ICD-10: 26 Tips You Absolutely Want to Know!
The 10th edition of the *International Classification of Diseases* (ICD-10) is almost upon you! Chances are you've been preparing, but the magnitude of the changes coming seems overwhelming to many physician practices. To help you manage the transition more easily, we've come up with an A to Z of 26 tips that can help you become more comfortable and more efficient with ICD-10.

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A Is for Active Treatment

- A is used for active treatment of an injury, not only the initial encounter. Injuries require a seventh character extender in ICD-10 that defines the episode of care and, for fractures, the healing status of the fracture. The diagnosis code for the injury remains constant throughout the care of the injury, but the seventh character extender changes.

- This significant change can be confusing because of the short descriptor of A—initial care, D—subsequent encounter, and S—sequela. When does initial care stop and subsequent care begin? The general guidelines that introduce the 2015 ICD-10 book clarified this: Don't just use the seventh character solely on the first service with the patient; continue to use the A seventh character on follow-up visits while the patient is still receiving active treatment. Switch to D for subsequent care when the patient is receiving routine care in the healing or recovery phase.

- When you see the A, don't think initial, think A for Active.
Bilateral Diagnosis Codes

- The eye and ear chapters in ICD-10 are filled with the word "bilateral." Does the patient have otitis in the right ear, left ear, both ears, or an unspecified ear? (Unspecified ear is obviously the wrong choice here.) Both the musculoskeletal chapter and the injury chapter also have laterality in code descriptions. Does the patient have right knee pain, left knee pain, or pain in an unspecified knee?

- If the patient has pain in both knees and there isn't a bilateral code, report two codes, right and left knee pain. Having a bilateral diagnosis code, however, doesn't change how we report the CPT code for procedure performed bilaterally. Continue to use modifier 50 on the CPT code and select a bilateral diagnosis code or report the condition twice using the diagnosis code for right and left.

- Using a bilateral diagnosis code doesn't change CPT reporting.
Causes of Injury

- How did the patient get hurt? What was the cause of the injury?

- ICD-10 (like its predecessor, ICD-9) has an index of external causes that describe how the patient was injured. In both code sets, these codes are optional, although some payers may require external cause codes or slow down payment without them. The external cause codes in ICD-10 are detailed, sometimes funny, and difficult to search. If a worker's compensation or insurance company requires their use, plan on extra time to code the services. There are also three optional occurrence codes as part of the external cause code set. Look for a description of these under tip "Y."

- Collect more detailed information about the cause of injury if payers require external cause codes.
The letter D is a seventh character extender for diagnosis codes from Chapter 19, "Injury, poisoning and certain other consequences of external causes."

The definition is found in its entirety at the start of the general guidelines. "[Seventh] character 'D' subsequent encounter is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing and recovery phase." The guidelines give examples, such as cast change or removal, medication adjustment or other aftercare, and follow up visits following treatment of the injury or condition.

However, not all subsequent care is reported with D. For fractures, there are different seventh characters for fractures with delayed healing, nonunion, and malunion.

D is used on trauma codes for visits during the healing phase. Fracture care has more options.
Examination Coding

- There are twice as many codes for annual gynecologic exam in ICD-10 as an ICD-9, increasing from one to two. And there are twice as many codes for a general medical exam.

- That's because ICD-10 has codes for preventive exams with or without abnormal findings at the time of the visit. Does a provider need to wait for lab results in order to code the visit? No. The general guidelines section of ICD-10 states, "For example, if no abnormal findings were found during the examination, but the encounter is being coded before test results are back, it is acceptable to assign the code for 'without abnormal findings.'"

- Let's say that at a well-child visit the clinician notes enlarged lymph nodes. Code the exam with abnormal findings and, in addition, add the code for enlarged cervical lymph nodes:
  - Z00.121—Encounter for routine child health examination with abnormal findings
  - R59.0—Localized enlarged lymph nodes.

- There are also codes for with and without abnormal finding for general medical exams, vision exams, and hearing exams.

  Reporting examination codes now requires the clinician to say whether it was with or without abnormal findings.
Fracture Coding

- I could write books about fracture coding in ICD-10, but who would read them? When selecting a fracture code, first determine if the fracture is pathologic or traumatic. The clinician determines if the fracture is pathologic. A pathologic fracture is one in a patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that trauma would not normally break a bone in a healthy patient. A stress fracture is caused by repetitive rather than sudden trauma. Both of these types of fractures are in the musculoskeletal chapter and start with the letter M and require a seventh character extender.

