Diagnostic Coding Series II: ICD-10 in Radiology

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REVENUE CYCLE MANAGEMENT

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Agenda

- ICD-10 Basics
  - Code Selection
  - Clinical History
  - Specificity
  - Signs & Symptoms
  - Fractures
- Challenging Scenarios
- Medical Necessity Considerations

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Resources

- AMA
- CMS
- AHA

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ICD-10 Basics-Coding Systems

- ICD-10-CM
  - Diagnosis Coding
  - CMS/CDC/NCHS/American Hospital Association
- ICD-10-PCS
- CPT-HCPCS Level I
  - Procedural Coding:
    - Category 1-Procedures
    - Category 2-Quality Measures
    - Category 3-New & Emerging Technology
  - American Medical Association
- HCPCS Level II
  - Drugs, Supplies, Biologicals
  - Payer Specific Codes
  - CMS

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ICD-10 Basics

- ICD-10-CM is the classification system for diagnosis coding. It was developed by the Centers for Disease Control and Prevention for use in all U.S. health care settings.
- Designed for the classification of morbidity (sickness) and mortality (death) information for statistical purposes
- Format:
  - Alphanumeric
  - 3-7 characters

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ICD-10 Guidelines for Diagnostic Services

- Primary diagnosis is defined as the “diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided”
- Should answer the question “Why is this patient having this service?”

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The Radiology Report

Patient Name: DOE, JANE
Birth Date: 01/01/1901
Referring Doctor: DOCTOR, DOCTOR
Acct No.: 12345789
MRN: 12345
Exam Date: 01/01/2022
Exam Description: CT HEAD WO CONTRAST
Reason for Exam: Headache

HEADER

PROCEDURE: CT of the head without contrast

EXAM TITLE

CLINICAL INFORMATION: Headache

CLINICAL HISTORY

TECHNIQUE: CT scan of the head was performed from the vertex to the skull base without use of intravenous contrast. Axial images as well as coronal and sagittal reconstructions were obtained.

TECHNIQUE

All CT scans at this facility use dose modulation, iterative reconstruction, and/or weight-based dosing when appropriate to reduce radiation dose. to as low as reasonably achievable.

Comparison: CT head 6/3/2007

FINDINGS: There is no mass effect, midline shift or acute hemorrhage. Ventricles and CSF spaces are within normal limits. Gray-white matter differentiation is preserved. Visualized orbits, paranasal sinuses and mastoid air cells are unremarkable.

FINDINGS

IMPRESSION:
No mass effect or acute hemorrhage.
Electronically signed by: DOCTOR, DOCTOR

