      - Fracture lateral to posterior lateral tibial plateau
      - Complete mid substance anterior cruciate ligament and medial collateral ligament tear
      - Vertical longitudinal tear at the meniscus most pronounced along superior margin
      - S82.145A vs S83.512A vs S83.412A vs **S83.242A M25.462**
  • Example 3 -
    - **History:** Pain and trauma *(CT chest w/contrast)*
    - **Findings:** Displaced fracture of the lateral third of the left clavicle
    - **Impression:** Displaced left clavicular fracture
    - S42.032A **R07.9**
  • Example 4 -
    - **Impression:**
      - Again noted are right-sided C7 and T1 transverse process fractures. No displaced rib fracture is seen. Close follow-up chest x-ray is recommended.
    - S22.018A **R07.9**
  • Example 5 -
    - **Clinical indications:** Trauma related pain, gunshot wound to the face and head
    - **Findings:** There is a gunshot wound to the face and head, with multiple metallic bullet fragments within the right frontal lobe … there is a right frontal extra-axial hemorrhage anteriorly measuring up to 10mm in thickness. … Calvaria fracture of the right frontal bone with approximately 3mm displacement in the midline.”
      - S06.3—vs S02.0— vs S02.4— vs S01.8—vs **R51 G93.9**

• Monitor the Entire Process
• Abstract carefully
  - Coding : translating clinical language into an established code set for reporting purposes
• Beyond matching words
  - Coders need to understand clinical language to appropriate abstract the conditions into codes.
  - Understand your provider’s most common conditions
• **Key Terms – Spinal Imaging**
  - Degenerative disc disease - follow the alphabetic index *(Degeneration, intervertebral disc)* and make sure you follow the hierarchy
  - Discogenic disease spine – another term for degenerative disc disease
  - Disc degeneration – same as degenerative disc disease
  - Degenerative facet disease – follow the alphabetic index *Degeneration, facet joints* – see *Spondylosis*, report degenerative facet disease as spondylosis for the specific region.
- Disc space narrowing – This term is not typically in the Impression, but rather, in the body of a report as one of the radiological findings associated with degeneration and spondylosis.
- Foraminal stenosis follow the alphabetic index – all of these codes are in category M99 therefore if other diagnoses are documented that are causing foraminal stenosis, do not report.
- Foraminal narrowing - same as stenosis. This is indicated by the alphabetic index which states Narrowing (see also Stenosis)

- Bottom up coding
- Keep Conditions in Context
  - ICD-10-CM directs coders to assign I50.9 for heart failure without any reference to also code J91.8, pleural effusion in other conditions classified elsewhere.
  - PE is commonly seen with CHF. Ordinarily the PE is minimal and is not specifically addressed. In this situation it should not be reported. It is acceptable to add the PE as an additional diagnosis code IF the condition requires either therapeutic intervention or diagnostic testing.
  - AHA Coding Clinica Q2 2015

- Discuss Options with Providers
- When is Enough – Enough?
  - What the primary reason the imaging was requested?
  - What chronic conditions will impact the medical decision making for this encounter?
  - What risk factors may impact the patient’s outcome for this condition?
  - What information is required by the code set?
In Summary
- ICD-10-CM is \textit{NOT} a One and Done Install
  - Go-Live vs. Implementation process
  - Mechanism for communicating Medical Necessity
  - Tool to facilitate other changes in the business of medicine
- Education/Resources
  - Data suggests that a single 90 min. billing and coding education session is effective in preparing those with limited experience to competently bill and code.
  - \url{www.ncbi.nlm.nih.gov/pubmed/23277302}
  - Education is an on-going requirement
    - New codes
    - New guidelines
    - Feedback from internal/external auditing
  - Not optional
  - Not always “free”
  - Not something to delegate
  - Not always convenient
  - Not always boring

A complete listing of all of the code changes (as of 6/16/16) can be found at: \url{ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2017/NewICD10CMCodes_FY2017.txt}

Thank You!

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