- Traumatic fractures are coded in the injury chapter and have multiplied like rabbits. Look for greater specificity in location (proximal, mid, distal), type (greenstick, torus), and episode of care. There are seventh characters for fractures with delayed healing, nonunion, or malunion, and some fractures also have seventh characters that describe the Gustilo classification.

Fractures are fraught with complexity in ICD-10.
Mental health codes are found in Chapter 5, "Mental, behavioral, and neurodevelopmental disorders, F00-F99."

There are a few differences between coding for mental health disorders in ICD-9 and ICD-10. First there's a notation at the start of the intellectual disabilities category that states, "Code first any associated physical or developmental disorders."

Personal history of alcohol use is not in the last chapter along with other personal history codes. It is in the mental health chapter and is defined as alcohol dependence in remission F10.21. Substance-abuse codes are expanded greatly in ICD-10. Substance abuse codes are defined as use, abuse, or dependence, and many include "with" manifestations, such as with hallucination or with anxiety disorders. Use, abuse, and dependence are clinical terms—the clinician must define the patient's condition.

Coding for substance abuse has increased detail in ICD-10.
History of a Condition

- Like its predecessor ICD-9, ICD-10 has codes for family history or personal history of certain conditions. In the index, the history codes are divided into family history and personal history.
- The family history codes are in categories Z80 to Z84 and include neoplasms, heart disease, nervous system disorders, mental health disorders, digestive disorders, and other conditions.
- The personal history codes are in categories Z85-Z99. In addition to personal history of neoplasms, endocrine disorders, mental health issues, circulatory conditions, digestive conditions, and musculoskeletal conditions, there are codes to report ostomy status, acquired absence of a limb, noncompliance, and presence of an artificial medical device. All of these codes are in the last chapter of the ICD-10 book titled, "Factors influencing health status in contact with health services."
- Report personal and family history codes when these are relevant to the patient's treatment.
Injuries Are Going to Hurt

- Be kind to orthopedists, trauma surgeons, and emergency department physicians in October. The largest expansion in ICD-10 is in Chapter 19, the S and T codes, titled "Injury, poisoning and certain other consequences of external causes." These codes make up over 50% of all ICD-10 codes.

- How did they get so big? Location, laterality, and the seventh character extender. The locations of injuries described in ICD-10 are much more specific and, when relevant, include codes for the right and left body part. If there's a sprained ankle or broken bone, it defines which ligament or which part of the bone is injured. And the seventh character extender—discussed in other tip entries in this article—defines the episode of care, for fractures healing status, and for a limited number of codes the Gustilo classification.

- Clinicians: Use detailed descriptions for injuries. Coders: Be prepared to code from x-ray and procedure notes.
Chapter 13, "Diseases of the musculoskeletal system and connective tissue," is the chapter in which we find conditions related to joints, bones, and muscles.

Codes from this chapter are used for patients who have conditions that are a result of a previous injury or trauma or are recurrent conditions and conditions that are a result of the healed injury. A current, acute injury should be coded from Chapter 19. This chapter does include codes for pathologic fractures or stress or fatigue fractures. There is a code for osteoporosis without pathologic fracture and specific codes for osteoporosis with a current pathologic fracture. These codes frequently have laterality in their descriptions. For some conditions, such as osteoarthritis, there is a single code to report that the patient has the condition in multiple sites.

Use codes from the musculoskeletal chapter for non-traumatic conditions related to the bone, joint, or muscle.
Knowing When to Stop

- One in the internal medicine scenario was a typical post-hospital follow-up visit, and CMS selected nine ICD-10 codes for the encounter. Physicians raise their eyebrows because of the sheer number of codes CMS suggested for an office visit (probably at a 99214 level). Because many medical practitioners are selecting their own codes in the electronic health record, submitting nine diagnosis codes will certainly slow the provider down.

- Begin slowly in October when reporting ICD-10 codes and updating a patient’s problem list. In the first months, two accurate codes are better than nine unspecified codes. As the patient’s problem list is updated, gradually report more conditions on the claim form.

- Know when to stop.
Location, Location, Location

- Who hasn't heard a realtor describe the location of an apartment or house as a key factor? But, "location, location, location" could also be an ICD-10 rallying cry.

- There aren't any additional parts of the human body, but ICD-10 defines them in more detail. Was the skin ulcer on the left upper back or the right upper back? Which lid (or lids) suffered from conjunctivitis? Which ligament of the ankle did the patient sprain? The increase in location codes is most notable in chapters related to eyes, ears, skin, the musculoskeletal chapter, and trauma. Clinicians may find that their coders are asking them for more detail, and coders may find that it takes more time to code certain conditions and may require review of diagnostic reports for accuracy.