IMPRESSION

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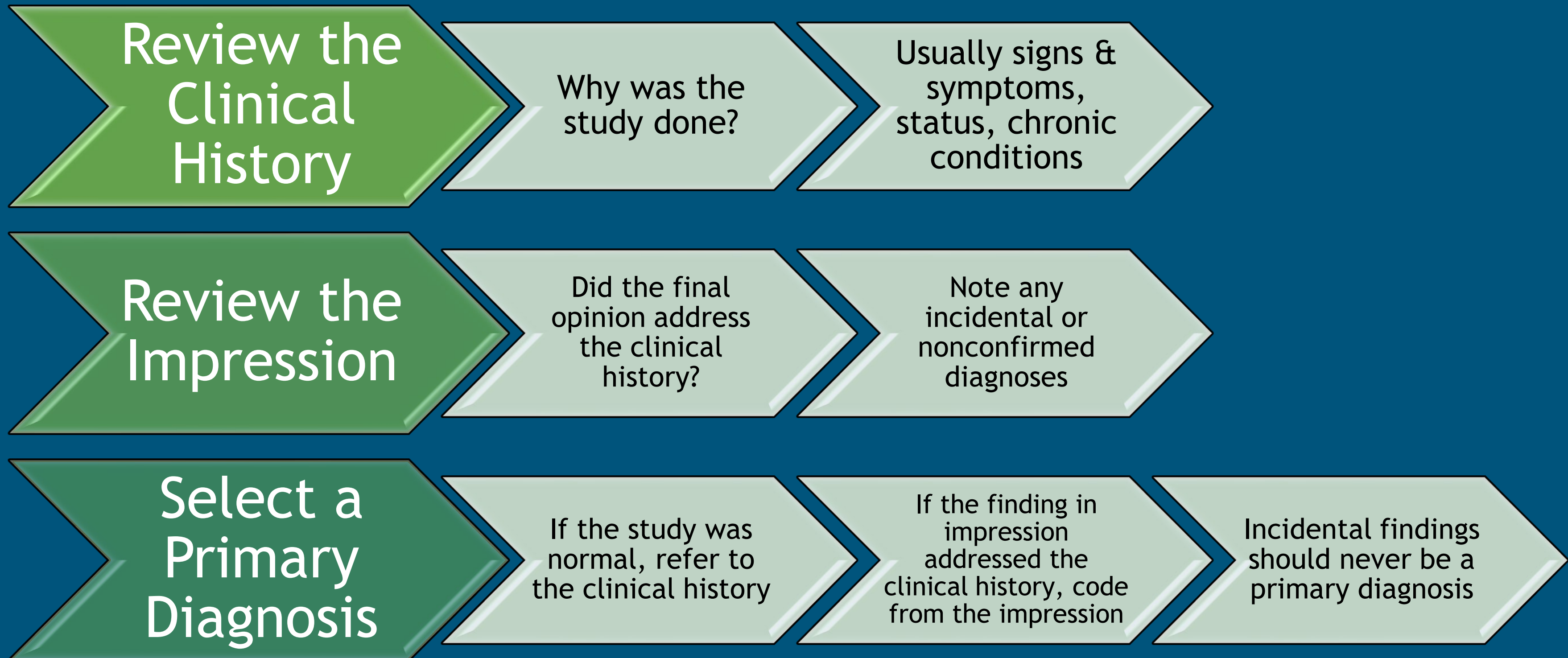
ICD-10 Code Selection Steps



- If study is abnormal but no confirmed diagnosis, refer to abnormal findings section or general conditions for that particular organ/system/structure
- Make sure to also code any pertinent secondary coexisting diagnoses
- Refer to findings sections if needed

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IMPRESSION:
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Electronically signed by: DOCTOR, DOCTOR

IMPRESSION

What would the primary diagnosis code be?

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Specificity

- Always code to the highest level of specificity
- It is not appropriate to nonspecific or less specific code when there documentation to support a more specific code
- If impression is nonspecific, refer to the findings section of the report for specificity

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Clinical History

- When an exam is normal, the coder will refer to the clinical history/reason for the exam.
- If the clinical history is missing, incomplete, nonspecific, or vague, there is an increased risk of denial/nonpayment due to lack of supporting documentation for medical necessity of the exam
- Essential for radiologists to have a relevant clinical history, including any signs or symptoms for the patient encounter

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Signs & Symptoms

- Signs and symptoms are acceptable for reporting when a related definitive diagnosis has not been established or confirmed by the provider.
- Do not code for a sign/symptom that is routinely associated with the patient diagnosis unless the ICD-10-CM manual instructs otherwise
- If a sign or symptom is NOT routinely associated with the patient diagnosis, it may be coded in addition to the diagnosis.
- Check for combination codes

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Fractures-Traumatic

- Key points to consider:
  - Displaced/Nondisplaced
  - Open/Closed
  - Type of Fracture
- 7th Character Designations:
  - Initial Encounter
    - Patient seen in ER
    - Initial eval by ortho or specialist
    - Fracture reduction/treatment
    - Delayed treatment
  - Subsequent Encounter
    - Monitoring or treatment of complications
    - Imaging to monitor healing
    - Normal aftercare/follow-up
  - Sequela Encounter
    - Late/Residual effect
- Determining encounter is a challenge in radiology
- Provider documentation is KEY
  - Documentation for the current encounter should clearly reflect those diagnoses that are current and relevant for that encounter.
    AHA Coding Clinic, First quarter 2015

Fractures-Nontraumatic

- Pathologic:
  - Osteoporosis
    - *Any patient with known osteoporosis that suffers a fracture should not be coded as a traumatic fracture, even if the patient had a minor fall or trauma*
  - Cancer
- 7th character designations for pathologic FX:
  - Initial (A)-Active fracture treatment
  - Subsequent
    - (G)-Delayed healing
    - (K)-Nonunion
    - (P)-Malunion
  - Sequela (S)-Late/residual effect
- Stress fractures, prosthetic-related fractures
- Vertebral compression fractures
  - May be either traumatic or nontraumatic

