

Improving your ICD-10 Diagnosis Coding

Now that ICD-10 is in place and claims are processing, physicians need to focus on the quality of their diagnosis coding. Is the chosen diagnosis code as specific as it could be? Are there additional diagnosis codes that could also be reported? Does the diagnosis code meet the guidelines for the patient's situation? As diagnosis codes are used more and more for alternative payment models and to evaluate quality of care, accuracy of coding will become more important.

Coding Specificity

In July 2015, the Centers for Medicare & Medicaid Services (CMS) announced an agreement with the AMA that Medicare Part B claims generally will not be denied solely based on the specificity of the diagnosis codes, as long as they are from the appropriate family of ICD-10 codes. In addition, some commercial payers have allowed flexibility with the level of detail of diagnosis codes during the early transition phase. CMS' acceptance of the "family of codes" will end in September 2016, and it is uncertain when the commercial payers will no longer allow less specific coding. Therefore, it is best for physicians to begin evaluating their level of coding specificity and ensure they are coding to the greatest level of detail representing the patient's condition and supported by the documentation of the encounter.

Example:

The more specific code of Mild intermittent asthma with (acute) exacerbation (J45.21) is coded instead of the general code of Mild intermittent asthma (J45.2).

Coding specificity includes reporting all diagnosis codes that identify the patient's condition. Reporting the patient's co-morbidities impacting their current diagnosis will demonstrate the necessity of the level of care provided. The additional diagnosis codes will also support risk-adjustment in any quality measures being considered.

Example:

A cardiologist treating a patient for hypertension may focus on coding for the just the hypertension. Also coding the patient's additional diagnoses of diabetes and kidney disease will provide important information about the patient's severity of illness.

Coding Guidelines

ICD-10 introduced new concepts and coding guidelines that differ from ICD-9. Not all of the coding guidelines are intuitive and so it is important to understand the specifics of them. The risk with incorrect coding is that it could be identified in an audit and may result in payment corrections or be looked at more harshly than a simple coding mistake.

The following are a few areas of the guidelines to further consider.

Acute vs. Persistent vs. Recurrent vs. Chronic

Review the guidelines for how the terms acute, persistent, recurrent, and chronic are defined for various diagnoses. The guidelines define how many episodes within a period of time constitute acute, persistent, recurrent, and chronic. In some cases, a condition that may be thought of in one way may be considered differently by the guidelines.

Example:

Diagnosis codes for gastric ulcer include the terms acute and chronic.

K25 Gastric ulcer

K25.0 Acute gastric ulcer with hemorrhage

K25.1 Acute gastric ulcer with perforation

K25.2 Acute gastric ulcer with both hemorrhage and perforation

K25.3 Acute gastric ulcer without hemorrhage or perforation

K25.4 Chronic or unspecified gastric ulcer with hemorrhage

K25.5 Chronic or unspecified gastric ulcer with perforation

K25.6 Chronic or unspecified gastric ulcer with both hemorrhage and perforation

K25.7 Chronic gastric ulcer without hemorrhage or perforation

K25.9 Gastric ulcer, unspecified as acute or chronic, without hemorrhage or perforation

Other Specified vs. Unspecified

Within a category of codes, it is possible to have an “other specified” or “other” code and an “unspecified” code. These two codes have different meanings. An “other” code means that there are codes for some diagnoses, but there is not one specific for the patient’s condition. In this case, the physician knows what the condition is, but there is no code for it. An “unspecified” code means that the condition is unknown at the time of coding. An “unspecified” diagnosis may be coded more specifically later, if more information is obtained about the patient’s condition.

Example:

There are multiple codes for hypothyroidism. If the cause of the patient’s hypothyroidism is known, but is not one of the existing codes, then code E03.8 would be used. If the type of the patient’s hypothyroidism is unknown, code E03.9 would be used.

E03 Other hypothyroidism

E03.0 Congenital hypothyroidism with diffuse goiter

E03.1 Congenital hypothyroidism without goiter

E03.2 Hypothyroidism due to medications and other exogenous substances

E03.3 Postinfectious hypothyroidism

E03.4 Atrophy of thyroid (acquired)

E03.5 Myxedema coma

E03.8 Other specified hypothyroidism

E03.9 Hypothyroidism, unspecified

Initial vs. Subsequent

The concepts of initial encounter vs. subsequent encounter are new in ICD-10. The concepts are only relevant for diagnosis codes for fractures, wounds, sprains, burns, and other general injuries, which are found in Chapters 13 and 19. They are also found in Chapter 20 for external causes of morbidity. A seventh character is used to identify that the encounter is initial or subsequent for the diagnosis code.

A - initial encounter

D - subsequent encounter

A subsequent encounter is coded when a patient is seen for follow up care of a condition that previously had a treatment plan and care. An initial encounter is coded when the patient is seen for a new treatment

of a condition. It is possible for a patient to be seen at a later point for a condition and have it be an initial encounter, if a new course of treatment is established during that visit.

Example:

A patient is seen initially in the emergency department for a second degree burn of the right hand and wrist (T23.291A). The patient receives superficial treatment and is instructed to follow up with a plastic surgeon the next day. When the plastic surgeon sees the patient and establishes a plan of care, the diagnosis is coded as an initial encounter. Additional treatment by the plastic surgeon will be coded as subsequent encounters (T23.291D). If during the course of treatment, the burn is not healing and the plastic surgeon established a new plan of treatment, that visit is coded as an initial encounter (T23.291A).

Conclusion

The quality of diagnosis coding will become more and more important as the industry settles into the use of ICD-10 and begins to use the greater level of detail of the codes in data analytics. It will be necessary for physicians to strive for the highest level of detail in the diagnosis codes, as well as accuracy in the use of codes, based on the coding guidelines. Physicians should look for education and resources that provide the necessary information about coding and the guidelines.

Visit the AMA's website for more resources on ICD-10
www.ama-assn.org/go/ICD-10