- One of the key changes in ICD-10 is increased specificity for location.
Mapping

- Medical practitioners see ICD-10 codes in their electronic health record next to the ICD-9 codes and think, "I'm done here, right? My system already has the ICD-10 codes in it."

- But accept those mapped codes with a grain of salt. Or maybe a salt shaker worth of salt. Not all mapped codes are created equal. Some were essentially mapped automatically while others were cross walked by a knowledgeable human being.

- Also, if the code is unspecified in ICD-9, and it is mapped, it doesn't get any more specific in ICD-10. For some conditions, there was an explosion of codes, and so accurate mapping is impossible. For example, in ICD-9 there were about a dozen codes for gout, but there are hundreds of codes for gout in ICD-10, making accurate mapping impossible.

- Verify mapped codes by reviewing the complete ICD-10 description.
Neoplasms

- Experienced coders will find that coding neoplasms is easy and familiar in ICD-10. The neoplasm chart moved from the "N" section of the index to the back of the index, but its utility remains the same.

- When selecting a neoplasm code, start with histology if known or with the location or organ in the neoplasm table. The neoplasm table is organized by location and by type of neoplasm—malignant primary, malignant secondary, in situ, benign, uncertain, and unspecified behavior. Then turn to the tabular listing to select the code. Some cancers have additional codes for location. Breast cancer in male patients expands from two codes to many by including location, and both male and female breast cancer have different codes for neoplasms of the right and left breast.

- Experienced coders will find coding neoplasms straightforward.
Codes in Chapter 15, "Pregnancy, childbirth, and puerperium" begin with the letter O, not to be confused with the number 0. Codes for supervision of normal pregnancy are found in the last chapter of ICD-10.

However, when a pregnancy or delivery is complicated by a maternal condition, just like in ICD-9, there are disease-related codes to describe the condition. Codes from this chapter are only used on the mother's record, never on the baby's record.

Some codes in this chapter are defined by trimester—a new feature of ICD-10. Also, there's a note to use an additional code from the final chapter category Z3A to identify the specific week of the pregnancy. In another change, if the mother is carrying more than one fetus, there are delivery codes that use a seventh character extender to identify the fetus.

Some pregnancy-related conditions are defined by the specific trimester.
Perinatal Coding

- Codes for newborn conditions are in Chapter 16, "Certain conditions originating in the perinatal period," and conveniently start with the letter P.

- Healthy newborns are coded from the final chapter in ICD-10. These perinatal codes are for use on newborn records and are never used on the mother's chart. Use these codes when the maternal condition is specified as the cause (confirmed or suspected) of potential morbidity to the baby, which has its origin in the perinatal period. These codes can also be used when a newborn is suspected of having a condition such as an infection, but it is later found not to exist.

- Use codes in this chapter for conditions originating in the perinatal period.
In the hospital setting, there are rules about "querying" a physician for additional documentation in selecting diagnosis codes. Diagnosis code selection drives the payment amount that a hospital receives for inpatient Medicare stays.

On the physician side, payment is driven by CPT code. When coders ask the physician to clarify a diagnosis code, it usually doesn’t change the amount the practice will be paid. It may, however, change whether or not the practice does get paid. Coders and billers have twin goals when they ask the clinician for clarification: They want to prevent denials by submitting clean claims, and they want to select an accurate diagnosis code based not on coverage but on the patient’s clinical conditions.

Asking for clarification before claims submission can prevent denials.
Risk-Adjusted Diagnosis Coding

- Or the answer to the question: "Who cares? This level of specificity doesn't change how I treat the patient."

- Physicians are understandably unhappy about the expansion of diagnosis coding. Using an electronic health record, most healthcare professionals themselves select the diagnosis code. Searching through the ICD-10 code set in a small pop-up box doesn’t seem like a good use of clinical time.

- However, practices that are or will be part of an accountable care organization or alternative payment model or who have risk-adjusted contracts with private payers will find that part of their reimbursement is based on the level of severity of patients they treat. Reporting conditions with manifestations (bleeding, psychosis, diarrhea) and reporting patients' underlying comorbid conditions are critical as we change reimbursement models.

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The table of drugs and chemicals has new headings for poisoning and a new column and concept of underdosing. Start in the table located in the index and then select a code from the tabular list. These codes are in Chapter 19, the injury chapter, and will require a seventh character extender of A (initial), D (subsequent), or S (sequela).