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Challenging Scenarios

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ICD-10 Codes as Documentation

- It is not appropriate for providers to list a code number or select a code number from a list of codes in place of a written diagnostic statement on the report *(AHA Coding Clinic, 4th Quarter, 2015)*
- A request for imaging should include the relevant clinical information, a working diagnosis, and/or pertinent clinical signs and symptoms (*ACR Practice Parameter for Communication of Diagnostic Imaging Findings)*
- The provider is responsible for providing the documentation for a diagnosis
- The coder is responsible for translating that documentation into the applicable ICD-10 code

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Unconfirmed Diagnoses

- Unconfirmed diagnoses should not be coded
- Terms that indicate a diagnosis is unconfirmed in the impression:
  - “Probable”
  - “Suspected”
  - “Questionable”
  - “Consistent with”
  - “Should be ruled out”
  - “Appears to be”
  - Other similar terms
- “Borderline”-Check the index
- When diagnosis is unconfirmed-code to highest degree of certainty for that visit

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“Rule Out”

- “Rule out”, “Evaluate for”…
- While “rule out” has clinical relevance, there is nothing to code for the radiologist if the study is normal/negative for the condition being ruled out
- Signs and symptoms must exist-documentation is key
- Sometimes the clinical history may not explicitly state “rule out” but is listed as a confirmed diagnosis and no confirmed diagnosis exists after imaging
  - “Pneumonia” on CXR with no confirmed finding/normal study
  - “DVT” or “R/O DVT” on LE Venous Duplex with no confirmed finding/normal study
- If a condition has been established and is being followed and now resolved, the radiology report should make that clear
- Keep in mind there are different coding conventions for inpatient coding and billing

Nonspecific “Injury” or “Trauma”

- When imaging is performed to evaluate a patient who has experienced a trauma and the exam is negative, the signs or symptoms should be coded.
- May also be ordered with a description of the specific type of injury/trauma
  - MVA/Accident
  - Fall
  - Gunshot wound
- If no signs or symptoms are provided it would not be appropriate assign a code for “injury” to area imaged.
- Most appropriate to assign a code from category Z04 in this situation.
- Monitoring use of Z04 codes and education to providers and facilities is key

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"Pain"

- Pain that does not point to a specific body site/system is classified into the Signs and Symptoms category of ICD
- If an order simply states "Pain" without specifying the location of the pain, it is recommended to query referring provider
- If a more specific site of the pain is not provided, it is acceptable to assign the code for pain to the site being imaged *(AHA Coding Clinic, Fourth Quarter 2016)*

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Medical Necessity Considerations

- Check coverage policies
- Improvement Opportunities:
  - Clinical History:
    - When an exam is normal, the coder will refer to the clinical history/reason for the exam.
    - If the clinical history is missing, incomplete, nonspecific, or vague, there is an increased risk of denial/nonpayment due to lack of supporting documentation for medical necessity of the exam
  - Impression
    - Specificity to site (laterality, quadrant, etc.)
- ICD-10 transition lag

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ICD-10 Transition Lag
Example-Extremity Pain

- ICD-9:
  - *729.5-Pain in limb*
- ICD-10:
  - Approximately 30 available codes based on the specific site in the extremity and laterality
  - *M79.609-Pain in limb, unspecified*
- For same diagnosis, coverage *may* have been available prior to ICD-10 transition.
- Providers/Facilities/Systems must provide the level of detail that exists in ICD-10

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MEDICAL NECESSITY:
Common Studies At Risk

- Modified Barium Swallow
  - Coverage often requires a secondary DX
- MRA
- PET Scans
- Preventive Services
  - BMM/DEXA
  - Screening Mammo
  - AAA US Screening
  - Lung CA Screening/LDCT

**Check your individual payor policies*

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MEDICAL NECESSITY: *Common Studies At Risk*

- Duplex
  - R/O, Assess or Possible DVT
  - "Swelling"
    - Swelling of the lower extremity should be coded as M79.89 *(AHA Central Office Response, September 2020)*
    - Should not be coded as "localized" or "generalized" swelling unless explicitly documented as such by the provider.

**Check your individual payor policies*

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Q&A

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Thank you!

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