Underdosing is used when the patient hasn't taken the medication as ordered. Code first the condition that was affected by the underdosing, and code second the code for underdosing. The adverse effect code is used when the patient took the medicine as prescribed and had a side effect or reaction such as nausea while taking erythromycin. In this case, code first the adverse effect (the nausea) and code second the adverse effect code—T36.3X5A Adverse effect of macrolides, initial encounter. If the patient has taken the wrong medicine or a medication that wasn't prescribed for them, use the poisoning accidental code and assign it as the first code.

Reactions to drugs and chemicals are trauma codes and need a seventh character extender.
It is surprising that in a coding system that has grown so large, there are still thousands of unspecified codes. Coders say to avoid them.

But not all unspecified codes are created equal. Do avoid the unspecified codes at the end of a category, such as H10.9, unspecified type of conjunctivitis. Do avoid a code that has the word unspecified in the description twice such as S93.409A, sprain of an unspecified ligament of unspecified ankle, initial encounter.

But sometimes, the clinician can't select a more specific code based on the available information. A patient seen in the office with pneumonia will be correctly assigned J18.9. pneumonia, unspecified organism. Yes, there are more specific diagnosis codes for pneumonia when the organism is known, but in the office setting the organism is rarely known, and the most accurate code is pneumonia from an unknown organism.

Not all unspecified codes are created equal.
The external cause codes in category V00-Y99 got all the press in the discussion of ICD-10. Walking into a lamp post, again, or being on fire while on water skis—these proved irresistible. However, reporting external cause codes remains optional in ICD-10, as it was in ICD-9. Some payers require practices to report these codes to tell them the cause of the injury or accident. In ICD-10, the types of accidents are mindlessly detailed, and practices won't typically have sufficient information to code with the level of detail possible. If reporting external cause codes (V00-Y84), they also require a seventh character extender. External cause codes are not used with codes listed in the drugs and chemicals chart, such as adverse effects of anticoagulant drugs, in categories T36-T50.

External cause codes are optional, per ICD-10, but your payer may require them.
With and Without

- ICD-9 had plenty of codes describing the symptoms or manifestations of the condition with the word "with." ICD-10 doubles down on that.

- There are many combination codes to describe both the condition and the symptoms. The uncomplicated condition is described as uncomplicated or without the symptoms such as "without angina." There are many more that describe the specific manifestation, "with acute exacerbation," "with hallucinations," or "with bleeding." If the patient has a manifestation of their disease, avoid using an unspecified code and avoid using a code with the word "uncomplicated." These codes don't communicate the severity of the patient's disease to the payer or explain higher costs, utilization, readmissions.

- If there is an ICD-10 code that describes a manifestation of the patient's condition, use it.
X-ray Abnormalities and Other Abnormal Diagnostic Test Results

- Codes for abnormal findings on diagnostic tests are found in Chapter 18, "Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified." They are category codes R70-R94.

- For example, R70-79 is abnormal findings on examination of blood, without diagnosis. R73.0-abnormal glucose has an "excludes1" note that includes diabetes. That is, if the patient has diabetes, don't report abnormal glucose as the diagnosis. Use the codes in this section when there is an abnormal diagnostic finding, but the patient hasn't been assigned a definitive diagnosis that explains the finding.

- Abnormal diagnostic test results are reported with codes from the signs and symptoms chapter.
In addition to the external cause codes, there are three categories of codes that further describe how and where an accident occurred. These are also optional—there is no mandate to use them.

Y92 describes where the accident happened, and these are as specific as the rest of ICD-10. Was the patient injured in the kitchen in a prison, in a swimming pool of a nursing home—well, you get the idea. Y93 is the activity code, and it is often redundant with the external cause codes. This code describes for a second time what the patient was doing when the accident occurred. Y99 is the external causes status; is the patient a civilian, in the military, or doing volunteer activity? Do not report a seventh character extender with these occurrence and activity codes.

Hold off on using these codes until you hear otherwise from your payers.
Disappointingly, there is no external cause code for an injury caused by a zebra. With 70,000 codes, couldn't they spare one for kicked by a zebra? Of course, even if there were an external cause code for injury by zebra, it would not start with the letter Z.

The final chapter in ICD-10 is called "Factors influencing health status and contact with health services." Z codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed.

These are equivalent to the V codes in ICD-9. This chapter includes personal and family history of medical conditions, examination codes, and aftercare codes. Aftercare codes are not to be used for the late effects of trauma but for conditions such as long-term use of anticoagulants, ostomy status, or the presence of a pacemaker. These codes are important in the patient's problem list in the medical record and on the claim form to report to the payer historical and current conditions of the patient.

Don't neglect Z codes—they provide important information on both the problem list and the claim form.